Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10	Base Reduction Item FY 2009-10 ☑	Supplemental FY 2008-09	Budget Amendment FY 2009-10

Request Title:	Medicaid Program Efficiencies		
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:** October 31, 2008
Priority Number:	BRI-2	**OSPB Approval:**	**Date:** 10-24-08

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
Total of All Line Items	**Total**	2,258,647,383	2,350,295,187	0	2,350,295,187	2,371,583,746	(1,731,018)	2,369,852,728	0	2,369,852,728	(2,463,499)
	FTE	243.8	272.7	0.0	272.7	276.0	0.9	276.9	0.0	276.9	1.0
	GF	723,799,430	714,561,414	0	714,561,414	715,132,818	(865,509)	714,267,309	0	714,267,309	(1,231,749)
	GFE	327,500,000	369,000,000	0	369,000,000	369,000,000	0	369,000,000	0	369,000,000	0
	CF	0	86,153,581	0	86,153,581	96,082,844	0	96,082,844	0	96,082,844	0
	CFE/RF	74,496,317	4,338,776	0	4,338,776	4,346,283	0	4,346,283	0	4,346,283	0
	FF	1,132,851,636	1,176,241,416	0	1,176,241,416	1,187,021,801	(865,509)	1,186,156,292	0	1,186,156,292	(1,231,750)
(1) Executive Director's Office; (A) General Administration, Personal Services	**Total**	20,382,113	19,251,491	0	19,251,491	19,989,456	86,785	20,076,241	0	20,076,241	92,902
	FTE	243.8	272.7	0.0	272.7	276.0	0.9	276.9	0.0	276.9	1.0
	GF	8,523,018	7,994,379	0	7,994,379	8,121,243	43,392	8,164,635	0	8,164,635	46,451
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	731,501	0	731,501	786,800	0	786,800	0	786,800	0
	CFE/RF	2,219,695	1,557,401	0	1,557,401	1,564,984	0	1,564,984	0	1,564,984	0
	FF	9,639,400	8,968,210	0	8,968,210	9,516,429	43,393	9,559,822	0	9,559,822	46,451
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	980,465	1,833,478	0	1,833,478	1,690,479	26,178	1,716,657	0	1,716,657	950
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	469,925	882,945	0	882,945	811,165	13,089	824,254	0	824,254	475
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	23,307	0	23,307	23,626	0	23,626	0	23,626	0
	CFE/RF	24,209	13,377	0	13,377	13,301	0	13,301	0	13,301	0
	FF	486,331	913,849	0	913,849	842,387	13,089	855,476	0	855,476	475

Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☐	Base Reduction Item FY 2009-10 ☑	Supplemental FY 2008-09 ☐	Budget Amendment FY 2009-10 ☐

Request Title:	Medicaid Program Efficiencies			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** October 31, 2008
Priority Number:	BRI-2	**OSPB Approval:**		**Date:**

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	0	2,443,584	0	2,443,584	1,625,334	441,964	2,067,298	0	2,067,298	441,964
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	1,099,292	0	1,099,292	752,667	220,982	973,649	0	973,649	220,982
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	62,500	0	62,500	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	1,281,792	0	1,281,792	872,667	220,982	1,093,649	0	1,093,649	220,982
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	Total	0	4,669,035	0	4,669,035	4,496,355	80,000	4,576,355	0	4,576,355	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	1,362,318	0	1,362,318	1,319,148	40,000	1,359,148	0	1,359,148	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	54,949	0	54,949	54,949	0	54,949	0	54,949	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	3,251,768	0	3,251,768	3,122,258	40,000	3,162,258	0	3,162,258	0
(2) Medical Services Premiums	Total	2,237,284,805	2,322,097,599	0	2,322,097,599	2,343,782,122	(2,365,945)	2,341,416,177	0	2,341,416,177	(2,999,315)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	714,806,487	703,222,480	0	703,222,480	704,128,595	(1,182,972)	702,945,623	0	702,945,623	(1,499,657)
	GFE	327,500,000	369,000,000	0	369,000,000	369,000,000	0	369,000,000	0	369,000,000	0
	CF	0	85,281,324	0	85,281,324	95,217,469	0	95,217,469	0	95,217,469	0
	CFE/RF	72,252,413	2,767,998	0	2,767,998	2,767,998	0	2,767,998	0	2,767,998	0
	FF	1,122,725,905	1,161,825,797	0	1,161,825,797	1,172,668,060	(1,182,973)	1,171,485,087	0	1,171,485,087	(1,499,658)

Non-Line Item Request:	None		
Letternote Revised Text:	None		
Cash or Federal Fund Name and COFRS Fund Number:	FF: Title XIX		
Reappropriated Funds Source, by Department and Line Item Name:	N/A		
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑
Schedule 13s from Affected Departments:	N/A		

CHANGE REQUEST for FY 2009-10 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-2
Change Request Title:	Medicaid Program Efficiencies

SELECT ONE (click on box):

☐ Decision Item FY 2009-10
☒ Base Reduction Item FY 2009-10
☐ Supplemental Request FY 2008-09
☐ Budget Request Amendment FY 2009-10

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:
☒ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: This request is for a total funds reduction of $1,731,018 in FY 2009-10, including $865,509 General Fund savings and 0.9 additional FTE, and; $2,463,499 in FY 2010-11, including $1,231,749 General Fund savings and 1.0 additional FTE, for a series of efficiencies in programs within Medicaid. This request achieves savings and improvements through six Governor's initiatives for Medicaid reform: Medicaid Benefit Package Reform, Health Outcomes Measurement Initiative, Fluoride Varnish Benefit, Hospital Back Up Program Enhancements, Oxygen Durable Medical Equipment Reform, and Serious Reportable Events Initiative.

Background and Appropriation History: The Department is committed to ensuring that clients are healthier when they leave the Medicaid and Children's Basic Health Plan programs than when they entered. To that end, the Department is proposing a set of enhancements to administrative and program functions and interventions designed to maximize the health, functioning and self-sufficiency of Medicaid clients and providers. The primary goals of all four proposals in the Department's Budget Request for FY 2009-10 are to (1) provide a model that delivers seamless, integrated care to clients between different delivery systems, (2) maximize

client health and satisfaction, and (3) achieve greater cost-effective care. The common thread underlying all of the proposals is making the health care delivery system, and access to programs, more outcomes-focused and client-centered. These enhancements and programmatic changes will lead to a more coordinated system based on shared responsibility; where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents.

The Department's set of proposals are divided into four Change Requests:

- DI-5 Improved Eligibility and Enrollment Processing;
- DI-6 Medicaid Value-Based Care Coordination Initiative;
- BRI-1 Pharmacy Technical and Pricing Efficiencies; and,
- BRI-2 Medicaid Program Efficiencies.

The request in DI-5 would improve eligibility and enrollment processing by creating a single state-level entity to enhance and complement the current multiple county-level processes. This entity would streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, create expedited eligibility and improve outreach and enrollment in both programs. In addition, the entity would modernize the current eligibility determination process by implementing an automated customer contact center and create an electronic document and workflow management system. This would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. These changes would ensure easier, more reliable and timely eligibility and enrollment processes, making the program more efficient and effective and delivering important benefits to clients, providers and enrollment staff.

The request in DI-6 for a Medicaid Value-Based Care Coordination Initiative would enable the Department to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. To achieve this, the Department will undertake a statewide competitive procurement process for physical health services that emphasizes the importance of increasing the availability and services of medical homes for all clients. The Department intends to regionally procure services from Accountable Care Organizations that would operate as Administrative Services Organizations (ASOs)

providing enhanced Primary Care Case Management services. The ASOs would be primarily responsible for establishing a coordinated care delivery system for all clients. The Department anticipates that payments to primary care physicians would be supplemented with care coordination fees as well as outcomes-based performance incentives.

In addition to strengthening primary care services, the ASO would administer a comprehensive network of care coordination services. Care coordinators would be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospitals and community care, and importantly serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. The ASO would also deploy evidence-based medical management tools designed to promote patient safety and reduce unwarranted variation in care practices. The ASO contract would also be performance based with guarantees established around health outcomes, functional improvements, and self-sufficiency attainment. The Department anticipates that ASOs will incorporate an electronic health exchange that will greatly facilitate effective communication between clients, providers, and government agencies. Through such efforts, errors and duplication can be reduced. Clinical decision support tools as well as electronic registries will help improve outcomes at the point of care. This initiative aims to create a comprehensive, coordinated, outcomes focused care delivery system that optimizes the well being of Medicaid clients.

The Department's BRI-1, Pharmacy Technical and Pricing Efficiencies, requests a reduction in funds as a result of implementing an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure. Automating prior authorizations would increase efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process would make it easier for providers to submit requests, it would be easier and faster for clients to obtain drugs with prior authorization restrictions, and provide savings within Medical Services Premiums.

The request in BRI-2, Medicaid Program efficiencies, would improve quality of service for clients through six initiatives:

- Medicaid Benefit Package Reform;
- Health Outcomes Measurement Initiative;
- Fluoride Varnish;
- Hospital Back Up Program Enhancements;
- Oxygen Durable Medical Equipment Administrator; and,
- Serious Reportable Events.

Through the Health Outcomes Measurement Initiative, the Department would directly survey Medicaid clients on a monthly basis regarding their health and functional status to measure effectiveness of the Medicaid program and find areas for improvement. In addition, the Department could analyze geographic indicators to identify and address health disparities between urban and rural areas; and analyze and compare the health and functional status of clients in different groups. Through the Hospital Back Up program, the Department would achieve cost savings and improvements to care by moving clients out of hospitals into more appropriate care settings. Potential cost savings would also be generated through the initiative for 1.0 FTE Oxygen Durable Medical Equipment Administrator. This FTE would help the Department contain oxygen related expenditures, which are the highest expenditure category within durable medical equipment, implement process improvements and introduce more technologically efficient oxygen delivery systems.

This package builds upon many recommendations from the Blue Ribbon Commission for Health Care Reform (commonly referred to as the 208 Commission). It draws upon successful Medicaid reform efforts in North Carolina, Indiana, Oklahoma, Arkansas, and New Hampshire. By awarding health care service contracts regionally, the Department anticipates community organizations coming together to serve their own community and be accountable for their performance. The regional model allows for a rough overlap with behavioral health organization regions allowing for more effective coordination of services between physical and behavioral health. Also, alignment with Children's Basic Health Plan regions will help create seamless care for children traversing between

programs. A key goal of these initiatives is seamless care to the client between different delivery systems. The initiatives call for a holistic and systems approach to care delivery. The Department recognizes the varying needs of different populations served within Medicaid and expects to set outcome measures that differ between TANF, SSI, waiver, and dual eligible populations. A key component of the model is comprehensively defining the Medicaid benefit so coverage, duration, amount, and scope are clearly articulated.

General Description of Request: This request is for a total funds reduction of $1,731,018 in FY 2009-10 and $2,463,499 in FY 2010-11 for a series of efficiencies in programs within Medicaid. This request achieves savings and improvements through six Governor's initiatives for Medicaid reform: Medicaid Benefit Package Reform, Health Outcomes Measurement Initiative, Fluoride Varnish Benefit, Hospital Back Up Program Enhancements, Oxygen Durable Medical Equipment Reform, and Serious Reportable Events Initiative.

Medicaid Benefit Package Reform

As part of this initiative, the Department requests $300,000 totals funds in FY 2009-10, FY 2010-11 and FY 2011-12 in order to perform a comprehensive evaluation of the current fee-for-service benefit package and propose changes to ensure that the program is able to provide a comprehensive, coordinated, customer-centered and outcome-based continuum of care. Historically, benefit and eligibility expansions have focused on the scope of services received by clients, and not the quality of care or the client outcomes. The focus on reimbursement systems has relegated quality and outcomes to secondary goals. Therefore, the Department is proposing to begin a comprehensive reform of the Medicaid program, designed to shift the priority from the system to the clients. This work continues the expansions of the Department's February 15, 2008 Building Blocks request.

The Department intends to utilize consultation services in establishing priorities and processes in benefits definition that will incorporate a wide range of concepts critical to an outcomes-based program. Although this is a multi-year process, the Department has

identified the following areas as goals of this project: establishing a process for endorsing best medical practices and benefit determination; establishing a process for consideration and endorsement of new procedures and equipment; defining and/or refining the amount, duration, and scope of the mandatory and optional State Plan services provided; defining a systematic process for consideration of requests to exceed amount, duration, scope, and frequency limitations when medically indicated; establishing a process to use for outreach to stakeholders seeking input on benefit definition and limitations; and, exploring the feasibility of consolidating the prior authorization review process for mandatory and optional services to one reviewing agency. The goal of the review would not be to reduce services, but rather, to enable the Department to focus the program administration on client outcomes.

With the establishment of these standards, the Department can potentially allow for a much larger variety of delivery methods and reimbursement models than have been permitted in the past. The Department has already begun down this path, starting with elements contained in the Building Blocks proposal, such as enrolling children in a medical home, and the Department's proposal in Decision Item 6 ("Medicaid Value-Based Coordinated Care Initiative"). Further, the Department has received a large number of proposals for risk-based and non-risk based delivery systems, including traditional managed care and non traditional primary care coordination models. The Department can even allow for non-traditional proposals that target specific populations, as long as the delivery system achieves the required standards of care. The overarching goal will be to ensure that every Medicaid client, regardless of age or health status, will be part of a coordinated delivery system.

Health Outcomes Measurement Initiative

The Department is requesting an increase of $141,964 in total funds to the (1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects line item. The funds would be used to implement a process to survey the health and functional outcomes of Medicaid clients.

One of the Department's objectives in its FY 2009-10 Strategic Plan (November 3, 2008 FY 2009-10 Budget Request, Volume 2, Strategic Plan, Page C-6) includes designing programs that result in improved health status and outcomes for Medicaid clients. Improved health and functioning enables clients to be more self-sufficient and involved in choices affecting their health care. By focusing on improvements in client health and functioning, the Department would be able to tailor its programs in response to the results of this health outcomes measurement initiative.

The Department is always working to improve access and quality of services to achieve improved health and functional outcomes for clients. However, the Department currently has no resources for systematic evaluation of health outcomes as reported by clients themselves. The Department currently administers surveys to clients through the Consumer Assessment of Health Plans Survey (CAHPS). CAHPS measures consumer satisfaction with their health plan and plan providers, however, consumer satisfaction is not comparable to measuring self-reported functional health status. In addition to CAHPS, the Department also collects data through the Health Plan Employer Data Information Set (HEDIS) which is a set of clinical measures that is taken from claims data and/or medical record review; clients are not surveyed through HEDIS. HEDIS traditionally measures the processes of care, to determine if for example, a diabetic client received the required tests and health screenings recommended for persons with diabetes. These processes of care measures are helpful in assessing quality of care; however, they are not measures of health status.

Although the Department reviews utilization data and clinical data to measure client health outcomes through HEDIS, implementing a survey-based evaluation model for clients to self-report health status information would greatly improve the Department's ability to measure, understand and improve the health status of Medicaid clients. Sole reliance on administrative data provides indirect measures of health and functioning and assists in determining whether events associated with illness are decreasing. The requested funding would provide a direct, more useful measure to determine if health status is improving among Medicaid clients. Direct assessment of health and functional status would be critically important to stakeholders including providers, clients, citizens

and government to know whether the services rendered result in improved or stable health. By focusing all parties on performance outcomes rather than treatment provided or processes followed, the Department aims to increase accountability for results.

The Department's current methods of evaluation include analysis of utilization data which provides information regarding a client's "sickness" level or resource consumption, but does not provide a measure of a client's health status or functional status. Along with expenditure and clinical process data, the Department believes measuring health and functional outcomes is one of the most important metrics to use in determining the true effectiveness of its programs. Administrative utilization data assists in determining whether events associated with illness are decreasing and provides an extremely useful metric that ties to both cost and morbidity, however, it fails to provide a direct assessment from clients regarding their health. Implementing a survey-based evaluation model for clients to self-report health status information would greatly improve the Department's ability to measure, understand and improve the health status of Medicaid clients.

An example of a commonly used survey to measure individual health and functional status directly is the Short Form-12 Health Survey. This survey is used to measure the general health status of individuals from the individual's point of view. Through the survey, clients are asked to rate different aspects of their daily functioning in order to measure the individual's quality of life. While clinicians tend to focus on simply treating symptoms, this survey provides the individual's perspective of their day-to-day health status. The Short Form-12 Health Survey measures general health concepts across different populations and measures functional health status for both physical health and mental well being.

The Short Form-12 Health Survey includes concepts commonly represented in various surveys measuring health status: physical functioning, bodily pain, general health, vitality, social functioning, emotional functioning, and mental health. The Short Form-12 Health Survey is scored so that a higher score indicates better functioning. Results are

expressed in terms of two scores: the Physical Component Summary (PCS) and the Mental Component Summary (MCS).

Using client-reported health status from the Short Form-12 Health Survey would assist the Department in determining if clients' health is improving or declining while receiving Medicaid services. By measuring what is meaningful to clients in addition to utilization data, the Department could obtain information that is more reflective of the net result of care. When the measurement is applied over time (for example, every month) a picture of health and well being emerges, allowing for the identification of symptoms important in managing chronic conditions.

This survey would provide a validated measurement of client health status and would be a complement to utilization data currently used to measure effectiveness of the Medicaid program. This survey is a data collection tool that would assist the Department with obtaining a broad measure of program success. The data would be used to determine program effectiveness by eligibility category and geography. Through the collection of this data, the Department would be able to identify areas of focus for improvement in order to improve the overall functional health of clients and increase program success. Once areas for improvement have been identified, the Department would use existing resources to adapt processes or enhance communications with providers, case managers or other involved parties as needed. Any improvements identified through the survey results that would require additional funding would be requested through the normal budget process.

In addition, the Department could analyze and compare the health and functional status of clients in different groups, such as those receiving Temporary Assistance to Needy Families and Supplemental Security Income benefits, as well as waiver populations. Results from the surveys would also assist the Department with the following:

- screening and stratifying potential clients for case management or disease management;

- predicting those clients most likely to incur high future medical costs. This allows for better management of conditions in order to improve clients' health and avoid more costly health interventions, and;
- measuring and monitoring treatment effectiveness over time and evaluating the health status of clients.

The Department anticipates the survey would be administered using Interactive Voice Response (IVR) technology, which is a telephone-based system that can detect voice and touch tones using a normal phone. This technology would be more successful and cost-effective in reaching Medicaid clients than other survey methods, such as direct mail. IVR systems can work in different ways. One way is the traditional IVR which provides menu options and the caller is asked to press a number as a response. This method is the least expensive option but also the least user friendly.

Another way IVR systems work is through speech recognition. The Department anticipates using IVR with voice recognition capabilities. Voice recognition systems can be broken down into a series of simple menu choices, or nodes. An IVR system with voice recognition capabilities can handle large call volumes, and would be ideal for administering surveys for the Medicaid program. In addition, because of the voice recognition technology, the Department could ensure that surveys are not left on answering machines, and the system can recognize a request to call back at a more convenient time. If the system is unable to recognize a particular speech pattern, there are other options to choose from to assure the survey can be completed.

This survey process would provide a monthly "snapshot" of the health status for the entire Medicaid population and assist the Department in gauging the overall health status of Medicaid clients. In order to achieve this snapshot, the Department would conduct monthly surveys on identified samples of the client population. The Department estimates it would need a total of $107,264 per year for a contractor to conduct these surveys via telephone using IVR technology.

The Department estimates it would issue a request for proposals for a vendor to conduct surveys every month on a random sample of clients. The Department would provide all client contact data to the vendor and ensure the vendor has the most up-to-date and accurate information that is available. The vendor would conduct the telephone surveys and transfer the results of the surveys to the Department using a web-based system. In addition to sampling the entire Medicaid population, the Department would target surveys to clients in the Home and Community Based Services Waiver for the Elderly, Blind and Disabled. The Department anticipates there would be 12,000 waiver clients who would receive a targeted survey twice per year for an additional cost of $69,000 per year.

Based on the results of completed surveys, the Department would conduct analysis to identify clients and populations that require individualized follow-up to collect additional data on a subset of the population. Through the survey the Department would identify patterns of poor functional health in order to identify areas that require additional data collection. The Department estimates an additional $5,000 would be necessary to provide follow-up with clients identified through the survey. The number of clients who would require follow-up is unknown until the Department has generated initial data for making this determination.

In addition to the cost of conducting the surveys, the Department anticipates costs for scoring and reporting the survey results. Survey scores are calculated and normalized using a complex algorithm, and the Department would use a different vendor for this purpose. Based on information from vendors which provide comparable services, the Department estimates an additional $20,000 would be needed for software licensing, scoring and reporting the survey results.

The total estimated annual cost of the health outcomes survey is $141,964. See tables B.1 and B.2 of the attached appendix for assumptions and calculations.

Fluoride Varnish

As part of this initiative, the Department requests $146,182 total funds in FY 2009-10 in order to initiate a fluoride varnish benefit for Medicaid children up to the age of 6. Fluoride varnish is a topical agent containing a high concentration of fluoride in a resin or synthetic base and is painted directly onto teeth. It is intended to remain in close contact with the tooth surface for several hours facilitating maximum fluoride uptake and is easily applied with any convenient applicator. Trained medical as well as dental providers will be allowed to administer fluoride varnish to young children and to conduct an oral health risk assessment and examination. The impetus for this request is to increase access for children to preventive services and reduce the incidence of early childhood cavities. Access to dental services is an EPSDT participation performance measure.

Provider training will be required prior to reimbursing providers for the procedure. The Rose Foundation, Delta Dental Foundation, Colorado Health Foundation, Caring for Colorado Foundation, Kaiser Permanente, and others, are jointly funding Cavity Free at Three, a three year, statewide effort to prevent oral disease in young children. A technical assistance team comprised of leading dentists, physicians and dental hygienists who have received in-depth training in the prevention of oral disease in pregnant women and young children will be providing free, hands-on education to professionals across the state. This training will include an evidence–based infant and prenatal oral care protocol which includes oral disease risk assessment tools, clinical guidelines, supporting educational documents, patient information and education as well as ready to use kits which includes fluoride varnish.

Increased access to early dental intervention and reduced incidence of dental decay ultimately results in less necessary dental treatment and less cost to the Department. Dental decay is the most common chronic disease of childhood and is largely a disease of poverty. The rate of early childhood dental caries is near epidemic proportions in populations with low socioeconomic status. Cavities are found in 18% of children age 2

to 4 years and 52% of children age 6-8 years. The consequences of dental cavities may include pain to the child, missed school days, impaired language development, possible facial cellulitis and possible systemic illness for children with compromised immune systems. While fluoridated water provides some protection against decay, 26% of Colorado's population lives in communities without fluoridated water.

Studies demonstrate that fluoride varnish is the safest and most effective form of topical fluoride for young children. One important study demonstrated that subjects receiving 3 or 4 treatments over a two year period fluoride varnish showed a statistically significant decrease in cavities in comparison to subjects who received 2 or less treatments over the same time frame. By four years of age, children who had received fluoride varnishes demonstrated a statistically significant cumulative reduction in then number of restorative treatments needed for anterior teeth of 39%.

The fluoride varnish benefit and exam for Medicaid children up to age six would be administered by both medical and dental providers. In an effort to piggyback with the Colorado Health Foundations' educational initiative, the Department would want to implement this benefit in July 2009. In FY 2009-10, the Department anticipates that 4,016 clients will access the benefit at a cost of $36.40 per client, for a total of $146,182. The Department anticipates that the cost of the benefit will grow to $611,047 by FY 2010-11 as more providers become training on administering the benefit, serving 16,787. The limiting factor will be the number of trained providers.

See table C.1 of the attached appendix for assumptions and calculations for the fluoride varnish benefit.

Hospital Back Up Program Enhancements

As part of this initiative, the Department request is for $20,000 in total funds for Operating Expenses in FY 2009-10; $80,000 in total funds for Utilization and Quality Review Contracts in FY 2009-10; and a reduction in total funds to Medical Services

Premiums in FY 2009-10 and FY 2010-11 of $1,937,867 and $2,971,096, respectively, in order to expand the Hospital Back Up program.

The Hospital Back Up program was created in 1987. The program admits patients whose conditions require around-the-clock oversight and treatment that can only be rendered by licensed nurses and therapists at a level commensurate to hospital care. Facilities that are certified for Hospital Back Up are equipped and staffed to provide rehabilitation and nursing care for patients who are bedridden or who require treatment for chronic conditions as well as assistance with the activities of daily living for extended periods of time. Clients placed in the Hospital Back Up program are provided the care they require without the additional costs associated with acute care hospitalization. The general profile of clients in the program is consistent with extended post-acute hospitalization for ventilator dependent tracheotomy care, treatment of extensive wounds, or medically complex conditions. Patients in the program typically require specialized equipment such as ventilators, therapeutic beds, or wound vac (a process which cleans and protects wounds to help healing). These patients also require frequent review of the care regimen by their physician, often one or more times per week. Given the complexity of the care needs, patients do not qualify for discharge into regular nursing facilities or community settings and in the absence of the Hospital Back Up program the only alternative is for the patient to remain in an acute care hospital.

Expenditures for the Hospital Back Up program from FY 2004-05 through FY 2007-08 were reported as follows in the FY 2009-10 Budget Request, Medical Services Premiums, Exhibit H, page EH-5:

- FY 2004-05: $5,756,929
- FY 2005-06: $5,020,937
- FY 2006-07: $5,468,784
- FY 2007-08: $5,223,654

Expenditures in FY 2007-08 were lower than those in the previous three fiscal years due to a facility which was placed under a "Denial of Payment for New Admissions" status for failure to comply with regulatory standards, although this has since been rectified.

Total Hospital Back Up expenditures are expected to be $5,484,836 in FY 2008-09 and $5,759,078 in FY 2009-10.

Approximately 30 patients received Hospital Back Up services at some point during FY 2007-08. There are currently three providers that participate in the Hospital Back Up program. Two of the current providers are in the Denver metro area, and one is in Pueblo.

From July to September 2007 the Department conducted a survey of 97 acute care hospitals across the state to evaluate the efficiency and effectiveness of the Hospital Back Up program. Of those surveyed, 91 hospitals responded including all 27 facilities that routinely refer Medicaid clients to the Hospital Back Up program. The results of the survey indicated that the majority of respondents are dissatisfied with the availability of beds for the Hospital Back Up program in the state. The program, which is currently at full capacity, has approximately 30 clients enrolled in it. The survey also reported that there were 30 additional Medicaid clients identified around the state who would qualify for, and benefit from, Hospital Back Up services. These patients require a level of care and services beyond the scope provided in a typical nursing facility. In the absence of an alternative such as the Hospital Back Up program, these patients will have to remain in costly acute care hospital settings. The Department estimates that the daily reimbursement rate for acute care outlier days are approximately twice the current average Hospital Back Up daily reimbursement rate. As a result, the Department can realize savings by moving these clients into a more appropriate and cost effective level of care.

As a result of the increased demand for Hospital Back Up placement, the Department has approached several prospective Hospital Back Up providers to expand the number of beds available in the program. As a consequence of these discussions the Department found that there were a number of stumbling blocks that prevent prospective providers from participating in the program. The first of these is the unease with which the current cost-based reimbursement rates are viewed. The current cost-based rates are negotiated for each individual entering the program and are not fully understood by the provider

community. This confusion leads to financial uncertainty for providers. The second obstacle to greater provider participation is the time required to process admission into the program. Under the current paper-based system admission to the program takes an average of 58 days. This long admission process further increases uncertainty and the reluctance of providers to participate in the program.

Adult Hospital Back Up Program Expansion

In order to attract the required additional capacity the Department will adopt reimbursement rates based on the federal guidelines set forth under the Prospective Payment System for skilled nursing facilities. The Prospective Payment System rates are adjusted to reflect geographic differences in wage rates, using the hospital wage index, and patient case-mix (the relative intensity that would be associated with each patient's clinical condition as identified through the resident assessment process), using a patient classification system of 53 Resource Utilization Groups (RUG-53). The Prospective Payment System reimbursement rates are updated annually to reflect inflation in the cost of the goods and services necessary to produce a given level of care and to reflect changes in local wages using the latest hospital wage index. Based on an analysis of current patients in the program, patients are expected to be classified in the middle range of those requiring extensive services (SE2) of the 53 Resource Utilization Groups associated with the Prospective Payment System.

If approved, the Department would supplement the Prospective Payment System rate with a quality incentive Medicaid add-on based on the type of facility. All providers under the Hospital Back Up program must meet certification requirements as administered by the Colorado Department of Public Health and Environment. Hospital-based facilities that are additionally accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities would receive an additional 15% incentive payment on top of the base Prospective Payment System determined daily rate. Stand-alone facilities (not hospital-based) that are additionally fully accredited for sub-acute care by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of

Rehabilitation Facilities would receive an additional 10% incentive payment on top of the Prospective Payment System determined daily rate. Rates that have been negotiated for clients enrolled in the program prior to the date the new rates are adopted would remain in effect for two years after implementation of the new rates.

The average of the new rates, $369.73 per day, is lower than the average of the current rates in the program, $668.00 per day. As a result of cost report audits conducted by the Department of current providers in the program and conversations with provider associations, the Department believes the new rates would be sufficient to both cover provider costs and increase provider participation in the program. See tables D.2 and D.3 of the attached appendix for assumptions and calculations of the new Hospital Back Up rates.

In order to address the remaining concern of the prospective providers, the Department is proposing to implement a web-based system that would reduce the application and admission process from the current average of 58 days to no more than five days. In order to implement this new system, the Department requests one-time funding of $80,000 total funds for the current utilization review contractor to develop the necessary software. The Department also requests one-time funding of $20,000 total funds to develop training materials and conduct statewide trainings on the new admission process for hospital discharge planners, nursing facilities, and single entry point agencies.

In order to estimate savings from the changes to the adult Hospital Back Up program, the Department assumes that under the new rate methodology for the adult Hospital Back Up program the average base reimbursement rate (not including the quality incentive add-on) will be equal to the federal Prospective Payment System middle level Extensive Services (SE2) reimbursement rate. The Department assumes that under the federal Prospective Payment System, the mid-level Extensive Services reimbursement rate will be $333.59 in FY 2009-10 and $347.27 in FY 2010-11. These estimates are derived by trending the 2008 mid-level extensive services rate ($307.83) forward using the average Consumer Price Index for Medical Care as estimated in May 2008 by the United States Department of Labor, Bureau of Labor Statistics (4.1%). The resulting rates for each type of provider

are detailed in Table D.2 for FY 2009-10 and in Table D.3 for FY 2010-11. The derivation of savings estimates resulting from rate changes to the adult Hospital Back Up program is presented in Table D.4.

The Department further assumes that enrollment in the Hospital Back Up program for a full year would prevent a patient from having to spend at least 180 days in an acute care hospital under outlier day reimbursement. Outlier days are paid at 80% of the average daily payment under the Diagnosis Related Group (DRG) payment system. Under the Diagnosis Related Group reimbursement system the Department pays a fixed price for up to a given number of days of inpatient hospital care. Outlier days represent the bulk of savings since inpatient days prior to outlier days are reimbursed at a flat rate for a fixed number of days and therefore represent a sunk cost. The Department assumes that in FY 2009-10 and in FY 2010-11, the average outlier day reimbursement rate will be $1,216.09 per day and $1,239.16, respectively. These figures are based on the weighted average outlier day rate for the mix of Diagnosis Related Groups for a sample of 40 current and past adult Hospital Back Up patients in the 6 months prior to admission into the Hospital Back Up program. These amounts were trended forward using the average annual increase from FY 2005-06 through FY 2007-08 (about 3.8% per year).

Based on an analysis of historical data for the program, the Department estimates that there will be 12 clients who will be exempt from the new rate for 2 years.

The Department assumes that once new providers have been enrolled in the program there will be a phase-in period during which the Department will increase enrollment in the program. The Department assumes that it can enroll 10 new clients in October 2009, January 2010, and April 2010, for a total of 30 new clients.

In order to safeguard against unexpected delays in the implementation of the expansion of the adult Hospital Back Up program as well as unexpected difficulties in attracting new providers under the new rate methodology, the Department assumes that savings in the adult Hospital Back Up program will be half of those derived analytically. The

derivation of savings estimates resulting from all changes in the adult Hospital Back Up program are displayed in tables D.5 and D.6.

New Pediatric Hospital Back Up Program

The Department is also implementing a new pediatric Hospital Back Up program for individuals under 21 years of age who require the same level of care as clients in the Adult Hospital Back Up program. The Department has been in communication with prospective providers for the new Pediatric Hospital Back Up program to set rates and determine the capacity of the new program. Based on these discussions, the Department expects to have 30 beds available for pediatric clients in the program by July 1, 2009. The Department estimates it would pay a fixed rate of $650.00 per day for the pediatric Hospital Back Up program. The new pediatric Hospital Back Up program would be a part of the Department's Early and Periodic Screening, Diagnosis and Treatment program.

In order to estimate savings resulting from the implementation of the pediatric Hospital Back up program, the Department assumes that enrollment in the pediatric Hospital Back Up program for a full year would prevent a pediatric patient from having to spend at least 180 days in an acute care hospital under outlier day reimbursement. The Department assumes that in FY 2009-10 and in FY 2010-11, the average outlier day reimbursement rate for pediatric patients will be $1,439.72 per day and $1,466.69, respectively. These figures are based on the weighted average outlier day reimbursement rate for a mix of Diagnosis Related Groups for current Medicaid patients under the age of 21 who had at least one hospital claim under a diagnosis related group code that would make the patient a likely candidate for the pediatric Hospital Back Up program. These amounts were trended forward using the average annual increase from FY 2005-06 through FY 2007-08 (about 1.9% per year).

The Department further assumes that once the new pediatric Hospital Back Up program is implemented there will be a phase-in period during which the Department will increase enrollment in the program. The Department assumes that it will enroll 10 new pediatric

clients in October 2009, January 2010, and April 2010, for a total of 30 new clients. The derivation of savings estimates resulting from the implementation of a pediatric Hospital Back Up program is provided in tables D.7 and D.8.

Oxygen Durable Medical Equipment Administrator

As part of this initiative, the Department requests 1.0 FTE, Oxygen Durable Medical Equipment Administrator (General Professional V), in the Department's Acute Care Benefits Section. Oxygen related expenditures are the highest expenditure category within durable medical equipment, and the Department lacks reimbursement guidelines pertaining to the use of oxygen by Medicaid clients. The Department requests this additional 1.0 FTE to help contain oxygen related expenditures, implement process improvements and introduce more technologically efficient oxygen delivery systems. The Department anticipates cost savings of $574,260 in FY 2009-10 and $639,266 in FY 2010-11 as a result of process improvements derived by this FTE.

Durable medical equipment are devices that assist clients to function normally outside a medical facility, can withstand repeated use, and have a defined medical purpose. These devices enable clients to remain outside an institutional setting by promoting, maintaining, or restoring health, or by minimizing the effects of illness, disability, or handicapping condition. Durable medical equipment is a Medicaid benefit for eligible clients when ordered by a provider as part of a comprehensive treatment plan.

In FY 2006-07 and FY 2007-08, the Department's expenditures for Acute Care Benefits totaled $1,203,363,838 or 58.75% and $1,336,004,286 or 59.99% of total Medical Services Premiums expenditures, respectively (the Department's FY 2009-10 Budget Request, Medical Services Premiums, Exhibit N, page EN-1). Within the service category of Acute Care Benefits, the Department provides clients with durable medical equipment. In FY 2006-07 and FY 2007-08, the Department's expenditures for durable medical equipment were $66,822,166 and $75,815,972, respectively. This represents an increase in durable medical equipment expenditures of 13.46%. Expenditures on durable

medical equipment have seen double-digit growth rates in six of the last ten years, for a total increase of 193.13% since FY 1997-98.

To ensure that requests for acute care benefits are a covered benefit and that the service is medically necessary and appropriate, the Department contracts with an independent contractor to perform prospective and retrospective reviews. The contractor is responsible for conducting a minimum of 9,500 prospective and 4,000 retrospective reviews per fiscal year. In the Department's Long Bill (SB 07-239), the Department was appropriated $1,375,906 total funds in Acute Care Utilization Review for these services in FY 2007-08.

Under the existing contract, the contractor performs prospective reviews for durable medical equipment, but is not required to review claims for oxygen and oxygen equipment and supplies. One emphasis of the Department's acute care benefits utilization review contract is to review high dollar items like power wheelchairs. However, as shown in table E.2 of the attached appendix, the Department's total expenditures for oxygen related items was more than five times the total expenditures for power wheelchairs and scooters in FY 2007-08. In each of the three fiscal years shown in the table, oxygen related expenditures were the highest expenditure category for all durable medical equipment. The second highest expenditure category, enteral and parenteral therapy, lagged oxygen related expenditures by as much as $13,768,725.

The Department has 1.0 FTE in its Acute Care Benefits Section working with durable medical equipment, however the section does not have a dedicated staff person to monitor and administer oxygen durable medical equipment. Given that oxygen related expenditures are the highest expenditure category within durable medical equipment, and the lack of reimbursement guidelines pertaining to the use of oxygen by Medicaid clients, the Department believes the addition of an Oxygen Durable Medical Equipment Administrator would help contain oxygen related expenditures and implement process improvements and introduce more technologically efficient oxygen delivery systems.

In an effort to begin exploring cost containment strategies, the Department has identified four possible approaches to achieve potential costs savings within oxygen durable medical equipment:

- Create an oxygen prior authorization request or oxygen certificate of medical necessity and require the form for all oxygen clients;
- Establish gate-keeping provisions that require documentation of hypoxemia levels along with retesting after 90 days;
- Combine select oxygen procedure codes and reimburse providers for a complete oxygen system rather than a base oxygen unit and several accessories, and;
- Rent-to-own alternatives for high-cost oxygen equipment.

Oxygen Prior Authorization Requests

The Department's rules regarding oxygen durable medical equipment do not require that providers submit a prior authorization request or oxygen certificate of medical necessity to the Department's fiscal agent, Affiliated Computer Services, Inc. By not requiring an oxygen prior authorization request to be submitted for review of medical necessity by Affiliated Computer Services or the Department's acute care benefits utilization review contractor, the Department is denied the opportunity to determine whether or not oxygen claims are a covered benefit and that the level of service is medically necessary and appropriate. Furthermore, without an oxygen prior authorization request or oxygen certificate of medical necessity, the Department cannot adjudicate oxygen claims that fail to properly document medical necessity.

If the Department could create an oxygen certificate of medical necessity and require that all providers submit the certificates to either the Department or contractor for review, then the Department believes that cost savings could be achieved in oxygen durable medical equipment.

Systems development costs or modifications may be required for the Medicaid Management Information System. The proposed FTE would research the extent of the changes required to the Medicaid Management Information System or other systems and

reevaluate the estimated savings developed above. The Department may submit an additional budget action if system modifications are determined to be necessary to implement portions of this Request.

Gate-keeping Provisions for Oxygen Durable Medical Equipment

The Department's rules regarding oxygen durable medical equipment do not require that providers submit documentation showing what medical criteria or examinations were used to determine medical necessity. Nor do the rules require providers to conduct follow-up evaluation of the client's oxygen medical necessity. The Centers for Medicare and Medicaid Services have such rules in place.

The Department recommends that rules regarding gate-keeping provisions be developed and promulgated whereby providers would be required to document a client's hypoxemia levels on an oxygen certificate of medical necessity. Similar gate-keeping provisions have been developed and implemented for California Medicare. As an example, the Department would only approve prior authorizations requests for clients who have hypoxemia levels below 55 PO^2 mm Hg; however this level could be adjusted with input from the client's physician.

The Department may also explore the possibility of establishing a demonstration project to evaluate the utilization of resources for long-term oxygen therapy. This follows from one of the recommendations from the 6th Annual Long-term Oxygen Therapy Consensus Conference held August 2005 in Denver, CO. The conference recommended that a regional facility be established for conduct of recertification examinations. The facility would be capable of evaluating long-term oxygen therapy prescription at rest, during exercise, and during sleep. These examinations would ensure that the client is prescribed the correct equipment modality providing the greatest benefit based on his or her individualized activities of daily living and lifestyle. This level of testing would relieve the primary-care physician or respiratory therapist from conducting these examinations. The proposed FTE could further research and explore the possibility of using some of the

estimated savings to issue a request for proposals and contract with a local contractor to provide these services.

Combine Select Oxygen Procedure Codes

Colorado Medicaid uses the Centers for Medicare and Medicaid Services Healthcare Common Procedural Coding System to identify Medicaid services. Level II of the Healthcare Common Procedural Coding System is a standardized coding system that is used primarily to identify durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

Using the standardized coding system, the Department would research alternatives to its existing method of reimbursement for oxygen related procedure codes whereby the Department reimburses for a base oxygen unit and oxygen accessories. If a new reimbursement rate were developed for a complete and more efficient oxygen system, it would allow the Department to contain costs on select oxygen accessories.

The proposed FTE would extend this preliminary research into revising and updating the Department's oxygen reimbursement methodology and educate its oxygen providers through provider bulletins and presentations at the monthly Durable Medical Equipment Advisory meetings.

Rent-to-own Oxygen Equipment

The Department's existing rental-only reimbursement policy for oxygen equipment could be modified to include a rent-to-own alternative for certain oxygen equipment and supplies. When the continuous rental period exceeds the purchase price of the oxygen equipment, the provider would transfer title to the client. After such time the provider would receive payments for certain equipment maintenance and servicing.

The proposed FTE would further research this alternative and establish the rent-to-own criteria and provider reimbursement guidelines for maintenance and servicing.

Additional work would include educating oxygen providers through provider bulletins and presentations at the monthly Durable Medical Equipment Advisory meetings. If system modifications are required under this alternative, then the FTE would work with the Department's fiscal agent to establish the business requirements and reevaluate the estimated savings.

Estimated Savings

The Personal Services and Operating Expenses costs for the proposed Oxygen Durable Medical Equipment Administrator (1.0 FTE General Professional V) are $73,463 in FY 2009-10 and $74,352 in FY 2010-11. The estimated net savings from implementing the proposed alternatives are $500,797 in FY 2009-10 and $564,914 in FY 2010-11. Please see tables E.2, E.3, and F of the attached appendix for assumptions and calculations.

The Department anticipates that this FTE will spend approximately two years analyzing and implementing alternative oxygen related processes. This will include researching options, communicating with the Centers for Medicare and Medicaid Services regarding federal guidelines, compiling cost savings estimates, conducting stakeholder meetings to solicit feedback on potential processes, and developing population-specific policy related to oxygen services. In the long-term, this FTE would be responsible for monitoring the implemented processes to ensure efficiencies are being realized, administering home use, and ongoing policy development and refinement. The Department believes that once the oxygen related procedures are fully implemented, this position would become a generalized Durable Medical Equipment FTE. This would allow the Department to investigate new policies and procedures for other types of Durable Medical Equipment

Serious Reportable Events Initiative

Serious reportable events are identified as avoidable errors that occur during hospitalization. Momentum is currently building around ending payment for these events by national groups, states, health care facilities, and others to improve patient safety. The Department plans to adjust reimbursement for hospital claims that include serious

reportable events beginning on July 1, 2009. The objective of the policy is to ensure patient safety and high quality care. As of October 1, 2008, reimbursement will not be increased for additional costs resulting from the 12 following events also identified for non-reimbursement by the Centers for Medicare and Medicaid Services for Medicare patients:[1]

- Foreign object inadvertently left in patients after surgery;
- Sir embolism – an air bubble that enters the blood stream and can obstruct the flow of blood to the brain and vital organs;
- Transfusion with the wrong type of blood;
- Severe pressure ulcers – deterioration of the skin, due to the patient staying in one position too long, that has progressed to the point that tissue under the skin is affected (Stage III), or that has become so deep that there is damage to the muscle and bone, and sometimes tendons and joints (Stage IV);
- Falls and trauma, including fractures, joint dislocations, head injury, crushing injury, burn and electric shock;
- Catheter-associated urinary tract infection;
- Vascular catheter-associated infection;
- Manifestations of poor glycemic control;
- Surgical site infection following coronary artery bypass graft;
- Surgical site infection following certain orthopedic procedures;
- Surgical site infection following bariatric surgery for obesity, and;
- Deep vein thrombosis (a blood clot in a major vein) and pulmonary embolism (blockage in the lungs) following certain orthopedic procedures.

The Centers for Medicare and Medicaid Services is opening a National Coverage Decision process to look at how to handle the following three surgical events, which they term "never events:"

- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient, and;
- Wrong surgical procedure on a patient.

[1] Source: "Medicare takes new steps to make your hospital stay safer," August 4, 2008, http://www.cms.hhs.gov/apps/media/fact_sheets.asp

The Department terms all 15 of these conditions serious reportable events. The Department is planning to address the 15 conditions and surgical events above with its own non-payment policy. The policy encompasses Medicaid fee-for-service, Medicaid managed care, and the Children's Basic Health Plan. In the event that any of the first 12 serious reportable events listed above happen to clients enrolled in either Medicaid or the Children's Basic Health Plan, the Department will decline reimbursement for any additional costs associated with care resulting from the events. Should one of the remaining three events occur to a client enrolled in either Medicaid or the Children's Basic Health Plan, the Department will deny payment to the hospital for all costs associated with the surgical event.

Improved patient safety and ensuring the highest quality of care across programs drive the Department's support of this initiative. While the Department anticipates cost savings upon implementation of the policy, the amount is indeterminate. The Department's Medicaid Management Information System currently lacks a "present on admission" indicator. Such an indicator allows for the accurate tracking of the incidence and cost of claims for serious reportable events. Absent this indicator, the Department cannot confidently project what the potential cost savings could be. Once the systems changes are completed and the policy is in place for approximately 12 months, the Department will be able to project future savings based on the data that is generated.

Implementation Plan for Medicaid fee-for-Service

The Department's Medicaid fee-for-service program pays hospitals for hospital stays based on a diagnosis related group system. Each claim submitted by the hospitals is processed by the Medicaid Management Information System which subsequently groups the claim to a specific diagnosis related group. The grouper system uses diagnosis and procedure codes and other hospital-generated information about clients, to assign the claim to a specific diagnosis related group and respective weight. Depending on the client's condition and the treatment provided, the corresponding diagnosis related group could be associated with a complication, and, in most cases, a higher weight. The

associated payment to the hospital is a calculation of the hospital's specific rate, the claim's specific diagnosis related group's weight, and the length of stay. Because of this system, cases with complications, which may be caused by a serious reportable event, often result in a higher payment to the hospital by the Department.

In order to implement this policy in FY 2009-10, the Department is modifying the Medicaid Management Information System in FY 2008-09. These changes are being made using available programming hours under contract in its information technology pool. The changes are needed to allow for accurate tracking of the existence of, and payment for, each of the 15 serious reportable events. The changes include the creation of a "present on admission" code so that hospitals will be able to report which, if any, of the 15 serious reportable events are present when a Medicaid client is admitted to the hospital. Also, two additional adjustment reason codes are being put into place for accurate tracking, processing, and recoupment of funds by the Department's Accounting section within the Medicaid Management Information System. Further, the web portal through which hospitals access the Medicaid Management Information System is being modified and updated. All changes are scheduled for completion by July 1, 2009.

Once the system is updated, the Department will begin performing data queries to identify claims on which a serious reportable event was reported. These queries will be run once the claim is paid out of the Medicaid Management Information System. After reviewing the amount paid by the Department for the affected claim, the Department will adjust the claim where there is evidence of overpayment, and communicate with the hospital regarding recoupment of the overpayment.

In the event that the hospital disputes the Department's decision, the claim in question would be forwarded to the Department's Medicaid utilization review contractor for further review, analysis, and handling. The Department assumes that the number of claims requiring this kind of review would be relatively small, and could be completed under the terms of the existing contract. As a result, no additional funds would be needed for this part of the initiative.

Implementation Plan for Medicaid Managed Care and the Children's Basic Health Plan

Medicaid managed care and the Children's Basic Health Plan are public-private partnerships between the Department and the managed care organizations the Department contracts with to provide services. As such, the Department pays the managed care organizations a per-member, per-month capitation rate for services. The Department does not reimburse on a per-service basis for inpatient hospital care.

The Department is responsible for neither the handling nor the payment of claims for these programs. Once the serious reportable event policy is adopted, the Department will contractually require that the managed care organizations not reimburse hospitals for any additional costs associated with patient care deriving from any of the first 12 serious reportable events defined above. Further, the Department will require that the managed care organizations decline all payment for costs associated with the final three surgical procedures. The Department will work with the managed care organizations to determine an appropriate implementation date in the event that a serious reportable event policy is put into place.

Contracting costs

Although the Department is taking steps to implement policy around serious reportable events using existing resources in FY 2008-09, the Department is requesting funding to meet increased staffing needs beginning in FY 2009-10. The Department assumes it would need one part-time contractor beginning in FY 2009-10 to assist with the manual review and adjustment of payment for claims affected by the policy. This part-time contractor is estimated to cost $19,500 per year based on approximately 650 hours of work contracted at $30 per hour. The Department assumes it could handle the additional accounting duties and policy coordination with hospitals and other stakeholders within existing resources.

Consequences if Not Funded: The Department would not be able to provide efficiencies to obtain savings resulting from its proposed changes to the Hospital Back Up Program and oxygen related durable

medical equipment functions. The Department would continue to operate existing programs, but it is unlikely that any cost efficiencies will be achieved under current practices. Without these savings, the Department can not continue to improve quality of care for existing clients and expand eligibility to currently underserved Coloradans.

The Department is committed to focus on cost, quality, and access to health care, and is taking a realistic, building-block approach to make progress toward covering more currently uninsured Coloradans. As the Department finds efficiencies in the system, cuts waste and brings more transparency to the system, it can reinvest those savings toward coverage and access. The Department views each of the steps outlined in this Change Request as critical in order to prepare for broader health care reform in the State of Colorado. Without implementing efficiencies in existing programs and functions, the Department will not be able to prepare for large shifts in enrollment and the expansion of benefits. Failure to fund analysis and infrastructure is likely to result in a destabilized system environment that will significantly reduce the Department's ability to meet its state and federal obligations for health care programs. Inefficiencies and programmatic barriers to enrollment must be addressed before the Department can expand coverage for children and families; to increase eligibility but then continue to make it difficult for families to receive comprehensive coordinated care is counter-productive.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	General Fund	Federal Funds	FTE
Total Request	**($1,731,018)**	**($865,509)**	**($865,509)**	**0.9**
Medicaid Benefit Package Reform	$300,000	$150,000	$150,000	0.0
Health Outcomes Survey	$141,964	$70,982	$70,982	0.0
Fluoride Varnish	$146,182	$73,091	$73,091	0.0
Hospital Back Up Program Enhancements	($1,837,867)	($918,933)	($918,934)	0.0
Oxygen Related Durable Medical Equipment	($500,797)	($250,399)	($250,398)	0.9
Serious Reportable Events	$19,500	$9,750	$9,750	0.0

Summary of Request FY 2010-11	Total Funds	General Fund	Federal Funds	FTE
Total Request	**($2,463,499)**	**($1,231,749)**	**($1,231,750)**	**1.0**
Medicaid Benefit Package Reform	$300,000	$150,000	$150,000	0.0
Health Outcomes Survey	$141,964	$70,982	$70,982	0.0
Fluoride Varnish	$611,047	$305,524	$305,523	0.0
Hospital Back Up Program Enhancements	($2,971,096)	($1,485,548)	($1,485,548)	0.0
Oxygen Related Durable Medical Equipment	($564,914)	($282,457)	($282,457)	1.0
Serious Reportable Events	$19,500	$9,750	$9,750	0.0

Cash Funds Projections: Not applicable.

Assumptions for Calculations: Where applicable, assumptions are noted in the relevant locations in each table in the appendix, and in the narrative above. The Department has estimated projected expenditure and utilization based on historical information and assumptions about future changes in caseload or utilization. As actual experience with new programs is obtained, the Department would use the standard budget process to request adjustments to funding as appropriate.

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

This request includes total net savings of $1,731,018 in FY 2009-10 anticipated due to program efficiencies. These savings help offset the costs of outcome enhancements included in this request. While a quantitative cost-benefit analysis is not applicable to this request, the Department believes that there are significant benefits to this proposal, including:

- Ensuring that Medicaid is able to provide a comprehensive, coordinated, customer-centered and outcome-based continuum of care evaluation through the current fee-for-service;
- Improvement in health and functional status for existing Medicaid clients, and;
- Fluoride varnish benefit for children under age 6.

Implementation Schedule:

Implementation Schedule	
Item	**Date Complete**
State Plan Amendments for Hospital Back Up Written	January 2009
New Rules for Hospital Back Up Written	January 2009
RFP for Health Outcomes Survey Issued	March 2009
State Plan Amendments for Hospital Back Up Approved	June 2009
New Rules for Hospital Back Up Approved	June 2009
Contract for Health Outcomes Survey Written	June 2009
Contract for Health Outcomes Survey Awarded/Signed	July 2009
Health Outcomes Survey Implemented	July 2009
Oxygen Durable Medical Equipment Administrator Hired	July 2009
Develop and Implement Web-based Admission Process for Hospital Back Up Program	July 2009 - December 2009
Hospital Back Up Web-based Admission Process Implemented	January 2010

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2008). Program of medical assistance - single state agency.

(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in

accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

25.5-5-101, C.R.S. (2008). Mandatory provisions - eligible groups - repeal.

(1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203.

Performance Measures:

This request would assist the Department in achieving the following Department-wide performance measures:

- Improve access to health care, increase health outcomes and provide more cost effective services using information technology.
- Improve access to and the quality of Medicaid health care as demonstrated through improvements in Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.

This request would provide the Department with the resources necessary to determine health status and measure the effectiveness of services and access to those services. The survey results would complement measures the Department currently uses to help better assess if it is truly meeting its performance measures related to improving health outcomes for clients.

Summary of Request FY 2009-10	Total Funds	General Fund	Federal Funds
Total Request	**($1,731,018)**	**($865,509)**	**($865,509)**
Medicaid Benefit Package Reform			
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$300,000	$150,000	$150,000
Health Outcomes Survey			
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$141,964	$70,982	$70,982
Fluoride Varnish			
(2) Medical Services Premiums	$146,182	$73,091	$73,091
Hospital Back Up Program Enhancements			
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$20,000	$10,000	$10,000
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$80,000	$40,000	$40,000
(2) Medical Services Premiums	($1,937,867)	($968,933)	($968,934)
Subtotal Hospital Back Up	*($1,837,867)*	*($918,933)*	*($918,934)*
Oxygen Related Durable Medical Equipment			
(1) Executive Director's Office; (A) General Administration, Personal Services	$67,285	$33,642	$33,643
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$6,178	$3,089	$3,089
(2) Medical Services Premiums	($574,260)	($287,130)	($287,130)
Subtotal Oxygen Related Durable Medical Equipment	*($500,797)*	*($250,399)*	*($250,398)*
Serious Reportable Events			
(1) Executive Director's Office; (A) General Administration, Personal Services	$19,500	$9,750	$9,750

Summary of Request FY 2010-11	Total Funds	General Fund	Federal Funds
Total Request	**($2,463,499)**	**($1,231,749)**	**($1,231,750)**
Medicaid Benefit Package Reform			
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$300,000	$150,000	$150,000
Health Outcomes Survey			
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$141,964	$70,982	$70,982
Fluoride Varnish			
(2) Medical Services Premiums	$611,047	$305,524	$305,523
Hospital Back Up Program Enhancements			
(2) Medical Services Premiums	($2,971,096)	($1,485,548)	($1,485,548)
Oxygen Related Durable Medical Equipment			
(1) Executive Director's Office; (A) General Administration, Personal Services	$73,402	$36,701	$36,701
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$950	$475	$475
(2) Medical Services Premiums	($639,266)	($319,633)	($319,633)
Subtotal Oxygen Related Durable Medical Equipment	*($564,914)*	*($282,457)*	*($282,457)*
Serious Reportable Events			
(1) Executive Director's Office; (A) General Administration, Personal Services	$19,500	$9,750	$9,750

Table B.1: Calculation of Survey Costs			
Row	**Item**	**Total**	**Description**
A	Number of Medicaid groups to be surveyed	3	Groups based on caseload categories for elderly and disabled; low-income adults; and low-income children.
B	Statistically valid sample size per group	385	Based on a standard calculation for statistically valid sample size using caseload information from the November 3, 2008 Budget Request, Exhibits for Medical Services Premiums, Exhibit B, Page EB-1
C	Necessary surveys to be conducted per month	5,775	Row B / 0.2 (Assuming a 20% response rate) * Row A
D	Total number of surveys conducted per year	69,300	Row C * 12
E	Price per survey	$0.48	Estimate based on research with survey vendors ($0.12 per minute, calls last 4 minutes on average, inclusive of incomplete calls)
F	Total cost per year for survey sampling	$33,264	Row D * Row E
G	Cost for approximately 12,000 waiver client targeted surveys per year	$69,000	Based on an estimated cost of $5.75 per client, which includes costs for the survey as well as follow-up
H	Individual follow-up costs	$5,000	Includes funding for follow-up calls to collect additional necessary data. Since the quantity and type of follow-up needed is unknown at this time, a fixed amount is estimated until further information is obtained.
I	**Total Survey Costs**	**$107,264**	

Table B.2: Calculation of Vendor Costs			
J	Vendor Startup Costs	$2,500	Estimate based on research with survey vendors
K	Interactive Voice Response Development Costs	$7,200	Estimate based on research with survey vendors
L	Data Transfer	$5,000	Estimate based on research with survey vendors
M	Licensing and Scoring	$20,000	Estimate based on research with survey vendors
N	**Total Vendor Costs**	**$34,700**	Sum Row J through Row M

O	**TOTAL REQUEST**	**$141,964**	Row I + Row N

Table C.1 **Calculation of Fluoride Varnish Benefit**		
Fluoride Varnish	**FY 2009-10**	**FY 2010-11**
Estimated Clients Eligible for Participation	155,642	158,817
Estimated Participation Rate (Initial Screening)	2%	8%
Estimated Participation Rate (Follow-Up Screening)	1%	3%
Total Screenings	4,016	16,787
Cost Per Application	$36.40	$36.40
Total Cost	**$146,182**	**$611,047**

Table D.1
Summary of Hospital Back Up

Line Item	Description	FY 2009-10	FY 10-11	Source
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Software development costs for utilization contractor	$20,000	$0	See narrative.
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts: Professional Services Contracts	Develop and conduct training on new admission process.	$80,000	$0	See narrative.
(2) Medical Services Premiums	Savings due to reform of program.	($1,937,867)	($2,971,096)	Tables D.4 through D.8.
Total		**($1,837,867)**	**($2,971,096)**	

Table D.2: Development of New Adult Hospital Back Up Rates			
Row	**Item**	**Total**	**Description**
A	Base Rate for FFY 08	$307.83	Federal Prospective Payment System middle level Extensive Services (SE2) reimbursement rate.
B	Estimated Growth Rate	4.10%	Average Consumer Price Index for Medical Care as estimated in May 2008 by the Bureau of Labor Statistics.
C	Base Rate for FY 2009-10	$333.59	Base rate trended forward 2 years. Row A * (1 + Row B)^2.
D	Hospital Based Facilities Add-On	15.00%	Estimated incentive payments by facility type. This increase in applied to the base rate.
E	Accredited Stand Alone Facility Add-On	10.00%	
F	Non-accredited Stand Alone Facility Add-On	0.00%	
G	**Hospital Based Facilities**	**$383.63**	Row C * (1 + Row D).
H	**Accredited Stand Alone Facility**	**$366.95**	Row C * (1 + Row E).
I	**Non-accredited Stand Alone Facility**	**$333.59**	Row C * (1 + Row F).

Table D.3: FY 2009-10 Rate and Caseload Projections for Adult Hospital Back Up Expansion		
Hospital Back Up Provider Classification	**Estimated Rate (per diem)**	**Estimated Number of Clients Under New Rate**
Hospital Based Facilities	$383.63	24
Accredited Stand Alone Facility	$366.95	16
Non-accredited Stand Alone Facility	$333.59	8
Weighted Average FY 2009-10 and FY 10-11 Per Diem Rates		
Weighted average per diem FY 2009-10	**$369.73**	-
Estimated Per Diem Growth Rate[1]	4.10%	
Weighted average per diem FY 2010-11	**$384.89**	

[1] Source: Bureau of Labor Statistics, May 2008 Consumer Price Index for medical care.

Table D.4: FY 2009-10 and FY 10-11 Savings from New Adult Hospital Back Up Rates			
Row	**Item**	**Total**	**Description**
A	Estimated New Clients from New Rates	18	Number of clients under old capacity under new rates (30 - 12).
B	Current Average Rate (per diem)	$668.00	Average rate (per diem) under current rates.
C	FY 2009-10 Weighted Average New Rate	$369.73	FY 2009-10 estimated average new rate from Table D.3.
D	Estimated Per Diem Savings	($298.27)	Row C - Row B.
E	**Total FY 2009-10 Savings**	**($1,959,634)**	Row A * Row D * 365 days.
F	FY 2010-11 Weighted Average New Rate	$384.89	FY 2010-11 estimated average new rate from Table D.3.
G	Estimated Per Diem Savings	($283.11)	Row G - Row B.
H	**Total FY 2010-11 Savings**	**($1,860,033)**	Row A * Row G * 365 days.

Table D.5: Derivation of FY 2009-10 Adult Hospital Back Up Savings Estimates			
Row	**Item**	**Total**	**Description**
A	Projected Hospitalization Costs Per Client	$218,896	Assumes 180 outlier days at $1,216.09 per day. Based on data from the Medicaid Management Information System.
B	Estimated Full Year Hospital Back Up Cost	$134,951	365 days at $369.73 per day from Table D.3.
C	Estimated savings per client	($83,945)	Row B - Row A.
D	Estimated savings per client per month	($6,995)	Row C/12.
E	Estimated New Enrollment- October 2009	10	Based on an assumed total caseload increase of 30 clients, to be phased in equally over three quarters.
F	Estimated New Enrollment- January 2010	10	
G	Estimated New Enrollment- April 2010	10	
H	Annual savings for clients enrolled in October 2009	($629,550)	Row D * Row E * 9 months.
I	Annual savings for clients enrolled in January 2010	($419,700)	Row D * Row E * 6 months.
J	Annual savings for clients enrolled in April 2010	($209,850)	Row D * Row E * 3 months.
K	Savings from 30 expansion clients	($1,259,100)	(Row H + Row I + Row J).
L	Savings from New Rate Methodology	($1,959,634)	Table F.4, Row E.
M	Total Potential FY 2009-10 Savings	($3,218,734)	Row K + Row L.
N	**Total Estimated FY 2009-10 Savings**	**($1,609,367)**	The Department assumes that savings may be reduced by half. Row M * 50%.

Table D.6: Derivation of FY 2010-11 Adult Hospital Back Up Savings Estimates			
Row	**Item**	**Total**	**Description**
A	Projected Hospitalization Costs Per Client	$223,049	Assumes 180 outlier days at $1,239.16 per day. Based on data from the Medicaid Management Information System.
B	Estimated Full Year Hospital Back Up Cost	$140,485	365 days at $384.89 per day from Table D.3.
C	Estimated savings per client	($82,564)	Row B - Row A.
D	Estimated savings for 30 expansion clients	($2,476,920)	Row C * 30 clients.
E	Savings from New Rate Methodology	($1,860,033)	Table D.4, Row H.
F	Total Potential FY 2010-11 Savings	($4,336,953)	Row D + Row E.
G	**Total Estimated FY 2010-11 Savings**	**($2,168,476)**	The Department assumes that savings may be reduced by half. Row F * 50%.

Table D.7: Derivation of FY 2009-10 Pediatric Hospital Back Up Savings Estimates			
Row	**Item**	**Total**	**Description**
A	Projected covered costs per client	$259,150	Assumes 180 outlier days at $1,439.72 per day.
B	Estimated Full Year Hospital Back Up Cost	$237,250	365 days at $650 per day.
C	Estimated savings per client	($21,900)	Row B - Row A.
D	Estimated savings per client per month	($1,825)	Row C/12.
E	Estimated New Enrollment- October 2009	10	Based on an assumed total caseload increase of 30 clients, to be phased in equally over three quarters.
F	Estimated New Enrollment- January 2010	10	
G	Estimated New Enrollment- April 2010	10	
Total Savings Calculations			
H	Annual savings for clients enrolled in October 2009	($164,250)	Row D * Row E * 9 months.
I	Annual savings for clients enrolled in January 2010	($109,500)	Row D * Row E * 6 months.
J	Annual savings for clients enrolled in April 2010	($54,750)	Row D * Row E * 3 months.
K	**Total FY 2009-10 Savings**	**($328,500)**	Row H + Row I + Row J.

Table D.8: Derivation of FY 2010-11 Pediatric Hospital Back Up Savings Estimates			
Row		**Total**	**Description**
A	Projected covered costs per client	$264,004	Assumes 180 outlier days at $1,466.69 per day.
B	Estimated Full Year Hospital Back Up Cost	$237,250	365 days at $650 per day.
C	Estimated savings per client	($26,754)	Row B - Row A.
D	**Estimated savings for 30 clients**	**($802,620)**	Row C * 30 clients.

Table E.1
Summary of Oxygen Related DME

Line Item	Description	FY 2009-10	FY 10-11	Source
(1) Executive Director's Office; (A) General Administration, Personal Services	FTE Costs for Oxygen Related DME	$67,285	$73,402	Table F.
(1) Executive Director's Office; (A) General Administration, Operating Expenses	FTE Costs for Oxygen Related DME	$6,178	$950	Table F.
(2) Medical Services Premiums	Savings Due Oxygen Related DME Reform	($574,260)	($639,266)	Table E.3.
Total		**($500,797)**	**($564,914)**	

Table E.2: Durable Medical Equipment Expenditures by Category			
Category	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**
Beds	$752,428	$905,334	$1,199,010
Power wheel chairs/scooters	$5,641,140	$5,354,485	$4,994,273
Enteral & Parenteral Therapy	$8,568,752	$10,888,068	$11,391,653
Incontinence Supplies	$7,269,709	$8,523,858	$10,100,684
Medical and Surgical Supplies	$4,280,235	$5,177,580	$5,135,780
Miscellaneous DME	$977,848	$1,129,171	$628,191
Orthotic Procedures	$466,143	$672,537	$649,310
Other	$4,577,121	$6,463,023	$5,613,350
Oxygen related	$20,890,773	$24,656,793	$25,793,208
Totals	**$53,424,149**	**$63,770,849**	**$65,505,459**
Annual percent change in oxgyen expenditures		18.03%	4.61%

Payments based on accrual accounting for procedure codes for which total payments were more than $100,000. FY 2007-08 data current as of September 30, 2008. Expenditures are for three categories of client eligibility: Dual eligible, Medicaid with third-party insurance, and Medicaid only.

Table H.3: Estimated Net Savings from Implementing Proposed Alternatives			
Row	**Item**	**Total**	**Description**
A	FY 2007-08 Oxygen Related Expenditures	$25,793,208	From Table E.2.
B	Assumed Annual Growth in Expenditures	11.32%	From Table E.2, average growth in expenditures in FY 2006-07 and FY 2007-08.
C	Estimated FY 2008-09 Oxygen Related Expenditures	$28,712,999	FY 2007-08 expenditures increased by assumed growth rate. Row A * (1+ Row B).
D	Estimated savings in FY 2009-10 from Implementing Proposed Alternatives	($574,260)	The Department estimates savings at 2% of estimated oxygen related expenditures. Row C * 2%.
E	Personal Services and Operating Expenses	$73,463	Table F.
F	**Estimated FY 2009-10 Net Savings**	**($500,797)**	Row D + Row E.
G	Estimated savings in FY 2010-11 from Implementing Proposed Alternatives	($639,266)	FY 2009-10 savings increased by assumed FY 2009-10 growth rate. Row D * (1+ Row B).
H	Personal Services and Operating Expenses	$74,352	Table F.
I	**Estimated FY 2010-11 Net Savings**	**($564,914)**	Row G + Row H.

Table F: FTE Costs					
FTE and Operating Costs				***GRAND TOTAL***	
Fiscal Year(s) of Request		**FY 09-10**	**FY 10-11**	**FY 09-10**	**FY 10-11**
PERSONAL SERVICES	**Title:**	**General Professional V**			
Number of PERSONS / class title		1	1		
Number of months working in FY 08-09, FY 09-10 and FY 10-11		12	12		
Number months paid in FY 08-09, FY 09-10 and FY 10-11		11	12		
Calculated FTE per classification		**0.9**	**1.0**	0.9	1.0
Annual base salary		$65,772	$65,772		
Salary		$60,291	$65,772	$60,291	$65,772
PERA	**10.15%**	$6,120	$6,676	$6,120	$6,676
Medicare	**1.45%**	$874	$954	$874	$954
Subtotal Personal Services at Division Level		**$67,285**	**$73,402**	**$67,285**	**$73,402**
OPERATING EXPENSES					
Supplies @ $500/$500	**$500**	$500	$500	$500	$500
Computer @ $900/$0	**$900**	$900	$0	$900	$0
Office Suite Software @ $330/$0	**$330**	$330	$0	$330	$0
Office Equipment @ $3,998/$0 (includes cubicle and chai	**$3,998**	$3,998	$0	$3,998	$0
Telephone Base @ $450/$450	**$450**	$450	$450	$450	$450
Subtotal Operating Expenses		**$6,178**	**$950**	**$6,178**	**$950**
GRAND TOTAL ALL COSTS		**$73,463**	**$74,352**	**$73,463**	**$74,352**