Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11		**Base Reduction Item FY 2010-11** ☑	**Supplemental FY 2009-10**	**Budget Amendment FY 2010-11**
Request Title:	Prevention and Benefits for Enhanced Value (P-BEV)			
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:**	November 2, 2009 10/15/09
Priority Number:	BRI-1	**OSPB Approval:**	**Date:**	11/2/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	**Total**	2,553,778,279	2,574,951,386	0	2,574,951,386	3,043,000,452	118,359	3,043,118,811	0	3,043,118,811	117,276
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	926,152,259	779,738,814	0	779,738,814	1,148,287,104	(11,201)	1,148,275,903	0	1,148,275,903	(15,077)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,228,606	170,040,016	0	170,040,016	355,125,060	(1,672)	355,123,388	0	355,123,388	(2,251)
	CFE/RF	2,731,396	2,839,847	0	2,839,847	2,836,488	0	2,836,488	0	2,836,488	0
	FF	1,475,414,226	1,622,332,709	0	1,622,332,709	1,536,751,800	131,232	1,536,883,032	0	1,536,883,032	134,604
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	22,200,548	27,451,189	0	27,451,189	36,883,007	(384,276)	36,498,731	0	36,498,731	(384,276)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
	GF	5,299,911	6,006,676	0	6,006,676	6,205,903	(134,052)	6,071,851	0	6,071,851	(134,052)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	540,118	1,176,844	0	1,176,844	2,488,901	0	2,488,901	0	2,488,901	0
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,167,341	0	20,167,341	28,087,875	(250,224)	27,837,651	0	27,837,651	(250,224)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**Total**	4,586,288	4,576,355	0	4,576,355	5,204,383	536,208	5,740,591	0	5,740,591	536,208
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,142,390	1,359,148	0	1,359,148	1,470,343	134,052	1,604,395	0	1,604,395	134,052
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	54,949	54,949	0	54,949	86,596	0	86,596	0	86,596	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,388,949	3,162,258	0	3,162,258	3,647,444	402,156	4,049,600	0	4,049,600	402,156

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☑	**Supplemental FY 2009-10**	☐	**Budget Amendment FY 2010-11**	☐				
Request Title:	Prevention and Benefits for Enhanced Value (P-BEV)										
Department:	Health Care Policy and Financing			**Dept. Approval by:**	John Bartholomew			**Date:**	November 2, 2009		
Priority Number:	BRI-1			**OSPB Approval:**				**Date:**			

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 2008-09	FY 2009-10	FY 2009-10	FY 2009-10	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2011-12
(2) Medical Services Premiums	**Total**	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(33,573)	3,000,879,489	0	3,000,879,489	(34,656)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	1,037,363,033	0	1,037,363,033	1,140,610,858	(14,606)	1,140,596,252	0	1,140,596,252	(15,077)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	(2,181)	352,547,382	0	352,547,382	(2,251)
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(16,786)	1,504,999,695	0	1,504,999,695	(17,328)
(2) Medical Services Premiums; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	3,405	3,405	0	3,405	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	509	509	0	509	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	(3,914)	(3,914)	0	(3,914)	0

Non-Line Item Request:	None.
Letternote Revised Text:	[a] Of this amount, $85,414,587 shall be from the Health Care Expansion Fund; $784,875 shall be from the Colorado Autism Treatment Fund; $250,000 shall be from the Coordinated Care for People with Disabilities Fund; $3,026,893 shall be from the Comprehensive Primary and Preventive Care Fund; $1,725,479 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund; $27,040,854 shall be from the Nursing Facility Cash Fund; $212,806,547 shall be from the Hospital Provider Fee; and $21,498,147 shall be certified public expenditures.
Cash or Federal Fund Name and COFRS Fund Number:	CF: Health Care Expansion Fund 18K; FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name:	None.
Approval by OIT?	**Yes:** ☐ **No:** ☐ **N/A:** ☑
Schedule 13s from Affected Departments:	None.

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-1
Change Request Title:	Prevention and Benefits for Enhanced Value

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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:

The Department requests an increase of $118,359, with a reduction of $11,201 General Fund in FY 2010-11, and an increase of $117,276 with a reduction of $15,077 General Fund in FY 2011-12, in order to 1) consolidate utilization review contracts as the first step towards development of a comprehensive evidence guided utilization review program; 2) an expanded set of dental procedures to be performed by dental hygienists; and, 3) improved non-emergency medical transportation policies.

Background and Appropriation History:

In 2006, SB 06-208 established the Blue Ribbon Commission for Health Care Reform ("the Commission"). The Commission was to study and establish health care reform models that expand health care coverage and decrease health care costs for Colorado residents. The Commission was authorized to examine options for expanding cost effective health coverage for all Colorado residents in both the public and private sector markets, with special attention given to the uninsured, underinsured, and those at risk of

financial hardship due to medical expenses. The Commission provided a final set of recommendations to the General Assembly on January 31, 2008.[1]

Consistent with Governor Ritter's vision and the Commission's recommendations for a 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 is continuing to purposefully and systematically advance its health care reform efforts; this request is the next in that series of steps.

In FY 2007-08, the Department presented its Building Blocks to Health Care Reform request, which offered to centralize Medicaid and Children's Basic Health Plan Eligibility; provide a Medical Home for over 270,000 children enrolled in Medicaid and the Children's Basic Health Plan; increase rates for physicians and dentists; enhance the Children's Basic Health Plan mental health benefit; enroll 200,000 Medicaid clients in an integrated care delivery model; and, fund the Colorado Regional Health Information Organization (CORHIO).

In FY 2008-09, the Department offered a coordinated set of requests:

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

In sum, these requests offered to streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan; deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado; improve quality of service for clients; and implement an automated prior authorization system for drug prescriptions, changes to the reimbursement rates of drugs using a state maximum allowable cost

[1] The Commission's report is available on its website, http://www.colorado.gov/208commission/

structure, and changes in federal requirements with regard to pharmacy claims submitted by physicians and hospitals.

In alignment with these reform efforts, the Department now requests authority for a third phase, one which takes into careful consideration the difficult economic decisions facing the State by offering a General Fund savings while positioning the Department to further advance the principles of adopting best practices to avoid delivering acute and chronic care that is deemed unnecessary, improving provider access and enhancing program integrity through the use of technology and data systems.

Through the Prevention and Benefits for Enhanced Value request, the Department would generate service efficiencies while improving the quality of service for clients through a series of initiatives focused on enhancing quality and health outcomes:

- Consolidation of Current Utilization Review Functions
- Expanded Procedures for Dental Hygienists
- Non-Emergency Medical Transportation Policies Reform

The cornerstone of these initiatives is the consolidation of current utilization review functions. This consolidation is a first step towards a transition to "evidence guided utilization review." The Department is currently preparing a Request for Proposals (RFP) to enhance its current acute care utilization review structure. This RFP would consolidate prior authorization review activities now provided to the Department by two vendors into one contract. As part of this effort, the Department will require its new vendor have the capacity to not only handle the consolidated current utilization review functions but also have the capacity to meet Departmental options within the contract to comprehensively overhaul the utilization review program, following other states that in recent years have adopted advanced approaches to control medical costs and reduce unwarranted variation in care.

The Department seeks to adopt best practices to address unnecessary medical expenditure, and securing the services of a contractor that can handle the potentially increased scope of

utilization review practices is a necessary first step. Upon successful completion of the utilization review consolidation, the Department may request additional funding through the standard budget process to increase the scope of utilization review services to be performed by the contractor. By more clearly defining benefit limits, and exceptions to those limits that require prior-authorizations, and by consolidating administrative functions for utilization and prior-authorization reviews, the Department can more efficiently guarantee access to care for its clients while ensuring that only medically necessary services are provided.

In addition, the Department is seeking to further define benefits to focus on preventive care that avoids more costly emergency and acute treatment. By allowing dental hygienists to provide an expanded menu of dental services, clients will have better access to dental care and avoid more costly acute and emergency dental procedures. The Department has also been instructed by the Centers for Medicare and Medicaid Services (CMS) to provide non-emergency medical transportation reimbursement for pharmacy visits and repair trips for durable medical equipment. Reimbursing for these services allows for the Department better assists clients' receipt of preventive and maintenance care that will avoid more costly acute and emergency procedures while ensuring the Department remains in compliance with federal regulations.

General Description of Request:

The Department requests an increase of $118,359, with a reduction of $11,201 General Fund in FY 2010-11, and an increase of $117,276 with a reduction of $15,077 General Fund in FY 2011-12, in order to 1) consolidate utilization review contracts as the first step towards development of a comprehensive evidence guided utilization review program; 2) an expanded set of dental procedures to be performed by dental hygienists; and, 3) improved non-emergency medical transportation policies.

Consolidation of Current Utilization Review Functions

The Department requests an increase of $151,932 total funds, but with a $0 General Fund impact in FY 2010-11 to perform a comprehensive reformation of its benefit definitions and utilization review practices. Through this initiative, the Department is continuing to

follow through on the Blue Ribbon Commission for Health Care Reform's recommendation "to enhance quality and lower cost."[2] See Appendix Table A.1, A.2, and A.3 for additional calculations.

As part of last fiscal year's Medicaid Program Efficiencies request, the Department was granted $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 was able to provide a comprehensive, coordinated, customer-centered and outcome-based continuum of care. Historically, benefit and eligibility expansions had focused on the scope of services received by clients, and not the quality of care or the client outcomes. The focus on reimbursement systems had previously relegated quality and outcomes to secondary goals. This Request continued the Department's focus on ensuring that appropriate care is delivered in the most efficient manner possible.

The Department has contracted with a consultant to organize and plan a series of stakeholder sessions and to assist the Department in establishing priorities and processes to refine benefits definitions so that they incorporate a wide range of concepts critical to a health outcomes-based program. In addition, the Department is instituting the Accountable Care Collaborative, in which care coordinators will be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospital 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. Using a primary care case management/administrative services organization (PCCM/ASO) contract model allows the Department to implement reform quickly, by hiring expertise externally and adopting a few off-the-shelf improvements immediately, while simultaneously working on the programmatic need to shift Colorado Medicaid to an outcome-based system.

[2] Blue Ribbon Commission for Health Care Reform. "Final Report to the Colorado General Assembly." January 31, 2008, p. 14.

Though this is a multi-year process, the Department identified the following areas as benefits collaborative goals: 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 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.

In addition, the Accountable Care Collaborative is charged with: determining what health outcomes are appropriate; development of minimum standards of care; conducting a comprehensive review and revision of the traditional fee-for-service benefit package; updating regulations to prevent waste and abuse; and, removing outdated rules and system edits to increase efficiency.

As the next step in meeting these goals, the Department has determined that its prior authorization review processes must be modernized and improved. The first step in transitioning to evidence guided utilization review is to consolidate its current acute care utilization reviews. The Department believes that utilization review can better be handled by a single contractor, and simultaneously produce a savings to the State's General Fund.

Consolidation of Acute Care Utilization Review Contracts

For FY 2010-11, the Department's first step would be to require that its acute care utilization reviews are performed by Quality Improvement Organizations (QIO). When utilization reviews are performed by QIOs, the Department receives a 75% federal match on its expenditure (see 42 CFR § 476). Currently, the Department contracts with two prior authorization review agencies: Affiliated Computer Services (ACS) and Colorado Foundation for Medical Care (CFMC). Some of ACS prior authorization review services receive a 75% federal match and some portion receives a 50% federal match. By

consolidating all prior authorization review under a contract with a QIO, the Department would increase its federal funds total from the consolidated contract to $402,156 from an initial total of $250,224. The Department's calculations are contained in Table A.1 and A.2.

The Department is releasing a request for proposals (RFP) in late 2009 to solicit bids for a new utilization review vendor, expected to being work in July, 2010. The newly contracted QIO would be responsible for prior authorization and retrospective reviews of acute care utilization. Additionally, the new QIO would be required to have the capacity to interface with technology upgrades in future years, when and if the Department incorporates technology and systems changes in later phases of this reform. A single QIO would allow for all reviews to be conducted by appropriate medical professionals, ensuring reviews adhere to the principles of medical necessity and improvement of health outcomes. Additionally, by contracting with a single QIO, any future systems enhancements would not be complicated by the need to integrate multiple technologies from multiple vendors. Finally, any QIO activity would also receive the enhanced 75% federal match rate.

Upon execution of the new contract, the Department and its QIO contractor will begin a two-fold process: 1) performing the required utilization review practices, and 2) develop the technical requirements for implementing a comprehensive utilization management system, positioning the Department to request additional funds for utilization review and systems changes that would allow the Department to more efficiently target a larger number of claims for utilization review and thereby generate additional savings across the Medicaid program. Procurement of a new, single contractor will position the Department to later request additional funding in support of evidence guided utilization review:[3]

[3] It is important to note that prior authorizations for pharmacy services and long term care services are not included in this request because the delivery structure for those benefits fundamentally differs from that of most acute care services. After the evidence guided utilization review program is established, the Department may consider expanding the scope of the program.

Evidence Guided Utilization Review

The Need to Modernize the Current Utilization Review System

Analysis of the Department's utilization review programs by external reviewers describe fragmented, outdated practices that have failed to keep pace with best practices among commercial and public health plans. The Department's current review activities focus on demand management strategies including prospective review of a handful of high-cost procedures, out-of-state admissions, occupational and physical therapies, durable medical equipment, transportation, and behavioral health services. In addition to these prospective reviews – or prior authorization reviews (PARs) – the Department's vendors also review claims data (retrospective reviews) to ensure appropriateness of hospital admissions, coding, and billing.

The Department's review activities do not currently address outpatient hospital services, one of the Department's largest and fastest growing cost categories and the subject of intensive review activities among commercial plans and other states. The Department's review activities do not include concurrent review strategies to control excessive patient utilization (e.g. frequent emergency department visits, or extended stays in a hospital setting beyond the average duration) and to efficiently transition patients from acute settings into intermediate care or home-based care settings.

The Department's movement towards evidence guided utilization review reform builds upon the proven efforts of other states, Medicare, and advanced commercial plans. The approach focuses on four core strategies:

- Stabilize medical costs by adopting best practices in medical review as developed by other states that have successfully contained growth in medical spending.
- Enhance access to information to enable rapid cost-containment interventions based on utilization trends, cost modeling, event notification, provider profiling, and client health status.

- Engage providers through streamlined and automated medical review, profiling, education, and incentives.
- Empower clients to access preventive care services and to limit high-cost services in a responsible way.

Investment in Utilization Review

After consolidation of utilization review functions, the Department may to request additional funds for its Utilization and Quality Review Contracts, Professional Services Contracts line item to implement the evidence guided utilization review concept. Any request will be offset by demonstrated savings to the Medical Services Premiums line item resulting from increased utilization review; further, as a result of the utilization review contract consolidation, any General Fund investment will receive an enhanced federal matching percentage of 75%. The additional federal funds and resulting total funds increase will increase the savings return on utilization spending.

Multiple studies have demonstrated the impact of utilization management and medical review practices. While no study has been specific to the Colorado experience, return on investment estimates have ranged from two times the cost of the program to nine times the cost of the program.[4] An aggregated review of available studies suggests a return of approximately three-and-a-half times cost on prior authorization and utilization review.[5] Evidence guided utilization review reform seeks, among other objectives, to adopt best practices for the Department to continue to address the estimated 20-30 percent of acute and chronic care that is deemed unnecessary, according to national researchers.[6]

[4] See Shutan, Bruce, "The DM Rx: Disease Management Programs Producing Fast and Meaningful Outcomes, Impressive ROI," Employee Benefit News, Vol. 18, No. 13, October, 2004. and KePro Care Management Solutions, http://www.kepro.org/services/utilrev.aspx.

[5] Dove, Henry G and Duncan, Ian, "An Introduction to Care Management Interventions and their Implications for Actuaries," Society of Actuaries, October 15, 2004, p. 8.

[6] Becher EC and Chassin MR. "Improving The Quality of Health Care: Who Will Lead?", *Health Affairs*, 20(5), 164-179, 2001.

Understanding the current fiscal environment, the Department may propose instituting this comprehensive reform in phases, ensuring that each phase is capable of covering its own costs of implementation as well as achieving additional savings over time.

Evidence guided utilization review would focus on high-growth, high-cost medical spending categories, including radiology, hospital outpatient services, selected outpatient therapies, ancillary services, emerging technologies, and selected client groups such as high risk deliveries and pre-term newborns. Evidence guided utilization review would also allow for concurrent review selected activities such as inpatient outlier days.

Furthermore, the Department believes evidence guided utilization review reform would lead to enhanced quality and improved health outcomes. Research has repeatedly shown excessive and unwarranted variations in care lead not only to waste, but poor outcomes as well. A landmark study of Medicare patients by researcher Elliot Fisher and colleagues at Dartmouth found an inverse relationship between health care spending and health care quality.

Moreover, evidence guided utilization review would involve continuing the work of the Accountable Care Collaborative and the Benefits Collaborative, described above, to review policies, to encourage the development of community-wide standards, and to confirming local best practices while shaping medical review policy around best research evidence. As provider panels and client and stakeholder sessions yield newly documented best practices and community standards, and upon request of additional funding, the Department may require its QIO to integrate these standards with evidence-based clinical guidelines – such as the Milliman Care Guidelines and McKesson's InterQual decision support criteria – and adjudicate its reviews based on those standards through a new technology system.

Technological Enhancements for Utilization Review

Through the request for proposals process, the Department aims to implement a key technological initiative that would allow for more effective evidence guided utilization

review. The Department would, in conjunction with its utilization review vendor, develop a rapid, web-based PAR system allowing providers to submit prior authorization requests through a web portal and receive timely and/or automated responses. The new QIO vendor, procured through the consolidated contract for utilization review, would be required to have the capacity to work with these technological advancements upon the Department's option should funding be requested and received.

Due to the current fiscal situation, the Department is not requesting funding to implement the web-based PAR system at this time. The Department is investigating the potential savings from implemented such a system, and may request a change in funding at a future date.

A central barrier to the Department's understanding of its medical utilization patterns is access to data. Currently, program administrators must wait for information systems specialists to manipulate data and present actionable reports. There are frequently delays due to backlogs and other priority projects. As part of the Department's RFP process, the Department would require its vendor to have the capacity to create reports and tools which allow for intuitive access so program administrators could rapidly identify cost trends and intervene, if necessary.

The Department's ultimate goal is to use current technologies to streamline the prior authorization process and reduce administrative burdens for providers and the Department. To accomplish these goals, the Department may request funding for the implementation of a rapid, web-based utilization review and management system. The Department anticipates that this system will include:

- The ability for provider to submit prior authorization requests through a web portal and receive timely and/or automated responses;
- Screening/assessment web and fax templates to enable prevention- and diagnostic-based authorizations;

- A central "dashboard" to assist provider decision making, including rapid notification of events such as a patient presenting at the emergency department or being admitted to the hospital;
- Research databases to enable evaluation and documentation of review policies;
- Enhanced provider collaboration and communication to define community standards and best practices as supported by research; and,
- Web-based provider education modules to communicate these community standards and to inform providers of medical review policies.

As part of the Department's RFP process, the Department will seek a vendor that has as many of these components in a ready-to-go framework as possible and has the ability to expand its use of these and similar technologies should additional funding be requested and become available.

Future Evidence Guided Utilization Review Initiatives

The Department believes that the transition to the evidence guided utilization review program will generate Medicaid program savings, which can be reinvested to expand utilization review efforts. The Benefits Collaborative, which is gathering input from stakeholders to define appropriate limitations in the amount, duration, quantity, and scope of benefits, as well as the technical expertise of the vendor, should yield even further savings. Possible areas of program expansion include, but are not limited to:

- Site-of-service prior authorization policy for low-acuity outpatient surgeries and invasive procedures; this would follow Pennsylvania and other states who have actively steered cases to lower-cost settings such as ambulatory surgery centers.
- A 14-day re-admissions review policy, providing incentives for higher quality discharge planning and case management, and initially targeting ambulatory-sensitive admissions.
- Utilization threshold policies based on client diagnoses as determined by predictive modeling and other analytics; this would ensure appropriate access while preventing unwarranted utilization.

- Expanded client "lock-in" programs -- similar to the existing Client Over-Utilization Program for prescription drugs -- that seek to curb utilization by overly high-utilizing clients.
- Client registry systems such as the Colorado Immunization Information System and the new Prescription Drug Monitoring Program for controlled substances, which allow providers to view client utilization data and intervene at the point of care; benefits include community-wide care coordination, lower costs and enhanced population health outcomes.

The Department will submit additional budget actions in the future to account for any savings achieved through these initiatives.

Summary of Consolidation of Acute Care Utilization Review Contracts

Through the consolidation of acute care utilization review functions, the Department is in a position to contract with a new QIO vendor with the ability to not only perform current utilization review activities but also to help develop and use enhanced technologies that can dramatically increase the effectiveness of the Department's utilization review program. The Department currently requests to consolidate its utilization review contracts as a first step towards a broader movement to provide appropriate and efficient care while controlling Medicaid program costs.

Expanded Procedures for Dental Hygienists

The Department requests a reduction of $67,541 total funds, $29,383 General Fund, in FY 2010-11, as well as a reduction of $72,562 total funds, $31,567 General Fund in FY 2011-12, for allowing dental hygienists to provide an expanded menu of services to clients. This request is in alignment with both the Blue Ribbon Commission for Health Care Reform and the intent of the Colorado General Assembly. As part of its findings, the Commission recommended that the State "explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists, and others from practicing

to the fullest extent of their licensure and training."[7] The Colorado General Assembly recently passed Senate Bill 09-129, which allowed hygienists to perform unsupervised diagnoses and treatment planning, radiographs, and take impressions for use for study models, whether employed by a dentist or working as an unsupervised hygienist. See Table B.1 and B.2 for additional calculations.

As the bill was being considered, only the Department of Regulatory Agencies was contacted to provide a note of fiscal impact. After passage of the legislation, the Department, as part of its regular operations to examine the regulatory environment coming out of each legislative session, identified the potential savings made available by the bill's signing.

Currently Colorado Medicaid allows unsupervised/independent dental hygienists to bill nine procedure codes. SB 09-129 now allows unsupervised/independent hygienists in Colorado to perform an additional seventeen diagnostic, preventive and periodontal procedures related to:

- Dental hygiene assessment;
- Dental hygiene diagnosis;
- Dental hygiene treatment planning for dental hygiene services;
- Identifying dental abnormalities for immediate referral to a dentist (study casts, radiographic and x-ray survey); and,
- Administering fluoride, fluoride varnish, antimicrobial solutions, and antimicrobial agents.

This request is to add the 17 additional procedures to the list of those that hygienists can provide to Medicaid clients. By adding these procedures to the Medicaid reimbursement schedule for independent hygienists to perform, the Department anticipates increased access for an unmet need for some of our clients who are currently not accessing these services from dentists as often as needed.

[7] Blue Ribbon Commission for Health Care Reform. "Final Report to the Colorado General Assembly." January 31, 2008, p. 13.

Of the 9 procedure codes currently billable by both dentists and hygienists, approximately 1.93% of expenditure is from hygienist practice. This number represents the possible increase in utilization of the expanded services the Department may witness due to the increased access to providers that hygienists would supply. The Department assumes that only a portion of clients, 50%, will take advantage of the improved access to care. The result would be an estimated increase in total dental expenditure of $120,414 in FY 2010-11 and $129,366 in FY 2011-12.

By providing access to routine, and less costly, dental care, the Department anticipates a subsequent decrease in restorative, periodontal, endodontic, surgical, adjunctive, and hospital related dental procedures. The Department estimates those procedures will total $3,759,102 in expenditure for FY 2010-11 and $4,038,559 for FY 2011-12. The Department estimates a small offset of 5% of these costs due to improved access to preventive and routine dental procedures. Added to the cost of the program related above, the Department estimates net savings for this initiative of $67,541 in FY 2010-11 and $72,562 in FY 2011-12.

Non-Emergency Medical Transportation Policies Reform

The Department requests an increase of $33,968 total funds, $14,777 General Fund in FY 2010-11, as well as an increase of $37,906 total funds, $16,490 General Fund, in FY 2011-12, through the alteration of non-emergency medical transportation (NEMT) policy in the spirit of the Commission's recommendation that the State "enhance access to needed medical care, especially in rural Colorado where provider shortages are common."[8] See Appendix Table C for additional calculations.

Many Coloradans, and a proportionally large contingent of rural Coloradans, utilize NEMT services. The Department continually examines this vital program for efficiency and appropriateness of services provided. This request is to expand NEMT services to include client transportation to durable medical equipment (DME) providers for scheduled

[8] Blue Ribbon Commission for Health Care Reform. "Final Report to the Colorado General Assembly." January 31, 2008, p. 17.

repairs. The Centers for Medicare and Medicaid Services (CMS) informed the Department, through a series of emails in July 2009, that providing this service is necessary in order to remain in compliance with federal regulations. The implementation process only requires notification to the counties and can be accomplished with current Department resources.

Rural clients who have difficulty getting to their doctors are at increased risk for a variety of adverse health outcomes that can lead to expensive emergency room visits and ambulance trips. NEMT was designed to mitigate that risk. However, that risk is not properly dealt with if the DME a client needs in order to follow her doctor's orders cannot be repaired. Currently, NEMT does not reimburse trips to DME repair appointments.

Historically, 0.70% of all DME expenses are for DME repairs. Using that percentage, and applying it to the projected $2,469,468 in DME expenditure for clients who also use NEMT services for FY 2010-11 and $2,657,395 for FY 2011-12, the Department anticipates an increase of $17,163 and $18,469 in DME repair costs for the respective fiscal years.

Additionally, applying the percentage to the number of trips taken per fiscal year by NEMT clients who also use DME, the Department anticipates an additional 214 NEMT trips in FY 2011-12 at a cost of $16,805 and an additional 230 trips in FY 2011-12 at a cost of $19,437.

The time horizon for the savings could be as long as a lifetime. Determining what proportion of those will remain Medicaid clients, controlling for other behaviors over that time that may impact their health, and anticipating the severity of their future health issues complicate any savings calculation. Because of the complications, the Department does not assume any immediate savings. However, the requested funds would allow the Department to remain in compliance with federal regulation and provide the best access to heath care providers and the resources needed to carry out their treatment plans. The Department should realize a savings in future years through the avoided cost of acute and

emergency room treatment that would result from clients being denied the medical equipment they need.

Consequences if Not Funded:

The Department would not be able to provide efficiencies to obtain savings resulting from its proposed changes. 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.

The Department is committed to focus on cost, quality, and access to health care, and is taking a pragmatic approach to achieving the Governor's and the Blue Ribbon Commission for Health Care Reform's vision of effective health care for Coloradans. In the current fiscal climate, the Department continues to advance on this front while finding efficiencies in the system, cutting waste, and bringing more transparency to the system. The Department views each of the steps outlined in this change request as critical so as to not reverse the gains made in implementing broader health care reform in the State of Colorado. Moreover, beyond the immediate General Fund savings as presented in this change request, the Department's proposed initiatives are a significant opportunity to mitigate long term expenditure growth by providing better quality health outcomes for clients.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Summary of Request FY 2010-11					
Total Request	**$118,359**	**($11,201)**	**($1,672)**	**$0**	**$131,232**
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**($384,276)**	**($134,052)**	**$0**	**$0**	**($250,224)**
Consolidate Utilization Review Contract	($384,276)	($134,052)	$0	$0	($250,224)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**$536,208**	**$134,052**	**$0**	**$0**	**$402,156**
Consolidate Utilization Review Contract	$536,208	$134,052	$0	$0	$402,156
(2) Medical Services Premiums	**($33,573)**	**($14,606)**	**($2,181)**	**$0**	**($16,786)**
Dental Hygienists Procedure Expansion	($67,541)	($29,383)	($4,388)	$0	($33,770)
Non-Emergency Medical Transportation Policies Reform	$33,968	$14,777	$2,207	$0	$16,984
(2) Medical Services Premiums Long Bill Group Total (ARRA Adjustment)	**$0**	**$3,405**	**$509**		**($3,914)**

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$117,276**	**($15,077)**	**($2,251)**	**$0**	**$134,604**
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**($384,276)**	**($134,052)**	**$0**	**$0**	**($250,224)**
Consolidate Utilization Review Contract	($384,276)	($134,052)	$0	$0	($250,224)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**$536,208**	**$134,052**	**$0**	**$0**	**$402,156**
Consolidate Utilization Review Contract	$536,208	$134,052	$0	$0	$402,156
(2) Medical Services Premiums	**($34,656)**	**($15,077)**	**($2,251)**	**$0**	**($17,328)**
Dental Hygienists Procedure Expansion	($72,562)	($31,567)	($4,714)	$0	($36,281)
Non-Emergency Medical Transportation Policies Reform	$37,906	$16,490	$2,463	$0	$18,953

Cash Funds Projections: The Department used its FY 2009-10 appropriation as the basis to estimate the proportion of total funding to be dedicated to the Health Care Expansion Fund. The Department estimates reduction of $1,672 in FY 2010-11 and $2,251 in FY 2011-12 to the fund.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Health Care Expansion Fund	18K	$94,003,143	$119,601,623	$81,320,908	$34,980,659	($22,674,568)

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: Not applicable.

Cost Benefit Analysis:

This request includes total net savings of $11,201 General Fund in FY 2010-11 and a net savings of $15,077 General Fund in FY 2011-12 due to program efficiencies. However, the proposal includes an increase in federal funds of $131,232 in FY 2010-11 and an increase of federal funds of $134,604 in FY 2011-12. 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;
- Lowering costs while adhering to medical best practices;
- Providing increased access to services;
- Mitigating against future high-cost expenditures; and
- Empowering individual clients to manage their health in partnership with providers.

Coupled with the savings figures, for these reasons the Department believes that the short- and long-term benefits of these initiatives outweigh the costs.

Implementation Schedule:

To achieve the savings as indicated in this request, the Department is able to implement immediately within the resources requested.

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2009). 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.

12-35-128, C.R.S. (2009). Tasks authorized to be performed by dental assistants or dental hygienists.

(1) The responsibility for dental diagnosis, dental treatment planning, or the prescription of therapeutic measures in the practice of dentistry shall remain with a licensed dentist and may not be assigned to any dental hygienists; except that a dental hygienist may perform dental hygiene assessment, dental hygiene diagnosis, and dental hygiene treatment planning for dental hygiene services; identify dental abnormalities for immediate referral to a dentist as described in sections 12-25-124 and 12-35-125; and may administer fluoride, fluoride varnish, and antimicrobial solutions for mouth rinsing as described in sections 12-35-124 and 12-35-125, and resorbable antimicrobial agents pursuant to rules of the Board. No dental procedure that involves surgery or that will contribute to or result in an irremediable alteration of the oral anatomy may be assigned to anyone other than a licensed dentist. Prescriptive authority may not be assigned to anyone other than a licensed dentist.

Performance Measures:

This Change Request affects the following Performance Measures:

- Improve access to and the quality of Medicaid health care as demonstrated through improvements in the Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures;
- Increase the number of options for clients enrolling in Medicaid to select a focal point of care.

The Department uses the measures above to help assure delivery of appropriate, high quality health care in the most cost-effective manner possible. This request would assist the Department in designing programs that result in improved health status for clients served and improved health outcomes. In addition, this request would assist the Department in expanding and preserving health care services through the purchase of services in the most cost-effective manner possible.

Base Reduction Item - 1: Prevention and Benefits for Enhanced Value
Appendix

Table A.1 Requested Shift in Utilization Review Funding						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Description**
A	Current ACS Contract	($384,276)	($134,052)	$0	($250,224)	Table A.2, Row E
B	QIO Contract	$536,208	$134,052	$0	$402,156	Would receive 75% federal match
C	Incremental Change	$151,932	$0	$0	$151,932	Row A - Row B

Table A.2 Current Review Activities Subject to Contract Consolidation						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Description**
A	Monthly Cost of Reviews with an Enhanced Federal Match	$19,365	$4,842	$0	$14,523	The current contractor receives 75% federal match.
B	Monthly Cost of Reviews at the Standard 50% Federal Match	$12,658	$6,329	$0	$6,329	General Fund Only, adjusted for enhanced FMAP.
C	Total Monthly Cost of Reviews	$32,023	$11,171	$0	$20,852	General Fund Only, adjusted for enhanced FMAP.
D	Months in Effect	12	12	12	12	Row A + Row B + Row C
E	Current Total Yearly Cost of Reviews	$384,276	$134,052	$0	$250,224	Row C * Row D

Base Reduction Item - 1: Prevention and Benefits for Enhanced Value
Appendix

Table B.1
Estimated Savings from Dental Hygienists Procedure Expansion to Adults

Row	Item	FY 2010-11	FY 2011-12	Description
A	FY 2008-09 Dental Expenditure on Procedures to be Allowed to be Performed by a Hygienist	$10,797,306	-	Actuals.
B	Estimated Growth Rate of Dental Expenditure	7.43%	-	Average year-to-year growth from last three fiscal years.
C	Projected Dental Expenditure on Procedures Allowed to be Performed by a Hygienist	$12,462,355	$13,388,825	FY 2010-11: Row A * (1 + Row B)^2 FY 2011-12: Row C * (1 + Row B)
D	Increase in Dental Utilization on Selected Services	0.97%	0.97%	Table H.2, Row H.
E	New Total Dental Expenditure on Selected Services	$12,582,769	$13,518,191	Row C * (1 + Row D)
F	Increase in Expenditure	$120,414	$129,366	Row E - Row C
G	FY 2008-09 Dental Expenditure for Adults on Acute Procedures	$3,256,862	-	Actuals of adult expenditures on acute procedures.
H	Estimated Growth Rate of Dental Expenditure	7.43%	-	Average year-to-to year growth from last three fiscal years.
I	Projected Acute and Emergency Dental Expenditures	$3,759,102	$4,038,559	FY 2010-11: Row G * (1 + Row H)^2 FY 2011-12: Row I * (1 + Row H)
J	Estimated Savings	5.00%	5.00%	Assumption.
K	Total Reduction to Emergency Expenditure	($187,955)	($201,928)	-(Row I * Row J)
L	Total Estimated Net Savings	($67,541)	($72,562)	Row F + Row K

Table B.2
Estimated Utilization Increase from Dental Hygienists Procedure Expansion to Adults

Row	Procedure Description	Hygienist Units Reimbursed	Total Units Reimbursed	Hygienist Percentage of Total Units Reimbursed	Source
A	Prophylaxis Adult	811	24,927	3.25%	Actuals
B	Prophylaxis Child	1,011	92,681	1.09%	Actuals
C	Topical app fluoride child	1,312	92,637	1.42%	Actuals
D	Topical app fluoride adult	707	22,314	3.17%	Actuals
E	Sealant Per Tooth	1,531	45,431	3.37%	Actuals
F	Weighted Average			1.93%	Average weighted by units reimbursed.
G	Percentage of Clients Who Utilize New Access			50.00%	Assumption: 50% of clients utilize the expanded access hygienists supply.
H	Substitution Effect			0.97%	Row F * Row G

Base Reduction Item - 1: Prevention and Benefits for Enhanced Value
Appendix

Table C Non-Emergency Medical Transportation (NEMT) Policies Reform				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
A	Expenditure on Durable Medical Equipment (DME) by NEMT Clients	$2,469,468	$2,657,395	Projected from average growth of actual expenditure.
B	Proportion of All DME that is on Repairs	0.70%	0.70%	Average of the last two years of actual % of DME expenditure that is for repairs.
C	Estimated Additional DME Repair Expenditure	$17,163	$18,469	Row A * Row B
D	Estimated Number of NEMT Trips by DME Clients	30,805	33,149	Based on prior year acutals and growth rates
E	Estimated Additional NEMT Trips	214	230	Row B * Row D
F	FY 2008-09 Average Trip Cost	$67.82	-	Actuals.
G	Year-to-Year Inflationary Rate	7.61%	-	Average year-to-to year growth from last three fiscal years.
H	Average NEMT Trip Cost	$78.53	$84.51	Row F trended to the appropriate year using Row G.
I	Increase in NEMT Expenditure	$16,805	$19,437	Row E * Row H
K	Total Estimated Savings	$33,968	$37,906	Row C + Row I + Row J

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Joan Henneberry
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting ***November 2009***

BRI-1 Prevention and Benefits for Enhanced Value

Request: The Department requests an increase of $118,359, with a reduction of $11,201 General Fund in FY 2010-11, and an increase of $117,276 with a reduction of $15,077 General Fund in FY 2011-12, in order to 1) consolidate utilization review contracts as the first step towards development of a comprehensive evidence guided utilization review program; 2) an expanded set of dental procedures to be performed by dental hygienists; and, 3) improved non-emergency medical transportation policies.

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Federal Funds
Total Request	$118,359	($11,201)	($1,672)	$131,232

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Federal Funds
Total Request	$117,276	($15,077)	($2,251)	$134,604

Highlights: Through the Prevention and Benefits for Enhanced Value request, the Department would generate service efficiencies while improving the quality of service for clients through a series of initiatives focused on enhancing quality and health outcomes: 1) Consolidation of Current Utilization Review Functions; 2) Expanded Procedures for Dental Hygienists; 3) Non-Emergency Medical Transportation Policies Reform.

1. The Department is seeking to take a first step in transitioning to evidence guided utilization review. The Department's movement towards evidence guided utilization review reform builds upon the proven efforts of other states, Medicare, and advanced commercial plans. The approach focuses on four core strategies:

   - Stabilize medical costs by adopting best practices in medical review as developed by other states that have successfully contained growth in medical spending.
   - Enhance access to information to enable rapid cost-containment interventions based on utilization trends, cost modeling, event notification, provider profiling, and client health status.
   - Engage providers through streamlined and automated medical review, profiling, education, and incentives.
   - Empower clients to access preventive care services and to limit high-cost services in a responsible way.

The first step in this transition is to consolidate current acute care utilization reviews. Utilization review can better be handled by a single contractor, and simultaneously produce a savings to the State's General Fund by achieving a greater federal matching percentage (FMAP) by contracting to a single Quality Improvement Organization (QIO).

2. The Department is seeking funding to expand the list of available procedures that can be performed by dental hygienists. Currently Colorado Medicaid allows unsupervised/independent dental hygienists to bill nine procedure codes. SB 09-129 now allows unsupervised/independent hygienists in Colorado to perform an additional seventeen diagnostic, preventive and periodontal procedures related to:

   - Dental hygiene assessment;
   - Dental hygiene diagnosis;
   - Dental hygiene treatment planning for dental hygiene services;
   - Identifying dental abnormalities for immediate referral to a dentist (study casts, radiographic and x-ray survey); and
   - Administering fluoride, fluoride varnish, antimicrobial solutions, and antimicrobial agents.

3. This request would expand non-emergency medical transportation (NEMT) services to include client transportation to durable medical equipment (DME) providers for scheduled repairs. The Centers for Medicare and Medicaid Services (CMS) informed the Department, through a series of emails in July 2009, that providing this service is necessary in order to remain in compliance with federal regulations

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

Media inquires should be directed to Joanne Lindsay at 303-866-3144.

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☑	**Supplemental FY 2009-10** ☐ **Budget Amendment FY 2010-11** ☐
Request Title:	Coordinated Payment and Payment Reform			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 2, 2009 10/29/09
Priority Number:	BRI-2	**OSPB Approval:**		**Date:** 10-30-09

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 2008-09	FY 2009-10	FY 2009-10	FY 2009-10	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2011-12
Total of All Line Items	Total	2,644,862,260	2,685,778,769	0	2,596,970,183	3,154,785,608	(2,532,684)	3,152,252,924	0	3,152,252,924	(5,184,041)
	FTE	266.1	287.6	0.0	287.6	317.0	0.9	317.9	0.0	317.9	1.0
	GF	1,008,070,364	877,283,555	0	1,053,465,012	1,245,142,192	(454,577)	1,244,687,615	0	1,244,687,615	(1,317,938)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,791,140	171,911,010	0	229,811,201	357,612,743	(219,260)	357,393,483	0	357,393,483	(456,703)
	CFE/RF	4,245,540	4,432,897	0	4,432,897	4,679,994	0	4,679,994	0	4,679,994	0
	FF	1,482,503,424	1,632,151,307	0	1,309,261,073	1,547,350,679	(1,858,847)	1,545,491,832	0	1,545,491,832	(3,409,400)
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	19,502,741	20,887,436	0	20,887,436	22,608,612	48,699	22,657,311	0	22,657,311	53,126
	FTE	266.1	287.6	0.0	287.6	317.0	0.9	317.9	0.0	317.9	1.0
	GF	8,010,994	8,057,854	0	8,057,854	7,505,041	24,350	7,529,391	0	7,529,391	26,563
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	604,469	1,196,011	0	1,196,011	1,884,880	0	1,884,880	0	1,884,880	0
	CFE/RF	1,501,807	1,579,589	0	1,579,589	1,830,045	0	1,830,045	0	1,830,045	0
	FF	9,385,471	10,053,982	0	10,053,982	11,388,646	24,349	11,412,995	0	11,412,995	26,563
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	1,148,096	1,976,111	0	1,976,111	1,661,541	5,620	1,667,161	0	1,667,161	950
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	557,186	709,406	0	709,406	691,404	2,810	694,214	0	694,214	475
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	13,014	266,182	0	266,182	126,899	0	126,899	0	126,899	0
	CFE/RF	12,337	13,461	0	13,461	13,461	0	13,461	0	13,461	0
	FF	565,559	987,062	0	987,062	829,777	2,810	832,587	0	832,587	475
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	1,298,585	3,731,605	0	3,731,605	3,910,800	157,000	4,067,800	0	4,067,800	157,000
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	771,478	1,328,043	0	1,328,043	1,320,400	78,500	1,398,900	0	1,398,900	78,500
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	463,750	0	463,750	562,500	0	562,500	0	562,500	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	527,117	1,939,812	0	1,939,812	2,027,900	78,500	2,106,400	0	2,106,400	78,500

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☑	**Supplemental FY 2009-10**	☐	**Budget Amendment FY 2010-11**	☐
Request Title:	Coordinated Payment and Payment Reform				
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 2, 2009
Priority Number:	BRI-2	**OSPB Approval:**		**Date:**	

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	22,200,548	27,451,189	0	27,451,189	36,883,007	45,864	36,928,871	0	36,928,871	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,299,911	6,006,676	0	6,006,676	6,205,903	11,466	6,217,369	0	6,217,369	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	540,118	1,176,844	0	1,176,844	2,488,901	0	2,488,901	0	2,488,901	0
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,167,341	0	20,167,341	28,087,875	34,398	28,122,273	0	28,122,273	0
(2) Medical Services Premiums[a]	**Total**	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(3,582,587)	2,997,330,475	0	2,997,330,475	(7,029,877)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	1,037,363,033	0	1,037,363,033	1,140,610,858	(1,558,547)	1,139,052,311	0	1,139,052,311	(3,058,236)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	(232,747)	352,316,816	0	352,316,816	(456,703)
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(1,791,293)	1,503,225,188	0	1,503,225,188	(3,514,938)
(2) Medical Services Premiums; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	194,124	194,124	0	194,124	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	13,487	13,487	0	13,487	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	(207,611)	(207,611)	0	(207,611)	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐		**Base Reduction Item FY 2010-11**	☑		**Supplemental FY 2009-10**	☐		**Budget Amendment FY 2010-11**	☐	
Request Title:	Coordinated Payment and Payment Reform										
Department:	Health Care Policy and Financing				**Dept. Approval by:**	John Bartholomew			**Date:**	November 2, 2009	
Priority Number:	BRI-2				**OSPB Approval:**				**Date:**		
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	**Total**	73,720,837	88,808,586	0	88,808,586	88,808,586	792,720	89,601,306	0	89,601,306	1,634,760
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	73,720,837	88,808,586	0	88,808,586	88,808,586	792,720	89,601,306	0	89,601,306	1,634,760
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
Non-Line Item Request:	None.										
Letternote Revised Text:	[a]Medical Services Premiums: Of this amount, $85,184,021 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.; $21,498,147 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program; $784,875 shall be from the Autism Treatment Fund created in Section 25.5-6-805, C.R.S.; $1,725,479 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a), C.R.S.; $27,040,854 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S.; $250,000 shall be from the Coordinated Care for People with Disabilities Fund; $3,026,893 shall be from the Comprehensive Primary and Preventive Care Fund; and, $212,806,547 shall be from Hospital Provider Fee Cash Fund.										
Cash or Federal Fund Name and COFRS Fund Number:		CF: Health Care Expansion Fund 18K; FF: Title XIX									
Reappropriated Funds Source, by Department and Line Item Name:		None.									
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑								
Schedule 13s from Affected Departments:		None.									

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-2
Change Request Title:	Coordinated Payment and Payment Reform

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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 reduction of $2,532,684 in total funds for FY 2010-11, including a $454,577 General Fund reduction, and a reduction of $5,184,041 in total funds for FY 2011-12, including a $1,317,938 General Fund reduction, for the implementation of proposed steps toward payment coordination and payment reform. This proposal includes a request for 0.9 FTE in FY 2010-11 and 1.0 FTE in FY 2011-12.

Background and Appropriation History:

In 2006, SB 06-208 established the Blue Ribbon Commission on Health Care Reform ("the Commission"). The Commission was to study and establish health care reform models that expand health care coverage and decrease health care costs for Colorado residents. The Commission was authorized to examine options for expanding cost effective health coverage for all Colorado residents in both the public and private sector markets, with special attention given to the uninsured, underinsured, and those at risk of

financial hardship due to medical expenses. The Commission provided a final set of recommendations to the General Assembly on January 31, 2008.[1]

Consistent with Governor Ritter's vision and the Commission's recommendations for a 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 is continuing to purposefully and systematically advance its health care reform efforts; this request is the next in that series of steps.

In FY 2007-08, the Department presented its Building Blocks to Health Care Reform request, which offered to centralize Medicaid and Children's Basic Health Plan Eligibility; provide a Medical Home for over 270,000 children enrolled in Medicaid and the Children's Basic Health Plan; increase rates for physicians and dentists; enhance the Children's Basic Health Plan mental health benefit; enroll 200,000 Medicaid clients in an integrated care delivery model; and, fund the Colorado Regional Health Information Organization (CORHIO).

In FY 2008-09, the Department offered a coordinated set of 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.

In sum, these requests offered to streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan; deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado; improve quality of service for clients; and implement an automated prior authorization system, changes to the reimbursement rates of drugs using a state maximum allowable cost structure, and changes

[1] The Commission's report is available on its website, http://www.colorado.gov/208commission/

in federal requirements with regard to pharmacy claims submitted by physicians and hospitals.

In alignment with these reform efforts, the Department now requests authority for a set of initiatives which address the importance of having the appropriate economic incentives to achieve desired outcomes. When payments are made to providers based on procedures rather than outcomes, the incentive is to over-utilize services. The Dartmouth Institute for Health Policy and Clinical Practice describes the health care delivery system in America as "a flawed payment system that rewards more care, regardless of the value of that care." Their February 2009 study calls for accountability, better evidence and payment reform.[2]

This request includes four proposed initiatives which work in tandem to serve the goal of lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care.

In the future, the Department may develop a proposal to implement payment reform initiatives. Payment reform brings the economic incentives of the payment and rate structures into alignment with desired outcomes. Along with efforts to improve health outcomes of Medicaid clients through the implementation of a Medical Home model, to name one of the Department's recent reform initiatives, future requests will propose the development of methodologies to restructure payments which would enable full facilitation of an outcomes-based program. Initial target areas may include waiver rate reform, physician payment reform and rate reform with a performance payment model for Federally Qualified Health Centers.

General Description of Request:

This request is for a reduction of $2,532,684 in total funds for FY 2010-11, including a $454,577 General Fund reduction, and a reduction of $5,184,041 in total funds for FY 2011-12, including a $1,317,938 General Fund reduction, for the implementation of proposed steps toward payment coordination and payment reform. This proposal includes a request for 0.9 FTE in FY 2010-11 and 1.0 FTE in FY 2011-12.

[2] Dartmouth Institute for Health Policy and Clinical Practice, "Health Care Spending, Quality and Outcomes: More Isn't Always Better," February 27, 2009.

There are two major components to this request: payment coordination and payment reform. The payment coordination component contributes to the overall goal through streamlined payment processes, enhanced recovery efforts and proactive integration of care. The payment reform component supports the goal through performance-based payment structures which incentivize desired outcomes.

This request includes four payment coordination initiatives which complement each other and, if approved, would enable the Department to realize both short and long term efficiency savings.

Coordinated payment efforts achieve cost savings through efficient and accurate payment processes, increased resources toward recovery efforts and proactive steps to integrate the care of clients with complex health needs or who are dually eligible for both Medicaid and Medicare.

This request proposes four practical and specific steps toward payment coordination:

- Consolidation of Payment and Billing Processes (Federally Qualified Health Centers and Behavioral Health Organizations)
- Expand audits conducted by the Nursing Facilities Section
- Initiate a pilot audit of a Community Mental Health Center
- Increase enrollment of Medicare-eligible clients into Medicare

Further, under the Department's proposal, the Department would begin to investigate a series of initiatives to reform its current payment methodologies.

Payment Coordination

Consolidation of Payment and Billing Processes (Federally Qualified Health Centers and Behavioral Health Organizations)

As part of this initiative, the Department requests $29,153 in total funds for FY 2010-11 and a reduction of $35,685 in FY 2011-12 to streamline the process of making payments

for mental health services provided by Federally Qualified Health Centers. This request includes $45,864 in total funds for FY 2010-11 only for IT system changes. Appendix Tables A.1 and A.2 contain calculations of cost and savings estimates.

Federally Qualified Health Centers provide care to a large number of Medicaid clients, including those with a mental health-related diagnosis. Federally Qualified Health Centers receive reimbursement for clients with a mental health diagnosis code that is covered under the Behavioral Health Organization when the client was seen by a non-mental health professional at the Federally Qualified Health Center. In order for the claim to be paid, the Federally Qualified Health Center currently bills these claims on paper to the fiscal agent and attaches a statement that the client received treatment by a non-mental health professional or that the services are not covered under the Behavioral Health Capitated contract. This manual work around is utilized in lieu of an MMIS edit that automatically checks the procedure codes on the claim. Currently, the MMIS system is set up to only edit the diagnosis code but not the procedure code for Federally Qualified Health Center claims.

In order to effectively remove the current workaround, Federally Qualified Health Center claims need to be edited using both the diagnosis and procedure codes. In essence, the corrected billing method would process Federally Qualified Health Center claims more like claims received from a physician's office and less like hospital claims.

The Department's IT section estimates that the needed changes would require 364 hours and a timeline of four months for ACS, the Department's MMIS contractor, to fully implement the system changes. The contractor hours are assumed to come from the contractually-allotted enhancement pool hours. Since these hours are shared among IT tasks, the Department assumes that the changes will be completed half way through FY 2010-11.

For FY 2008-09, the Department reimbursed Federally Qualified Health Centers $586,376 for claims with a BHO covered diagnosis code. It is expected that once the

claims are edited for procedure code and diagnosis code, that volume will be reduced annually by 5%. However, total savings could be much greater than that.

Additional Auditor for the Nursing Facilities Section

As part of this initiative, the Department requests a reduction of $305,681 in total funds for FY 2010-11 and a reduction of $485,924 in FY 2011-12 to expand the existing in-house audit activities of the Nursing Facilities Section and includes a request for 1.0 FTE at the Auditor II level. The additional completed audits would allow the Department to realize $360,000 in additional audit recoveries from nursing facilities in FY 2010-11 and $540,000 in FY 2011-12. Appendix Table C contains detailed calculations of these estimated recoveries.

In FY 2008-09, in-house audits of nursing facilities reported $1.1 million in recoveries due to the Department, net of appeals. The level of audit recoveries decreased in FY 2008-09 from previous fiscal years due to an increasing number of facilities choosing a 100% audit rather than an audit which uses a sampling approach. In 2008, the State Attorney General's office made an interpretation of HB 04-1284 to give facilities this choice. With a sampling approach, the Department utilizes statistical techniques to review a portion of billings which infer conclusions on the total billings for the facility. With the 100% approach, every billing is audited. Currently, most facilities choose the latter, more time consuming audit.

The Nursing Facilities Section estimates that it would take over four years to audit all facilities which serve Medicaid patients. The Department audits forward from the last day included in the previous audit for the same facility. Per the provider agreements, records are kept for six years. If the Department reaches a point if having more than six years between audits, potential recoveries could be lost. The hiring of an additional auditor would enable the Department to again reach a higher number of annual audits completed and help to reduce the time period between audits for any given facility.

The Department currently has one Auditor II who completed 19 audits in FY 2008-09, recovering an average of $30,000 per audit. The Department assumes that a new auditor would reasonably complete twelve audits in the first year, increasing to 18 in the second year.

Pilot Audit of a Community Mental Health Center

As part of the initiative to implement changes which streamline payments and proactively prevent billing errors, the Department requests $35,000 in total funds for FY 2010-11 and an additional $35,000 in FY 2011-12 to hire a contract auditor to conduct a pilot audit of one Community Mental Health Center.

Since 2001, the Department has served the mental health needs of Medicaid clients through providers which are part of a network of one of the contracted Behavioral Health Organizations. Community Mental Health Centers are the primary providers of mental health services for clients served by the Department; more than half of the Department's $207.8 million (based on the FY 2008-09 appropriation) in annual mental health services claims are from these centers. Since rates within each Behavioral Health Organization are set based on the claims of providers within that organization, and since Community Mental Health Centers have a higher representation than other providers, the centers significantly influence rate setting of mental health services for Medicaid clients in Colorado and are an appropriate representative facility for a pilot audit.

The Department recently changed its Mental Health Accounting and Audit Guidelines, These changes were published effective August 2009 with an implementation period through December 2009. As of January 1, 2010, the revised guidelines will be mandatory for all providers. The requested pilot audit would occur at an opportune time to analyze the effectiveness of the new billing procedures.

All cost data is audited annually using a sampling method to determine compliance with accounting rules. This proposed audit differs and would complement existing audit processes; it would focus on the original coding of claims and examine 100% of claims

submitted for the existence of two specific types of systemic billing errors. The first type is the ambiguity of coding claims. The second type is services which may be billed as either managed care or fee-for-service, creating a situation where double billing is possible.

An example of a potential billing error due to the way procedures are coded: prior to the changes in the accounting and auditing guidelines, case management services could either be coded in fifteen minute increments or as a per contact rate. This ambiguity creates a situation where providers have an incentive to code in the way which gives the maximum benefit and introduces an inaccurate variance of rates among providers for the same services.

This inaccuracy not only creates the potential for overpayment, but also impacts the rate setting process; rates for mental health services (except in hospitals) are based on the claims of providers within each BHO. Therefore, the impact of inaccurate payment of claims fosters future inaccurate rates.

New guidelines changed the coding from an ambiguous list of seven service categories to a detailed and more clearly-defined list of over 130 procedure codes.

The second billing process to explore is the way services may be billed as either a managed care service or by a fee-for-service method. This sets up a situation where providers may be receiving double payment for a service provided.

The scope of work for the proposed contractor would include the examination of every Behavioral Health Organization claim paid for the selected provider for both fiscal years to determine if either or both of these billing errors occurred. Written reports would be required at the completion of each year's audit. The Department would require a contractor with extensive experience working with large data sets and performing database queries in addition to being knowledgeable about mental health claims coding. The requested funding of $35,000 each year is consistent with the cost of completed audits of similar scope.

The results of this pilot audit would give the Department guidance as to whether a more comprehensive audit program of Community Mental Health Centers or other mental health providers is recommended and provide insight about the effectiveness of the changes to Accounting and Auditing Guidelines. The audit results would quantify any savings realized due to pilot audit results and identify any savings which may be realized from a more comprehensive audit.

Increased enrollment of Medicare-eligible Clients into Medicare

This request is for a reduction of $2,291,156 in total funds in FY 2010-11, and an additional reduction of $4,697,432 in FY 2011-12 to increase the enrollment of Medicare-eligible clients into Medicare. This includes a request for $122,000 in total funds for FY 2010-11 and an additional $122,000 in FY 2011-12 to hire a contractor to implement a pilot program. There are two types of client to target for this program. Some clients are eligible for Medicare but have not enrolled. Other clients are enrolled in Medicare, but due to a system problem, these clients are not categorized as Medicare enrollees.

The contractor would work from a list of all Medicaid clients served by the Department who are age 65 and older but who are not categorized as a Medicare recipient and select 1000 clients each year for the pilot program. The contractor will determine which are actually enrolled in Medicare by coordinating efforts with the Social Security Administration. These clients would then be categorized correctly in the system. For Medicare-eligible clients who have not enrolled in Medicare, the contractor would assist in getting them enrolled. Table B includes detailed cost and savings estimates.

Payment Reform

Payment reform brings the economic incentives of the payment and rate structures into alignment with desired outcomes. Along with efforts to improve health outcomes of Medicaid clients through the implementation of a Medical Home model, to name one of the Department's recent reform initiatives, the development of methodologies to

restructure payments which would enable full facilitation of an outcomes-based program is of paramount importance to the Department.

In support of this goal, the Department is targeting three specific and tangible initiatives. One is a payment method restructuring which could be implemented in FY 2010-11, and two are specific areas of rate reform which require a longer term effort. At this time, the Department continues to investigate options and meet with stakeholders, and therefore, no request for funding is included in this request. However, the Department may submit a future budget action if it determines that additional funding would be required to implement specific payment reforms.

At present, the Department is targeting three areas for rate reform: Home and Community Based Services (HCBS) waivers; physician payments; and, federally qualified health center (FQHC) reform. The Department would use a methodical approach with actual claims data to examine how various outcomes-based methods would work for the Department. Rate reform is not something which may be implemented in a cookie cutter fashion; a customized plan based on actual claims data is necessary.

HCBS Waiver Rate Reform

For HCBS waiver services, the Department is investigating an alternative outcomes-based rate structure for at least two of the largest Home and Community Based Services waivers. The Department intends to research the potential of applying an outcomes-based approach to the payment of claims for waiver services. These services are provided to clients enrolled in one of the waiver programs which serve specialized needs such as the care of blind or disabled clients or individuals with AIDS or who have suffered a traumatic brain injury.

Physician Payment Rate Reform

The physician payment reform concept is similar to the waiver rate reform concept. The Department intends to research the potential of applying an outcomes-based approach to the payment of claims for physician services. The Department would look to current

research, other states' practices, and also seek federal guidance to create a new outcomes-based rate structure for payments to physicians. The Department would engage stakeholders to ensure that its partners in the community have input into any change in payment practices.

Reform Methodology of Payments to Federally Qualified Health Centers

Finally, the Department is investigating the feasibility of creating an outcomes-based performance payment for FQHCs. Because FQHCs are paid via an encounter rate, a different approach from physician rates may be required. Per the Benefits Improvement and Protection Act of 2000 (BIPA), Federally Qualified Health Centers (FQHC) are, at a minimum, to be paid a rate which is calculated based on cost and encounter data from 1999 and 2000. This rate is trended forward each year by a Medicare inflation factor. States may pay an alternative rate as long as it is at least as much as the BIPA rate. The Department pays a rate which is higher than the federally required BIPA rate; in FY 2008-09, the Department paid 13.4% over the BIPA rate for these claims. As part of budget balancing for FY 2009-10, the Department reduced rates paid to FQHCs by 50% of the difference between the current rate and the BIPA rate.

As stated previously, the Department is currently investigating the feasibility of undertaking a rate-reform process, and at present, is not requesting any additional spending authority. If the Department determines that it cannot implement rate reforms without additional resources, it may submit an additional budget request for that purpose.

Consequences if Not Funded:

If this request is not funded, the Department would not realize a total fund reduction of $2,532,684 for FY 2010-11, including a $454,577 General Fund reduction, and an additional $5,184,041 reduction in total funds for FY 2011-12, including a $1,317,938 General Fund reduction. Potential payment efficiencies would go untapped, and the Department would not be positioned to realize additional future savings. Efforts at improving outcomes will be hampered if the economic incentives are not in alignment with the desired outcomes.

Some elements of this proposed request would enable the Department to realize savings in the nearer term, savings which may be quantified for FY 2010-11 and FY 2011-12. Other elements would enable the Department to achieve efficiencies and savings in the longer term. For the latter, it is imperative that the Department lays the groundwork for future reform efforts.

If the request to implement a pilot audit of a Community Mental Health Center is not approved, the Department will not be able to evaluate the effectiveness of recent changes to the Mental Health Accounting and Audit Guidelines, an additional benefit of conducting the audit of the claims processing.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**($2,532,684)**	**($454,577)**	**($219,260)**	**$0**	**($1,858,847)**	**0.9**
(1) Executive Director's Office; (A) General Administration, Personal Services	$48,699	$24,350	$0	$0	$24,349	0.9
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,620	$2,810	$0	$0	$2,810	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$157,000	$78,500	$0	$0	$78,500	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$45,864	$11,466	$0	$0	$34,398	0.0
(2) Medical Services Premiums	($3,582,587)	($1,558,547)	($232,747)	$0	($1,791,293)	0.0
(2) Medical Services Premiums; Long Bill Group Total	$0	$194,124	$13,487	$0	($207,611)	0.0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$792,720	$792,720	$0	$0	$0	0.0

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**($5,184,041)**	**($1,317,938)**	**($456,703)**	**$0**	**($3,409,400)**	**1.0**
(1) Executive Director's Office; (A) General Administration, Personal Services	$53,126	$26,563	$0	$0	$26,563	1.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$950	$475	$0	$0	$475	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$157,000	$78,500	$0	$0	$78,500	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums	($7,029,877)	($3,058,236)	($456,703)	$0	($3,514,938)	0.0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$1,634,760	$1,634,760	$0	$0	$0	0.0

Summary of Request FY 2010-11 (50% FMAP)	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**($2,532,684)**	**($648,701)**	**($232,747)**	**$0**	**($1,651,236)**	**0.9**
Consolidation of Payment and Billing Processes (FQHCs and BHOs)						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$45,864	$11,466	$0	$0	$34,398	0.0
(2) Medical Services Premiums	($16,711)	($7,270)	($1,086)	$0	($8,355)	0.0
Subtotal Consolidation of Payment and Billing Processes	*$29,153*	*$4,196*	*($1,086)*	*$0*	*$26,043*	*0.0*
Auditor for Nursing Facilities Section						
(1) Executive Director's Office; (A) General Administration, Personal Services	$48,699	$24,350	$0	$0	$24,349	0.9
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,620	$2,810	$0	$0	$2,810	0.0
(2) Medical Services Premiums	($360,000)	($156,612)	($23,388)	$0	($180,000)	0.0
Subtotal Auditor for Nursing Facilities Section	*($305,681)*	*($129,452)*	*($23,388)*	*$0*	*($152,841)*	*0.9*
Pilot Audit of Community Mental Health Center						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$35,000	$17,500	$0	$0	$17,500	0.0
(2) Medical Services Premiums	$0	$0	$0	$0	$0	0.0
Subtotal Pilot Audit of Community Mental Health Center	*$35,000*	*$17,500*	*$0*	*$0*	*$17,500*	*0.0*
Increased enrollment of Medicare-eligible Clients into Medicare						
(1) Executive Director's Office; (A) General Administration, Personal Services		$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses		$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$122,000	$61,000	$0	$0	$61,000	0.0
(2) Medical Services Premiums	($3,205,876)	($1,394,665)	($208,273)	$0	($1,602,938)	0.0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$792,720	$792,720	$0	$0	$0	0.0
Subtotal Increased enrollment of Medicare-eligible Clients into Medicare	*($2,291,156)*	*($540,945)*	*($208,273)*	*$0*	*($1,541,938)*	*0.0*

Summary of Incremental ARRA Impact on FY 2010-11 Request	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**$0**	**$194,124**	**$13,487**	**$0**	**($207,611)**	**0.0**
Consolidation of Payment and Billing Processes (FQHCs and BHOs)						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums	$0	$905	$63	$0	($968)	0.0
Subtotal Consolidation of Payment and Billing Processes	*$0*	*$905*	*$63*	*$0*	*($968)*	*0.0*
Auditor for Nursing Facilities Section						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums	$0	$19,507	$1,355	$0	($20,862)	0.0
Subtotal Auditor for Nursing Facilities Section	*$0*	*$19,507*	*$1,355*	*$0*	*($20,862)*	*0.0*
Pilot Audit of Community Mental Health Center						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums	$0	$0	$0	$0	$0	0.0
Subtotal Pilot Audit of Community Mental Health Center	*$0*	*$0*	*$0*	*$0*	*$0*	*0.0*
Increased enrollment of Medicare-eligible Clients into Medicare						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums	$0	$173,712	$12,069	$0	($185,781)	0.0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$0	$0	$0	$0	$0	0.0
Subtotal Increased enrollment of Medicare-eligible Clients into Medicare	*$0*	*$173,712*	*$12,069*	*$0*	*($185,781)*	*0.0*

Summary of Request FY 2011-12 (50% FMAP)	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**($5,184,041)**	**($1,317,938)**	**($456,703)**	**$0**	**($3,409,400)**	**1.0**
Consolidation of Payment and Billing Processes (FQHCs and BHOs)						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums	($35,685)	($15,525)	($2,318)	$0	($17,842)	0.0
Subtotal Consolidation of Payment and Billing Processes	*($35,685)*	*($15,525)*	*($2,318)*	*$0*	*($17,842)*	*0.0*
Auditor for Nursing Facilities Section						
(1) Executive Director's Office; (A) General Administration, Personal Services	$53,126	$26,563	$0	$0	$26,563	1.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$950	$475	$0	$0	$475	0.0
(2) Medical Services Premiums	($540,000)	($234,918)	($35,082)	$0	($270,000)	0.0
Subtotal Auditor for Nursing Facilities Section	*($485,924)*	*($207,880)*	*($35,082)*	*$0*	*($242,962)*	*1.0*
Pilot Audit of Community Mental Health Center						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$35,000	$17,500	$0	$0	$17,500	0.0
(2) Medical Services Premiums	$0	$0	$0	$0	$0	0.0
Subtotal Pilot Audit of Community Mental Health Center	*$35,000*	*$17,500*	*$0*	*$0*	*$17,500*	*0.0*
Increased enrollment of Medicare-eligible Clients into Medicare						
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$0	$0	$0	$0	$0	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$122,000	$61,000	$0	$0	$61,000	0.0
(2) Medical Services Premiums	($6,454,192)	($2,807,793)	($419,303)	$0	($3,227,096)	0.0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	$1,634,760	$1,634,760	$0	$0	$0	0.0
Subtotal Increased enrollment of Medicare-eligible Clients into Medicare	*($4,697,432)*	*($1,112,033)*	*($419,303)*	*$0*	*($3,166,096)*	*0.0*

Cash Funds Projections: The Department used its FY 2009-10 appropriation as the basis to estimate the proportion of total funding to be dedicated to the Health Care Expansion Fund. The Department estimates reductions of $219,260 in FY 2010-11 and $456,703 in FY 2011-12 to the fund.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Health Care Expansion Fund	18K	$94,003,143	$119,601,623	$81,320,908	$34,980,659	($22,674,568)

Assumptions for Calculations: Refer to Appendix A, Tables A through C for detailed calculations.

Impact on Other Government Agencies: None

Cost Benefit Analysis: This request includes total net savings of $2,532,684 in FY 2010-11 and a net savings of $5,184,041 in FY 2011-12 due to payment coordination and reform. While a quantitative cost-benefit analysis is not applicable to this request, the Department believes that there are significant benefits to this proposal, including:

- Increased audit recoveries
- Streamlined payments of mental health services claims to Federally Qualified Health Centers
- Taking practical steps toward outcomes-based rate structures
- Lowering costs while adhering to medical best practices

- Providing increased access to services while realizing cost efficiencies in the care of clients eligible for both Medicaid and Medicare
- Mitigating against future high-cost expenditures

Coupled with the savings figures, for these reasons the Department believes that the short- and long-term benefits of these initiatives outweigh the costs.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	January 2010 – March 2011
FTE Hired	July 2010
State Plan Amendment(s) Written	March – May 2011
Waiver or State Plan Amendment Approved	June – July 2011
RFP Issued	October 2010
System Modifications Made	July 2010 – June 2011
Rules Written	March – June 2011
Rules Passed	June – July 2011
Contract or MOU Awarded/Signed	November – December 2010
Start-Up Date	July 2010 – June 2011

Statutory and Federal Authority: 25.5-5-411, C.R.S. (2009). Medicaid community mental health services – administration - rules.

(1) Except as provided for in subsection (3) of this section, the state department shall administer all medicaid community mental health services for medical assistance recipients including but not limited to the prepaid capitated single entry point system for mental health services, the fee-for-service mental health services, and alternatives to institutionalization. The administration of medicaid community mental health services shall include but shall not be limited to program approval, program monitoring, and data collection.

(b) The state department shall establish cost-effective, capitated rates for community mental health services in a manner that includes cost containment mechanisms. These cost containment mechanisms may include, but are not limited to, restricting average per member per month utilization growth, restricting unit cost growth, limiting allowable administrative cost, establishing minimum medical loss ratios, or establishing other cost containment mechanisms that the state department determines appropriate.

25.5-5-104, C.R.S. (2009). Qualified medicare beneficiaries.

Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation. For purposes of this article and articles 4 and 6 of this title, such individuals shall be referred to as "qualified medicare beneficiaries". The state department is hereby designated as the single state agency to administer benefits available to qualified medicare beneficiaries in accordance with Title XIX and this article and articles 4 and 6 of this title. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified medicare beneficiaries the entire range of services set forth in section 25.5-5-102.

25.5-4-401, C.R.S. (2009). Providers – payments - rules.

(1) (a) The state department shall establish rules for the payment of providers under this article and articles 5 and 6 of this title. Within the limits of available funds, such rules shall provide reasonable compensation to such providers, but no provider shall, by this section or any other provision of this article or article 5 or 6 of this title, be deemed to have any vested right to act as a provider under this article and articles 5 and 6 of this title or to receive any payment in addition to or different from that which is currently payable on behalf of a recipient at the time the medical benefits are provided by said provider.

25.5-4-403, C.R.S. (2009). Providers – community mental health center and clinics - reimbursement.
For the purpose of reimbursing community mental health center and clinic providers, the state department shall establish a price schedule annually with the department of human services in order to reimburse each provider for its actual or reasonable cost of services.

25.5-4-301, C.R.S. (2009). Recoveries – overpayments – penalties – interest – adjustments – liens – review or audit procedures – repeal.
(2) Any overpayment to a provider, including those of personal needs funds made pursuant to section 25.5-6-206, shall be recoverable regardless of whether the overpayment is the result of an error by the state department, a county department of social services, an entity acting on behalf of either department, or by the provider or any agent of the provider. (3) (a) A review or audit of a provider shall be subject to the following procedures.

25.5-6-206, C.R.S. (2009). Personal needs benefits - amount - patient personal needs trust fund required - funeral and burial expenses - penalty for illegal retention and use.
(5) All patient personal needs trust funds shall be subject to audit by the state department. A record of a patient's personal needs trust fund shall be kept by the facility for a period of three years from the date of the patient's discharge from the facility or until such records have been audited by the state department, whichever occurs later.

Performance Measures:

This Change Request affects the following Performance Measures:

- Improve access to and the quality of Medicaid health care as demonstrated through improvements in the Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.
- Increase the number of options for clients enrolling in Medicaid to select a focal point of care.
- Increase the number of clients with an identified focal point of care.
- Conduct nursing facility audits (both change of ownership or risk based audits) to recoup patient payment (third party liabilities).
- Conduct provider post payment audits to decrease fraud and abuse and increase recoveries.
- Actively audit expenditures to decrease fraud and abuse and increase recoveries.

The Department uses the measures above to help assure delivery of appropriate, high quality health care in the most cost-effective manner possible. The Department is committed to designing programs that result in improved health status for clients served and improved health outcomes. The Department expands and preserves health care services through the purchase of services in the most cost-effective manner possible.

Base Reduction Item - 2: Coordinated Payment and Payment Reform
Appendix A

Table A.1: Estimated IT Cost of Streamlining Payment of BHO Claims to FQHCs				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
A	Estimated hours to complete required system changes	364	0	Contracted requirements analysis, system design, software development and testing, and post-implementation review.
B	Hourly billing rate	$126	$126	The current contracted (vendor: ACS) billing rate is $126/hour.
C	Total estimated cost of IT implementation	$45,864	$0	Row A * B

Table A.2: Estimated Savings of Streamlining Payment of BHO Claims to FQHCs				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
D	FY 2008-09 claims reimbursed to Federally Qualified Health Centers with a BHO-covered diagnosis code	$586,376	$586,376	From MMIS claims data.
E	Estimated annual growth rate of claims expenditures	6.8%	6.8%	Average annual growth rate of cash based expenditures for claims paid to Federally Qualified Health Centers from FY 2004-05 to FY 2008-09. The Department assumes that the growth rate of expenditures for claims to FQHCs with a BHO-covered diagnosis code is consistent with the growth rate of expenditures for all claims paid to FQHCs.
F	Estimated claims reimbursed to Federally Qualified Health Centers with a BHO-covered diagnosis code	$668,451	$713,701	FY 2010-11: Row D * (1 + Row E)^2 FY 2011-12: Row F, FY 2010-11 column * (1 + Row E)
G	Estimated percentage of savings from reimbursed claims	5.0%	5.0%	Based on estimate from the Department's Rates Section.
H	Estinated potential annual savings	$33,423	$35,685	Row F * G
I	Number of months of new billing method	6	12	The Department estimates a mid-year implementation in FY 2010-11.
J	Total Estimated Savings	$16,711	$35,685	Row H / 12 * Row I

Base Reduction Item - 2: Coordinated Payment and Payment Reform
Appendix A

Table B.1: Estimated Cost of Increased Enrollment of Medicare-Eligible Clients into Medicare				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
A	Estimated Contractor Cost	$122,000	$122,000	Table B.2.L
B	Estimated Savings to Medical Services Premiums	($3,205,876)	($6,454,192)	Table B.3.W
C	Estimated Increase to Medicare Modernization Act Payment	$792,720	$1,634,760	Table B.3.T * Table B.3.X * 12
D	**Net Savings**	**($2,291,156)**	**($4,697,432)**	**Row A + Row B + Row C**

Table B.2 Estimated Contractor Cost				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
A	Estimated potential eligible clients	1,000	1,000	The cost estimate prepared by Public Consulting Group assumes 1,000 potential eligible clients per year to form a pilot group.
B	Estimated hours to complete Phase I	80	80	Phase I: Data Extract and Analysis
C	Rate per hour	$200	$200	
D	Estimated costs	$16,000	$16,000	Row B * C
E	Estimated hours to complete Phase II	1000	1000	Phase II: Pilot Outreach and Enrollment
F	Rate per hour	$100	$100	
G	Estimated costs	$100,000	$100,000	Row E * F
H	Estimated hours to complete Phase III	40	40	Phase III: Report Development (cost/benefit analysis)
I	Rate per hour	$150	$150	
J	Estimated costs	$6,000	$6,000	Row H * I
K	Phase IV	-	-	If the pilot program is successful, the program may be expanded. PCG estimates 12 hours @$150/hour, $1800, per each successful enrollee. Since the results of the pilot program are not known, this cost is not included in this cost estimate.
L	**Total estimated cost**	**$122,000**	**$122,000**	**Row D + G + J**
Source: Public Consulting Group				

Base Reduction Item - 2: Coordinated Payment and Payment Reform
Appendix A

Table B.3: Estimated Savings of Increased Enrollment of Medicare-eligible Clients into Medicare				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
M	HMO Rate - Medicaid Only	$739.77	-	The managed care rate paid for clients who receive Medicaid only through Denver Health per the Actuarial Certification Letter dated February 4, 2009, prepared by The Lewin Group. The rate blends institutional and non-institutional rates, weighted by number of member months.
N	HMO Rate - TPL	$163.99	-	Table B.3.W
O	Per Capita Savings Factor	22.17%	22.17%	Table B.3.T * Table B.3.X * 12
P	AND/AB Acute Care Per Capita (Base Year)	$9,668.67	$9,789.53	FY 2010-11: Estimated FY 2009-10 AND/AB Acute Care per capita rate from the Department's February 16, 2009 Budget Request FY 2011-12: Row R, FY 2010-11 column
Q	Trend	1.25%	1.25%	Estimated FY 2009-10 AND/AB Acute Care per capita trend from the Department's February 16, 2009 Budget Request; this will be updated when the base budget is submitted in November 2009.
R	Estimated Per Capita	$9,789.53	$9,911.90	Row P * (1 + Row Q)
S	Per Capita Savings	($7,619.19)	($7,714.43)	Row R * (1 - Row O) * -1
T	Clients	500	1,000	FY 2010-11: 1000 clients for the pilot program divided by 2; the Department assumes that savings will begin to be realized half way through FY 2010-11 FY 2011-12: Number of annual clients for the pilot program
U	Annual Savings	($3,809,596)	($7,714,432)	Row S * T
V	Monthly Cost of Part B Premium	$100.62	$105.02	FY 2010-11: Rate for calendar year 2009, trended forward FY 2011-12: Rate for calendar year 2010, trended forward The Part B Premium rate was not increased in 2009; the Department assumes that the rates will increase in 2010 and 2011, and the trend used is the average growth rate from 2006 to 2008.
W	**Total estimated savings**	**($3,205,876)**	**($6,454,192)**	**Row U + (Row T * Row V * 12)**
X	Monthly Cost of Additional Medicare Modernization Act Payment	$132.12	$136.23	FY 2010-11: Rate for calendar year 2010 FY 2011-12: Rate for calendar year 2011
Y	**Savings offset**	**$792,720**	**$1,634,760**	**Row T * Row X * 12**

Base Reduction Item - 2: Coordinated Payment and Payment Reform
Appendix A

Table C: Estimated Potential Recoveries from Hiring an Auditor II for the Nursing Facilities Section				
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**Description**
A	Estimated audits to be performed	12	18	An auditor with experience at the Auditor II level completed 19 audits in FY 2008-09. A new hire would reasonably be expected to complete one audit per month in the first year, and 18 in the second after getting more up to speed.
B	Estimated recovery amount per audit	$30,000	$30,000	Table B.3.W
C	Estimated total recovery	$360,000	$540,000	Table B.3.T * Table B.3.X * 12
**Note that this recovery rate ties to the rate projected in the Department's February 16, 2009 Budget Request for FY 2009-10 receivable amounts per audit to be received in the same fiscal year (Page EH-6 of the Request).				

Base Reduction Item - 2: Coordinated Payment and Payment Reform
Appendix A

OSPB Common Policy for FTE Requests

FTE and Operating Costs					*GRAND TOTAL*		
Fiscal Year(s) of Request		**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 10-11**	**FY 11-12**	**FY 12-13**
PERSONAL SERVICES	**Title:**	**Auditor II**					
Number of PERSONS / class title		1	1	1			
Number of months working in FY 09-10, 10-11, & 11-12		12	12	12			
Number months paid in FY 09-10, 10-11, & 11-12		11	12	12			
Calculated FTE per classification		**0.9**	**1.0**	**1.0**	0.9	1.0	1.0
Annual base salary		$47,604	$47,604	$47,604			
Salary		$43,637	$47,604	$47,604	$43,637	$47,604	$47,604
PERA	**10.15%**	$4,429	$4,832	$4,832	$4,429	$4,832	$4,832
Medicare	**1.45%**	$633	$690	$690	$633	$690	$690
Subtotal Personal Services at Division Level		**$48,699**	**$53,126**	**$53,126**	**$48,699**	**$53,126**	**$53,126**
OPERATING EXPENSES							
Supplies @ $500/$500[2]	**$500**	$500	$500	$500	$500	$500	$500
Computer @ $900/$0	**$900**	$900	$0	$0	$900	$0	$0
Office Suite Software @ $330/$0	**$330**	$330	$0	$0	$330	$0	$0
Office Equipment @ $3,440/$0 (includes cubicle and chair)	**$3,440**	$3,440	$0	$0	$3,440	$0	$0
Telephone Base @ $450/$450[2]	**$450**	$450	$450	$450	$450	$450	$450
Other[3,4]					$0	$0	$0
Other[3,4]					$0	$0	$0
Other[3,4]					$0	$0	$0
Subtotal Operating Expenses		**$5,620**	**$950**	**$950**	**$5,620**	**$950**	**$950**
GRAND TOTAL ALL COSTS		**$54,319**	**$54,076**	**$54,076**	**$54,319**	**$54,076**	**$54,076**

1 - Initial year full salary is 11 months to account for Pay Date Shift if General Fund employee.

2 - The $450 for Telephone Base and $500 for Supplies will carry over each year as an acceptable expense. Items are prorated for partial FTE.

3 - Other non-routine expenses such as Fleet, Leased space, or a laptop must be separately defended and calculated. Please provide documentation to justify these requested costs. Agencies must work with DPA or the Governor's Office of IT when requesting

4 - Computer contract hours should be estimated at $100 /hour for a Project Manager. Other costs could include $86/hour for an IT Business Analyst, $74/hour for a Programmer and $65 for a Network Administrator. Legal fees should be $75.38 (blended attorney and paralegal services estimate charged by Dept. of Law). Exceptions will only be given if sufficient justification is provided. Mileage reimbursement rates are outlined below:

Mileage Reimbursement	
2-wheel drive (90% of IRS rate (set at $0.55 in 2009))	$0.50
4-wheel drive (95% of IRS rate (set at $0.55 in 2009))	$0.52
nautical mileage	$0.40

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Joan Henneberry
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting ***November 2009***

BRI-2 Coordinated Payment and Payment Reform

Request: This request is for a reduction of $2,532,684 in total funds for FY 2010-11, including a $454,577 General Fund reduction, and a reduction of $5,184,041 in total funds for FY 2011-12, including a $1,317,938 General Fund reduction, for the implementation of steps toward payment coordination and payment reform. This proposal includes a request for 0.9 FTE in FY 2010-11 and 1.0 FTE in FY 2011-12.

Coordinated payment efforts achieve cost savings through efficient and accurate payment processes, increased resources toward recovery efforts and proactive steps to integrate the care of clients with complex health needs or who are dually eligible for both Medicaid and Medicare. Payment reform brings the economic incentives of the payment and rate structures into alignment with desired outcomes. The Department is currently investigating the feasibility of undertaking a rate-reform process, and at present, is not requesting any additional spending authority for the payment reform component.

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Total Request	**($2,532,684)**	**($454,577)**	**($219,260)**	**($1,858,847)**	**0.9**
Consolidation of Payment and Billing Processes*	$29,153	$5,101	($1,023)	$25,075	0.0
Auditor for Nursing Facilities Section*	($305,681)	($109,945)	($22,033)	($173,703)	0.9
Pilot Audit of Community Mental Health Center*	$35,000	$17,500	$0	$17,500	0.0
Increased enrollment of Medicare-eligible Clients into Medicare*	($2,291,156)	($367,233)	($196,204)	($1,727,719)	0.0

** Rows show costs by initiative not budget line item.*

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Total Request	**($5,184,041)**	**($1,317,938)**	**($456,703)**	**($3,409,400)**	**1.0**
Consolidation of Payment and Billing Processes*	($35,685)	($15,525)	($2,318)	($17,842)	0.0
Auditor for Nursing Facilities Section*	($485,924)	($207,880)	($35,082)	($242,962)	1.0
Pilot Audit of Community Mental Health Center*	$35,000	$17,500	$0	$17,500	0.0
Increased enrollment of Medicare-eligible Clients into Medicare*	($4,697,432)	($1,112,033)	($419,303)	($3,166,096)	0.0

** Rows show costs by initiative not budget line item.*

Highlights:

The Department requests funding for four initiatives which support the payment coordination component of this request.

- Consolidation of Payment and Billing: The Department requests spending authority to streamline the process of making payments for mental health services provided by Federally Qualified Health Centers (FQHCs). Federally Qualified Health Centers receive reimbursement for clients with a mental health diagnosis code that is covered under the Behavioral Health Organization when the client was seen by a non-mental health professional at the FQHC. The existing method of payment for these clients involves a manual work-around; this request is to make the system changes necessary to automate the process.

- Expand audits conducted by the Nursing Facilities Section: The Department requests spending authority to expand the existing in-house audit activities of the Nursing Facilities Section. The level of nursing facility audit recoveries decreased in FY 2008-09 from previous fiscal years due to an increasing number of facilities choosing a 100% audit rather than an audit which uses a sampling approach. This request is to hire an additional auditor so that the Department may again reach a higher number of annual audits completed and help to reduce the time period between audits for any given facility.

- Initiate a pilot audit of a Community Mental Health Center: The Department requests spending authority to hire a contract auditor to conduct a pilot audit of one Community Mental Health Center. These centers are the primary providers of mental health services for clients served by the Department and significantly influence rate setting of mental health services for Medicaid clients in Colorado. This proposed audit differs from existing audits of cost data and would complement existing audit processes; it would focus on the original coding of claims and examine 100% of claims submitted for the existence of two specific types of systemic billing errors. The first type is the ambiguity of coding claims. The second type is services which may be billed as either managed care or fee-for-service, creating a situation where double billing is possible. The results of this pilot audit would give the Department guidance as to whether a more comprehensive audit program of Community Mental Health Centers or other mental health providers is recommended.

- Increase enrollment of Medicare-eligible clients into Medicare: The Department requests spending authority to hire a contractor to increase the enrollment of Medicare-eligible clients into Medicare. There are two types of client to target for this program. Some clients are eligible for Medicare but have not enrolled. Other clients are enrolled in Medicare, but due to a system problem, these clients are not categorized as Medicare enrollees. The contractor would work from a list of all Medicaid clients served by the Department who are age 65 and older but who are not categorized as a Medicare recipient. The contractor would select 1,000 clients each year for the pilot program. The contractor will determine which are actually enrolled in Medicare by coordinating efforts with the Social Security Administration. These clients would then be categorized correctly in the system. For Medicare-eligible clients who have not enrolled in Medicare, the contractor would assist in getting them enrolled.

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

Media inquires should be directed to Joanne Lindsay at 303-866-3144.

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☑	**Supplemental FY 2009-10** ☐ **Budget Amendment FY 2010-11** ☐
Request Title:	Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 2, 2009 10/15/09
Priority Number:	BRI-3	**OSPB Approval:**		**Date:** 11/2/09

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 2008-09	FY 2009-10	FY 2009-10	FY 2009-10	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2011-12
Total of All Line Items	**Total**	2,549,191,991	2,570,375,031	0	2,570,375,031	3,037,796,069	(960,682)	3,036,835,387	0	3,036,835,387	(2,114,900)
	FTE	0.0	0	0.0	0	0	0.0	0	0.0	0	0.0
	GF	925,009,869	778,379,666	0	778,379,666	1,146,816,761	(443,253)	1,146,373,508	0	1,146,373,508	(1,057,450)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,173,657	169,985,067	0	169,985,067	355,038,464	0	355,038,464	0	355,038,464	0
	CFE/RF	2,731,396	2,839,847	0	2,839,847	2,836,488	0	2,836,488	0	2,836,488	0
	FF	1,472,025,277	1,619,170,451	0	1,619,170,451	1,533,104,356	(517,429)	1,532,586,927	0	1,532,586,927	(1,057,450)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	22,200,548	27,451,189	0	27,451,189	36,883,007	96,768	36,979,775	0	36,979,775	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,299,911	6,006,676	0	6,006,676	6,205,903	24,192	6,230,095	0	6,230,095	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	540,118	1,176,844	0	1,176,844	2,488,901	0	2,488,901	0	2,488,901	0
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,167,341	0	20,167,341	28,087,875	72,576	28,160,451	0	28,160,451	0
(2) Medical Services Premiums	**Total**	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(1,057,450)	2,999,855,612	0	2,999,855,612	(2,114,900)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
	GF	919,709,958	1,037,363,033	0	1,037,363,033	1,140,610,858	(528,725)	1,140,082,133	0	1,140,082,133	(1,057,450)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	0	352,549,563	0	352,549,563	0
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(528,725)	1,504,487,756	0	1,504,487,756	(1,057,450)

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐		**Base Reduction Item FY 2010-11**	☑	**Supplemental FY 2009-10**	☐		**Budget Amendment FY 2010-11**	☐		
Request Title:	Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology										
Department:	Health Care Policy and Financing			**Dept. Approval by:**	John Bartholomew		**Date:**	November 2, 2009			
Priority Number:	BRI-3			**OSPB Approval:**			**Date:**				
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(2) Medical Services Premiums; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	61,280	61,280	0	61,280	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	(61,280)	(61,280)	0	(61,280)	0
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:					None.						
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑								
Schedule 13s from Affected Departments:			None.								

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI – 3
Change Request Title:	Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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:

The Department of Health Care Policy and Financing requests a reduction of $960,682 total funds, $443,253 General Fund, for FY 2010-11. The reduction in FY 2011-12 would be $2,114,900 total funds and $1,057,450 General Fund. The request reduces total funds by $1,057,450 in (2) Medical Services Premiums in FY 2010-11 as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. A portion of the savings created through expansion of this program would be used to perform necessary one-time changes to the Medicaid Management Information System. Therefore, this request also includes one-time funding in FY 2010-11 of $96,768 for (1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts.

Background and Appropriation History:

Pharmacy Benefits Program

The Department's Pharmacy Benefits program incurs a substantial portion of the Department's expenditures through the Acute Care service category in Medical Services Premiums. In FY 2008-09 the Department reimbursed providers $233,666,309 for the provision of prescription drugs, although manufacturer rebates brought the net expenditure on prescription drugs to $141,848,205. This latter amount accounted for about 9.4% of total Acute Care expenditures, and 5.7% of total expenditures incurred through the Department's Medicaid program, (November 2, 2009 FY 2010-11 Budget Request, Exhibits for Medical Services Premiums, Exhibit N, Page EN-1).

Title XIX of the Social Security Act details provisions regulating the reimbursement of covered outpatient drugs by state Medicaid agencies. For a state to provide payment for these drugs, the manufacturer of a given drug must have a rebate agreement in effect with the state whereby a portion of the state's reimbursement is given back to the state by the manufacturers. In the Colorado Pharmacy Benefits program rebates received by the State were equal to 39.3% of the costs incurred in the reimbursement of pharmacies in FY 2007-08 (November 2, 2009 FY 2010-11 Budget Request, Exhibits for Medical Services Premiums, Exhibit N, Page EN-1).

The Department currently determines reimbursement rates based on the lowest rate as determined by four methodologies. This allows the Department to maximize the cost-effectiveness of the program while maintaining client access to prescription drugs. The four methodologies used are the Federal Upper Limit, Average Wholesale Price, Direct Price, and Usual and Customary Charge. The State Maximum Allowable Cost methodology was approved by the Joint Budget Committee on March 19, 2009 as part of the Department's Base Reduction Item #1 "Pharmacy Technical and Pricing Efficiencies" that was submitted as part of the Department's FY 2009-10 Budget Request, submitted November 3, 2008. The State Maximum Allowable Cost methodology is currently in the initial implementation stage. With the implementation of the State Maximum Allowable Cost methodology, the Department will determine reimbursement rates based on the lowest price obtained through the five methodologies. In FY 2008-09, the Department

reimbursed approximately 54% of all pharmacy claims using the Average Wholesale Price, 26% using the Federal Upper Limit, 19% using the Usual and Customary Pharmacy Charge, and approximately 0.5% using the Direct Price methodology.

Pricing Methodologies Overview

In 1987 the federal Centers for Medicare and Medicaid Services (CMS) implemented regulations limiting the amount state Medicaid agencies could reimburse pharmacies that dispensed prescription drugs to Medicaid clients. Known as the Federal Upper Limit, the regulations were designed to incorporate market prices into Medicaid pharmaceutical reimbursement rates. The Federal Upper Limit is instrumental in the determination of overall pharmacy reimbursements made by the Department. In addition to being used as a chosen reimbursement rate for 26% of all transactions, the Federal Upper Limit also determines the overall maximum amount of federal funds that will be available to the state.

The three other methodologies currently used by the Department to determine reimbursements are Average Wholesale Price, Direct Price, and Usual and Customary Charge. The Average Wholesale Price methodology is calculated on a national basis as the average price at which wholesalers of prescription drugs sell to pharmacies, and is adjusted downward before use by the Department by 14% for brand name drugs and 40% for generic drugs to arrive at a final reimbursement amount. For rural pharmacies with typically higher than average operating and acquisition costs, this reimbursement is calculated as Average Wholesale Price minus 12% for all drugs. The Direct Price methodology represents a manufacturer's published catalog or list price for a drug product to non-wholesalers. The Usual and Customary Charge methodology is defined as the prevailing price charged by a pharmacy to final consumers of a drug.

Recently, a settlement was reached in a lawsuit against First Data Bank related to reimbursement calculations on specific drug packaging types through specific manufacturers. The lawsuit contended that data integrity issues related to a specific set of information affected the outcomes calculated using the Average Wholesale Pricing method. As part of the settlement, the mark-up factor utilized in the Average Wholesale

Pricing methodology will be reduced for those prescription drugs identified in the legal complaint. The agreement comes into force September 26, 2009.

Deficit Reduction Act of 2005

In February 2006, President Bush signed into law the Deficit Reduction Act, which contains provisions for the reduction of overall federal funds in State Medicaid programs. One highly relevant provision of the Deficit Reduction Act revises the Federal Upper Limit calculation with the result that it will be defined as 250% of the Average Manufacturer's Price. The Average Manufacturer's Price is distinct from the Average Wholesale Price in that the Average Manufacturer's Price is calculated as the average price paid to manufacturers by wholesalers. The Average Wholesale Price is the average price at which wholesalers of prescription drugs sell to pharmacies. Each step in the transaction chain from production to consumption adds value to the good in question. Therefore, the Federal Upper Limit is expected to decrease in the aggregate by movement towards the point of production, explaining the reduction in overall federal funds.

Full implementation of the Deficit Reduction Act requires the Federal Upper Limit to be calculated as 250% of the lowest Average Manufacturer Price for a drug unless the lowest price is 40% less than the next lowest price, in which case the next lowest price is used. Also, the Federal Upper Limit is calculated only for drugs that have two generic equivalents available in the marketplace whereas previously three generic equivalents were the standard. This change increases the number of drugs that have a Federal Upper Limit payment. Finally, since the Federal Upper Limit is based off of the Average Manufacturer Price, which is submitted monthly by manufacturers to CMS, the Federal Upper Limit changes monthly. As the Federal Upper Limit is currently based on the Average Wholesale Price, this represents an increase in the number of times each year that the calculation is changed, and reimbursement to pharmacies could fluctuate monthly.

Although disputes have arisen challenging the constitutionality of the Deficit Reduction Act of 2005, delaying its implementation indefinitely, full implementation could have several negative consequences for both pharmacies and the state. If the Deficit Reduction

Act is implemented, pharmacies could be reimbursed less or more than their acquisition cost on particular drugs at a particular time. Fluctuations in reimbursement rates caused by monthly adjustments and other uncertainties could occur should the Act eventually be implemented. Under federal law, the Department has to ensure that the payments through a State Maximum Allowable Cost methodology do not exceed that which would have been paid using the Federal Upper Limit in the aggregate. Historically, states using a State Maximum Allowable Cost methodology have realized cost savings. These states also plan to rely on this reimbursement methodology to control fluctuations in the new Federal Upper Limit.

State Maximum Allowable Cost Reimbursement History

In FY 2008-09 the Department reimbursed pharmacy providers a total of $233,666,309 (November 2, 2009 FY 2010-11 Budget Request, Exhibits for Medical Services Premiums, Exhibit N, Page EN-1) for the provision of prescription drugs to Medicaid clients. Subtracting manufacturer rebates brings total expenditures to $141,848,205.

The Department submitted and received approval for implementation of a State Maximum Allowable Cost reimbursement methodology as part of its Base Reduction Item #1 "Pharmacy Technical and Pricing Efficiencies" in 2008 and included as part of the Long Bill (SB 09-259). Approval of the initial implementation resulted in a decrease of $285,123 total funds to the Department's FY 2009-10 Medical Services Premiums appropriation line item for the inclusion of 97 drugs in the State Maximum Allowable Cost methodology. Due to the relatively small number of drugs to be included in this new pricing methodology, the Department believed that processing the pricing under the State Maximum Allowable Cost methodology could be done manually, without any systems changes. Implementation is currently in the development phase and the Department believes that the program can be expanded in FY 2010-11 to generate greater savings.

Last year's legislative approval of a State Maximum Allowable Cost rate methodology provided the Department with a mechanism to control fluctuations in reimbursements to pharmacies. This helps mitigate risks associated with eventual implementation of the

Deficit Reduction Act where reimbursement to pharmacies may not align with their acquisition costs for certain drugs. Although the frequent updates in the Federal Upper Limit were designed to reflect changing pharmacy acquisition costs, they may not have the intended effect. Gathering the data necessary to publish the Federal Upper Limit on a national level is time-consuming. CMS established a schedule whereby there would be a three month lag between collecting the information and publishing the new Federal Upper Limits. By the time Colorado would have access to this information, pharmacy acquisition costs may have changed substantially above or below the lagging Federal Upper Limit. This has caused concern among the pharmacy community that they may be reimbursed below their acquisition cost at times.

General Description of Request: The Department of Health Care Policy and Financing requests a reduction of $960,682 total funds, $443,253 General Fund, for FY 2010-11. The annualized reduction in FY 2011-12 would be $2,114,900 total funds and $1,057,450 General Fund. The request reduces total funds by $1,057,450 in (2) Medical Services Premiums in FY 2010-11 as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. A portion of the savings created through expansion of this program would be used to perform necessary one-time changes to the Medicaid Management Information System. Therefore, this request also includes one-time funding in FY 2010-11 of $96,768 for (1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts.

Under an expansion the Department would include additional drugs in the pool priced using the State Maximum Allowable Cost methodology. This would allow the Department to take advantage of an approved reimbursement methodology, increasing opportunities for reimbursement savings associated with pharmacy claims. The State Maximum Allowable Cost methodology prices drugs at the average pharmacy acquisition cost plus an 18% markup.

The expansion would require changes to the Medicaid Management Information System interface and screens at a total cost of $96,768. The interface change is necessary to allow

data to be passed to the Medicaid Management Information System from the Department or vendor. These changes would enable the automated transfer of an increased number of State Maximum Allowable Cost eligible drugs for download into the system. Under the Department's original proposal for the inclusion of 97 drugs, the State Maximum Allowable Cost data could be processed manually with existing resources. However, with the addition of approximately 204 more drugs to the State Maximum Allowable Cost methodology, the Department would require additional FTE or changes to the Medicaid Management Information System. The automation of this process will effectively eliminate the need for additional FTE to manually process the additional data generated. The screen changes are needed to allow for coding enhancements that will help the Medicaid Management Information System distinguish pricing through State Maximum Allowable Cost from other methods already coded into the system. This will involve the addition of screen options adding the State Maximum Allowable Cost method as one of five alternatives for reimbursement. Also, behind-the-scenes coding changes will differentiate the information entered under this methodology so it will bill and track properly.

Determination of whether to include a given drug in the pool priced using the State Maximum Allowable Cost methodology will necessarily take into consideration the following:

- Availability of manufacturers;
- Broad wholesale price range;
- Cost of the drugs to retailers;
- Volume of Medicaid client utilization; and
- Bioequivalence or interchangeability of potential generic substitutes for brand name drugs.

All five elements consider the best interests and needs of the client and the State. The first two elements consider the degree of competition between various manufacturers for a single product and the range of wholesale pricing available among the manufacturers of

the drug. The third and fourth elements consider the impacts to the retailer. These elements address whether the retailers can obtain drugs and not incur significant financial losses. These elements also consider the volume as it impacts retailer profitability as well. The last element enables the retailer the ability to work collaboratively with the client when a generic equivalent is available. This element also addresses the requirement that any potential substitute for a given drug must be equivalent in effect and usage if it is to be incorporated into the calculation of the maximum allowable ingredient cost that is the basis for the State Maximum Allowable Cost.

An expansion of the State Maximum Allowable Cost methodology would provide several benefits:

- The Department would expect to see an annual reduction in expenses to its Medical Services Premiums line of $2,114,900;
- Flexibility in the determination of reimbursements for a greater number of prescription drugs;
- Ability to adjust the rates for a greater number of drugs in a more timely manner than is possible under the current Federal Upper Limit; and,
- Allow the Department to set rates for a larger number of drugs that have not been given a Federal Upper Limit.

Consequences if Not Funded:

If this request is not approved the Department would not realize net General Fund savings of $443,253 in FY 2010-11 and $1,057,450 in FY 2011-12. Not expanding the capability of the Medicaid Management Information System will inhibit the Department's ability to benefit from pricing efficiencies possible within the State Maximum Allowable Cost reimbursement methodology.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	Federal Funds
Total Request	($960,682)	($443,253)	($517,429)

(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$96,768	$24,192	$72,576
(2) Medical Services Premiums	($1,057,450)	($528,725)	($528,725)
(2) Medical Services Premiums - ARRA Adjustment	$0	$61,280	($61,280)

Summary of Request FY 2011-12	Total Funds	General Fund	Federal Funds
Total Request	($2,114,900)	($1,057,450)	($1,057,450)
(2) Medical Services Premiums	($2,114,900)	($1,057,450)	($1,057,450)

Table 1A: Potential Maximum Savings due to State Maximum Allowable Cost Pricing Expansion for Drugs with Annual Expenditures Greater than or Equal to $100,000			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$5,783,965	Total expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement (see Narrative).
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$2,891,862	Total estimated expenditures for drugs if utilizing highest known State Maximum Allowable Cost rate (see Narrative).
C	**Maximum Potential Savings**	**$2,892,103**	Total potential savings if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Number of Drugs with Estimated Annual Expenditures greater than or equal to $100,000	18	The number of individual drugs within the set for which estimated expenditures above have been compiled.
E	**Average Savings per Drug**	**$160,672**	Estimated Average Savings per drug within the set. **Row C / Row D**

Table 1B: Potential Maximum Savings due to State Maximum Allowable Cost Pricing Expansion for Drugs with Annual Expenditures from $50,000 to $99,999			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$1,558,009	Total expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement (see Narrative).
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$1,045,932	Total estimated expenditures for drugs if utilizing highest known State Maximum Allowable Cost rate (see Narrative).
C	**Maximum Potential Savings**	**$512,077**	Total potential savings if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Number of Drugs with Estimated Annual Expenditures from $50,000 to $99,999	21	The number of individual drugs within the set for which estimated expenditures above have been compiled.
E	**Average Savings per Drug**	**$24,385**	Estimated Average Savings per drug within the set. **Row C / Row D**

Table 1C: Potential Maximum Savings due to State Maximum Allowable Cost Pricing Expansion for Drugs with Annual Expenditures from $20,000 to $49,999			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$1,410,493	Total expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement (see Narrative).
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$907,379	Total estimated expenditures for drugs if utilizing highest known State Maximum Allowable Cost rate (see Narrative).
C	**Maximum Potential Savings**	**$503,114**	Total potential savings if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Number of Drugs with Estimated Annual Expenditures from $20,000 to $49,999	45	The number of individual drugs within the set for which estimated expenditures above have been compiled.
E	**Average Savings per Drug**	**$11,180**	Estimated Average Savings per drug within the set. **Row C / Row D**

Table 1D: Potential Maximum Savings due to State Maximum Allowable Cost Pricing Expansion for Drugs with Annual Expenditures from $10,000 to $19,999			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$707,127	Total expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement (see Narrative).
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$487,562	Total estimated expenditures for drugs if utilizing highest known State Maximum Allowable Cost rate (see Narrative).
C	**Maximum Potential Savings**	**$219,565**	Total potential savings if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Number of Drugs with Estimated Annual Expenditures from $10,000 to $19,999	49	The number of individual drugs within the set for which estimated expenditures above have been compiled.
E	**Average Savings per Drug**	**$4,481**	Estimated Average Savings per drug within the set. **Row C / Row D**

Table 1E: Potential Maximum Savings due to State Maximum Allowable Cost Pricing Expansion for Drugs with Annual Expenditures from $1,000 to $9,999			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$846,133	Total expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement (see Narrative).
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$612,278	Total estimated expenditures for drugs if utilizing highest known State Maximum Allowable Cost rate (see Narrative).
C	**Maximum Potential Savings**	**$233,855**	Total potential savings if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Number of Drugs with Estimated Annual Expenditures from $1,000 to $9,999	200	The number of individual drugs within the set for which estimated expenditures above have been compiled.
E	**Average Savings per Drug**	**$1,169**	Estimated Average Savings per drug within the set. **Row C / Row D**

Table 1F: Potential Maximum Savings due to State Maximum Allowable Cost pricing expansion for drugs with Annual Expenditures up to $999			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$47,267	Total expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement (see Narrative).
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$31,805	Total estimated expenditures for drugs if utilizing highest known State Maximum Allowable Cost rate (see Narrative).
C	**Maximum Potential Savings**	**$15,462**	Total potential savings if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Number of Drugs with Estimated Annual Expenditures up to $999	169	The number of individual drugs within the set for which estimated expenditures above have been compiled.
E	**Average Savings per Drug**	**$91**	Estimated Average Savings per drug within the set. **Row C / Row D**

Table 2: Potential Maximum Savings due to State Maximum Allowable Cost pricing			
Row	**Item**	**Amount**	**Description**
A	Estimated Annual Expenditures Using Existing Methodologies (excludes State Maximum Allowable Cost methodology)	$10,352,994	Cumulative total of Row A of Tables 1A - 1F. Total estimated expenditures for drugs, adjusted for known changes in reimbursement formulas and First Data Bank settlement. (See Narrative)
B	Estimated Expenditures using State Maximum Allowable Cost methodology	$5,976,818	Cumulative Total of Row B of Tables 1A - 1F. Total estimated expenditures for drugs utilizing highest known State Maximum Allowable Cost rate. (See Narrative.)
C	**Maximum Potential Savings**	**$4,376,176**	Total potential savings possible if all drugs are determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Row A - Row B**
D	Total Number of Drugs	502	The total number of individual drugs showing a lower estimated State Maximum Allowable Cost compared to existing methodology.
E	**Average Savings per Drug**	**$8,717**	Estimated Average Savings per drug. **Row C / Row D**

Table 3: Estimated Annual Savings due to State Maximum Allowable Cost Expansion			
Row	**Item**	**Amount**	**Description**
A	**Maximum Potential Savings**	**$4,376,176**	This amount represents the maximum potential savings if all drugs were determined to be suitable for inclusion in the State Maximum Allowable Cost methodology. **Table 2, Row C**
B	Suitability Ratio	60%	A drug may show possible savings from use of the State Maximum Allowable Cost methodology, however, may be determined to be unsuitable. The Department assumes 60% of potential drugs will be determined to be suitable for inclusion in the final reimbursement pool using the State Maximum Allowable Cost methodology.
C	**Total Estimated Savings from Implementation of State Maximum Allowable Cost methodology**	**$2,625,706**	**Row A * Row B**
D	Annualized savings from the implementation of the State Maximum Allowable Cost already reduced in the Department's appropriation	($510,806)	The initial State Maximum Allowable Cost implementation approved and appropriated in the Long Bill (SB 09-259) anticipated an annual savings in FY 2010-11 and beyond of $510,806.
E	**Estimated Annual Savings from Expansion of State Maximum Allowable Cost methodology**	**$2,114,900**	Estimated Annual Net Savings resulting from expansion of the State Maximum Allowable Cost methodology. **Row C + Row D**
F	**Estimated Savings in FY 2010-11**	**$1,057,450**	The Department expects implementation of the State Maximum Allowable Cost expansion to be completed by January 2011. **Row E * (6 months / 12 months)**

Table 4: Information and Technology Costs			
Row	**Item**	**FY 2010-11**	**Description**
A	Hours Required for Screen Changes to the Medicaid Management Information System	268	See Narrative.
B	Hours Required for New Interface Change to the Medicaid Management Information System	500	See Narrative.
C	Hourly Rate	$126	See Narrative.
D	**Total Automated Prior Authorization Amount**	**$96,768**	**(Row A + Row B) * Row C.**

Implementation Schedule:

NOTE: An implementation plan for the initial creation of State Maximum Allowable Cost methodology was submitted and approved as part of the FY 2009-10 budgets. That implementation plan remains in place and would serve as the foundation for the implementation of the expansion.

Task	**Start**	**Complete**	**Description**
Automation of State Maximum Allowable Cost expansion in the Medicaid Management Information System	7/1/2010	11/30/2010	Programming time required to complete is 768 hours. Expansion timeline assumes a 10% overlap of work capability for the two main tasks.
Initial Expansion Drug Data-gathering Period for Contractor	11/1/2010	11/30/2010	One month will be required for the contractor to gather, analyze, and prepare the first data report for submittal to the Department.
Transmittal of Expansion Drug Data into the Medicaid Management Information System	12/1/2010	12/31/2010	The first round of transmitting data into the Medicaid Management Information System is given a one-month timeline to allow for the high amount of data.
Expanded State Maximum Allowable Cost goes into Effect	1/1/2011	N/A	State Maximum Allowable Cost expansion fully implemented.

Assumptions for Calculations:

The Department assumes that expanding a State Maximum Allowable Cost rate structure would have no effect on co-pays, dispensing fees, or third-party paid amounts.

The Department analyzed data from other states and organizations that utilize a rate methodology similar to Colorado's State Maximum Allowable Cost methodology. In order to not underestimate the likely State Maximum Allowable Cost reimbursement rates, the Department used the highest rate retrieved from this database for each drug.

The Department analyzed Medicaid Management Information System claims data for FY 2008-09 for 3,833 unique drugs that met the minimum criteria for inclusion in the State Maximum Allowable Cost methodology. Based on this information, the Department developed estimated reimbursement rates reflecting the Department's current rate methodology for each drug in FY 2009-10 forward. This was achieved by incorporating expected changes into the FY 2008-09 reimbursement rates. These adjustments include changes to the discounts as well as adjustments to reflect the First Data Bank litigation settlement.

Of the 3,833 drugs, 502 were identified as having potential savings. The final selection of specific drugs within the pool of 502 potential drugs would ultimately be determined by the Department based upon consideration of several important factors. These factors include the following: the number of manufacturers producing a particular drug, the quantity of drugs produced, the range of wholesale pricing available, the ability of pharmacies to purchase drugs at a cost below State Maximum Allowable Cost reimbursement rates, the availability of generic equivalents, and other miscellaneous factors that may arise. Therefore, the Department assumes that approximately 60% of the 502 drugs with potential savings will be suitable for inclusion in the final State Maximum Allowable Cost reimbursement pool.

The Department assumes that future utilization patterns for a given drug will be similar to what was observed in FY 2008-09.

The 502 drugs identified as having potential savings include those used for the initial State Maximum Allowable Cost implementation. Therefore the total savings estimate includes the amount of the previous FY 2010-11 budget reduction of $510,806. For this reason, $510,806 is subtracted from the total savings estimate (see Table 3).

The Department assumes that savings materialize at a uniform rate over the course of the first year of implementation since payments to pharmacies are made weekly throughout the year.

The Department assumes that the necessary changes to the Medicaid Management Information System are eligible for 75% federal financial participation. The Department assumes 500 hours will be required for the interface changes, 268 hours will be required for the screen upgrades, and the hourly cost will be $126. These figures are based on the Department's experience with the Medicaid Management Information System vendor.

The Department assumes that the increased federal match as a result of the American Recovery and Reinvestment Act of 2009 **(**ARRA) will remain at 61.59% through December 31, 2010. Thereafter, the rate will revert to a 50% match. Therefore, the blended rate for FY 2010-11 is assumed to be 55.795%.

Impact on Other Government Agencies: This request will not impact other state agencies.

Cost Benefit Analysis:

FY 2010-11 Cost Benefit Analysis	Costs	Benefits
Request	Costs include one-time funding of $96,768 total funds, $24,192 General Fund, for changes to the Medicaid Management Information System to accommodate the expansion of the State Maximum Allowable Cost methodology.	By expanding the number of drugs that will be included in the State Maximum Allowable Cost pricing methodology, the Department would realize General Fund savings of $443,253 in FY 2010-11. These General Fund savings will annualize to $1,057,450 in FY 2011-12.
Consequences if not Funded	If the Department were unable to make the necessary changes to the Medicaid Management Information System to accommodate the expansion of the State Maximum Allowable Cost pricing methodology it is likely that Department would not realize all or part of the estimated General Fund savings of $443,253 in FY 2010-11 and $1,057,450 in FY 2011-12.	There are no benefits.

Statutory and Federal Authority:

25.5-4-401 (2), C.R.S. (2009) *As to all payments made pursuant to this article and articles 5 and 6 of this title, the state department rules for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.*

42 C.F.R. §447.205 (2008) *Public notice of changes in statewide methods and standards for setting payment rates. (a) Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates and services.*

(b) When notice is not required. Notice is not required if -- (3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

42 C.F.R. §447.514 (2008) *Upper Limits for Multiple Source Drugs. (a) Establishment and issuance of a listing. (1) CMS will establish and issue listings that identify and set upper limits for multiple source drugs that meet the following requirements:*

(i) The FDA has rated two or more drug products as therapeutically and pharmaceutically equivalent in its most current edition of "Approved Drug Products with Therapeutic Equivalence Evaluations" (including supplements or in successor publications), regardless of whether all such formulations are rated as such and only such formulations shall be used when determining any such upper limit.

(ii) At least two suppliers meet the criteria in paragraph (a)(1)(i) of this section.

(2) CMS publishes the list of multiple source drugs for which upper limits have been established and any revisions to the list in Medicaid Program issuances.

(b) Specific upper limits. The agency's payments for multiple source drugs identified and listed periodically by CMS in Medicaid Program issuances must not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee established by the State agency plus an amount established by CMS that is equal to 250 percent of the AMP (as computed without regard to customary prompt pay discounts extended to wholesalers) for the least costly therapeutic equivalent.

Performance Measures:

The Department believes that the expansion of the State Maximum Allowable Cost program will help maintain client access to prescription drugs through pharmacies while improving the cost-effectiveness of the Pharmacy Benefits program. Additionally, the use of information technology is crucial to the successful operation of this request, and would be utilized by the Department to create more efficient administration of a State Maximum Allowable Cost methodology. Further, the Department would make progress toward achieving the following Objective and Performance Measure:

Objective

- Assure delivery of appropriate, high quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Performance Measure

- Improve access to health care, increase health outcomes and provide more cost effective services using information technology.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Joan Henneberry
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting ***November 2009***

BRI-3 Expansion of a State Maximum Allowable Cost Reimbursement Rate Methodology

Request: The Department requests a reduction of $960,682 total funds, $443,253 General Fund, for FY 2010-11. The reduction in FY 2011-12 would be $2,114,900 total funds and $1,057,450 General Fund. The request reduces total funds by $1,057,450 in (2) Medical Services Premiums in FY 2010-11 as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. A portion of the savings created through expansion of this program would be used to perform one-time changes to the Medicaid Management Information System. Therefore, this request also includes one-time funding in FY 2010-11 of $96,768 for (1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts.

Summary of Request FY 2010-11	Total Funds	General Fund	Federal Funds
Total Request	**($960,682)**	**($443,253)**	**($517,429)**
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$96,768	$24,192	$72,576
(2) Medical Services Premiums	($1,057,450)	($528,725)	($528,725)
(2) Medical Services Premiums - ARRA Adjustment	$0	$61,280	($61,280)

Summary of Request FY 2011-12	Total Funds	General Fund	Federal Funds
Total Request	**($2,114,900)**	**($1,057,450)**	**($1,057,450)**
(2) Medical Services Premiums	($2,114,900)	($1,057,450)	($1,057,450)

Highlights: The Department requested and received approval for implementation of a State Maximum Allowable Cost reimbursement methodology in 2008. Implementation is currently in the development phase and the Department believes that the program can be expanded in FY 2010-11 to generate greater savings. The Department currently determines reimbursement rates based on the lowest rate as determined by four methodologies. In FY 2008-09, the Department reimbursed approximately 54% of all pharmacy claims using the *Average Wholesale Price*, 26% using the *Federal Upper Limit*, 19% using the *Usual and Customary Pharmacy Charge*, and approximately 0.5% using the *Direct Price* methodology. Utilizing multiple methodologies allows the Department to maximize the cost-effectiveness of the program while maintaining client access to prescription drugs.

The expansion would require changes to the Medicaid Management Information System interface and screens at a total one-time cost of $96,768.

The Department would take into account five elements when determining whether to include a given drug in the pool priced using the State Maximum Allowable Cost methodology while attending to the best interests and needs of the client and the State. The following would be considered in determining whether to include a given drug in the pool priced using the State Maximum Allowable Cost methodology:

- Availability of manufacturers;
- Broad wholesale price range;
- Cost of the drugs to retailers;
- Volume of Medicaid client utilization; and
- Bioequivalence or interchangeability of potential generic substitutes for brand name drugs.

The elements consider competition between manufacturers, ability of retailers to obtain drugs and not incur significant financial losses, and ability of retailer to work collaboratively with the client.

An expansion of the State Maximum Allowable Cost methodology would provide several benefits:

- The Department would expect to see an annual reduction in expenses to its Medical Services Premiums line of $2,114,900;
- Flexibility in the determination of reimbursements for a greater number of prescription drugs offers increased opportunity for incremental cost savings;
- Rates under Federal Upper Limit currently are based on data that is three months old. Expanding the State Maximum Allowable Cost methodology would provide the ability to adjust the rates for a greater number of drugs in a more timely manner than is possible under the current Federal Upper Limit; and,
- The Federal Upper Limit, because of its methodology, is limited in the number of drugs for which rate reimbursement can be set. Expanding the State Maximum Allowable Cost methodology would allow the Department to set rates for a larger number of drugs that have not been given a Federal Upper Limit.

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

Media inquires should be directed to Joanne Lindsay at 303-866-3144.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11 ▽	Supplemental FY 2009-10	Budget Amendment FY 2010-11

Request Title: Medicaid Program Efficiencies
Department: Health Care Policy and Financing
Priority Number: BRI-4
Dept. Approval by: John Bartholomew JB **Date:** November 2, 2009 10/30/09
OSPB Approval: **Date:** 11/2/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(10,097,162)	2,990,815,900	0	2,990,815,900	(10,595,649)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	772,372,990	0	772,372,990	1,140,610,858	(4,463,448)	1,136,147,410	0	1,136,147,410	(5,297,823)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	168,808,223	0	168,808,223	352,549,563	0	352,549,563	0	352,549,563	0
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,599,003,110	0	1,599,003,110	1,505,016,481	(5,633,714)	1,499,382,767	0	1,499,382,767	(5,297,826)
(2) Medical Services Premiums	Total	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(10,097,162)	2,990,815,900	0	2,990,815,900	(10,595,649)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
	GF	919,709,958	1,037,363,033	0	1,037,363,033	1,140,610,858	(5,048,579)	1,135,562,279	0	1,135,562,279	(5,297,823)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	0	352,549,563	0	352,549,563	0
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(5,048,583)	1,499,967,898	0	1,499,967,898	(5,297,826)
(2) Medical Services Premiums; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	585,131	585,131	0	585,131	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	(585,131)	(585,131)	0	(585,131)	0

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: None.
Approval by OIT? Yes: ☐ No: ☐ N/A: ▽
Schedule 13s from Affected Departments: None.

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-4
Change Request Title:	Medicaid Program Efficiencies

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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: The Department requests a reduction of $10,097,162 total funds, $4,463,448 General Fund in FY 2010-11, and a reduction of $10,595,649 totals funds, $5,297,823 General Fund in FY 2011-12 in order to reduce expenditure related to home health services for nursing, physical therapy, occupational therapy, speech therapy, and assessment and teaching visits. The Department will accomplish this reduction by requiring a change in the way that home health agencies and providers bill for services.

Background and Appropriation History: Not applicable.

General Description of Request: Under the Department's current billing rules, providers who perform home health services for nursing, physical therapy, occupational therapy, speech therapy, and assessment and teaching visits bill the Department for a single unit of service for every visit, regardless of the amount of time that the provider spends with the client. Currently, the Department

allows up to 2.5 hours of care per day. Thus, in instances where only a brief visit is required, the Department still pays for a full 2.5 hours of care. To ensure that the Department is paying only for the time that a provider spends with a client, the Department proposes to require providers to bill the Department in half hour increments.

Under the proposed rule, the Department would require providers to only bill for the time spent rendering service to a client. Because not all clients require a 2.5 hour visit, the Department will reduce expenditure by not paying providers for time that is not spent with clients. The Department estimates, on average, that clients receive an average of 2.0 hours of care per visit. This estimate is based on information from the Department's Program Integrity section; reviews of home health visits indicate that a large percentage of visits do not require the full 2.5 hours. In some cases, visits can be as brief as 5-10 minutes: for example, a visit where the only purpose is to check a patient's vital signs and refill the client's medication can typically be accomplished in approximately one half hour. No matter the length of the visit, providers cannot bill for less time than the full 2.5 hours. Under the proposal, the Department estimates that this change would correspond to a reduction in units billed and paid for of 20%.

The Department is not reducing the maximum daily amount of care that a client care can receive. Under this proposal, clients will still have access to up to 2.5 hours of care, depending on the client's health needs. Therefore, no client should be affected by this change to the billing practice.

The Department's calculations are contained in Table A.

Consequences if Not Funded: Not applicable.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($10,097,162)**	**($4,463,448)**	**$0**	**$0**	**($5,633,714)**
(2) Medical Services Premiums	**($10,097,162)**	**($5,048,579)**	**$0**	**$0**	**($5,048,583)**
Nursing	($6,691,289)	($3,345,644)	$0	$0	($3,345,645)
Physical Therapy	($1,360,644)	($680,322)	$0	$0	($680,322)
Occupational Therapy	($1,006,801)	($503,400)	$0	$0	($503,401)
Speech/Language Therapy	($1,036,927)	($518,463)	$0	$0	($518,464)
Nursing visit for Assessment and Teaching	($1,501)	($750)	$0	$0	($751)
Long Bill Group Total: Enhanced Federal Medical Assistance	**$0**	**$585,131**	**$0**	**$0**	**($585,131)**

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($10,595,649)**	**($5,297,823)**	**$0**	**$0**	**($5,297,826)**
(2) Medical Services Premiums	**($10,595,649)**	**($5,297,823)**	**$0**	**$0**	**($5,297,826)**
Nursing	($6,843,358)	($3,421,679)	$0	$0	($3,421,679)
Physical Therapy	($1,412,275)	($706,137)	$0	$0	($706,138)
Occupational Therapy	($1,076,958)	($538,479)	$0	$0	($538,479)
Speech/Language Therapy	($1,261,523)	($630,761)	$0	$0	($630,762)
Nursing visit for Assessment and Teaching	($1,535)	($767)	$0	$0	($768)

Table A
Home Health Unit Increments

Row	Item	Nursing	Physical Therapy	Occupational Therapy	Speech/Language Therapy	Nursing visit for Assessment and Teaching	**Total**	Comment
A	FY 2008-09 Service Units	328,062	59,295	41,040	30,236	74	458,707	Based on FY 2008-09 MMIS paid claims data
B	Estimated Unit Trend	2.27%	3.79%	6.97%	21.66%	2.27%		Based on the average annual percent increase in paid units between FY 2006-07 and FY 2008-09
C	Estimated FY 2010-11 Service Units	343,143	63,880	46,959	44,753	77	498,812	Row A * (1 + Row B)^2
D	Cost Per Unit	$97.46	$106.58	$107.28	$115.81	$97.46		FY 2009-10 Medicaid fee schedule
E	Estimated FY 2010-11 Cost	$33,442,717	$6,808,330	$5,037,762	$5,182,845	$7,504	$50,479,158	Row C * Row D
F	Current Unit Value (in Minutes)	150	150	150	150	150		FY 2009-10 Medicaid fee schedule
G	Revised Value (in Minutes)	30	30	30	30	30		Proposed
H	Unit Adjustment Factor	5.00	5.00	5.00	5.00	5.00		Row F / Row G
I	Rescaled Units	1,715,715	319,400	234,795	223,765	385	2,494,060	Row C * Row H
J	Estimated Reduction to Units	20.00%	20.00%	20.00%	20.00%	20.00%		Assumed
K	New Estimated Units	1,372,572	255,520	187,836	179,012	308	1,995,248	Row I * (1 - Row J)
L	Cost Per New Unit	$19.49	$21.32	$21.46	$23.16	$19.49		Row D / Row H
M	FY 2010-11 Estimated New Cost	$26,751,428	$5,447,686	$4,030,961	$4,145,918	$6,003	$40,381,996	Row K * Row L
N	**FY 2010-11 Estimated Savings**	**($6,691,289)**	**($1,360,644)**	**($1,006,801)**	**($1,036,927)**	**($1,501)**	**($10,097,162)**	Row M - Row E
O	Estimated Unit Trend	2.27%	3.79%	6.97%	21.66%	2.27%		Row B
P	**FY 2011-12 Estimated Savings**	**($6,843,358)**	**($1,412,275)**	**($1,076,958)**	**($1,261,523)**	**($1,535)**	**($10,595,649)**	Row N * (1 + Row O)

Cash Funds Projections:	Not applicable.
Assumptions for Calculations:	Where applicable, assumptions have been noted in the narrative, and in Table A, above. The Department has estimated projected expenditure and utilization based on historical information and assumptions about future changes in caseload or utilization. In particular, the Department has estimated a trend on incurred units for both FY 2010-11 and FY 2011-12 based on the average annual percent increase in paid units between FY 2006-07 and FY 2008-09. 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:	Not applicable.
Cost Benefit Analysis:	Not applicable.
Implementation Schedule:	The Department will implement the proposed changes effective July 1, 2010.
Statutory and Federal Authority:	*25.5-5-102, C.R.S. (2009). Basic services for the categorically needy - mandated services.* (1) Subject to the provisions of subsection (2) of this section and section 25.5-4-104, the program for the categorically needy shall include the following services as mandated and defined by federal law: (f) Home health services. (2) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation.
Performance Measures:	Not applicable.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Executive Director Name
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting *November 2009*

BRI-4 Medicaid Program Efficiencies

Request: The Department requests a reduction of $10,097,162 total funds, $4,463,450 General Fund in FY 2010-11 in order to reduce expenditure related to home health services for nursing, physical therapy, occupational therapy, speech therapy, and assessment and teaching visits. The Department will accomplish this reduction by requiring a change in the way that home health agencies and providers bill for services.

Summary of Request FY 2010-11	Total Funds	General Fund	Federal Funds
Total Request	**($10,097,162)**	**($4,463,448)**	**($5,633,714)**
Nursing	($6,691,289)	($3,345,644)	($3,345,645)
Physical Therapy	($1,360,644)	($680,322)	($680,322)
Occupational Therapy	($1,006,801)	($503,400)	($503,401)
Speech/Language Therapy	($1,036,927)	($518,463)	($518,464)
Nursing visit for Assessment and Teaching	($1,501)	($750)	($751)
Long Bill Group Total: Enhanced Federal Medical Assistance	$0	$585,131	($585,131)

Highlights:

- To ensure that the Department is paying only for the time that a provider spends with a client, the Department proposes to require providers to bill the Department in half hour increments. Under the Department's current billing rules, providers who perform these services bill the Department for a single unit of service for every visit, regardless of the amount of time that the provider spends with the client.

- Because not all clients require a 2.5 hour visit, the Department will reduce expenditure by not paying providers for time that is not spent with clients. The Department estimates, on average, that clients receive an average of 2.0 hours of care per visit.

- The Department is not reducing the maximum daily amount of care that a client care can receive. Under this proposal, clients will still have access to up to 2.5 hours of care, depending on the client's health needs. Therefore, no client should be affected by this change to the billing practice.

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

Media inquires should be directed to Joanne Lindsay at 303-866-3144.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11 ☑	Supplemental FY 2009-10	Budget Amendment FY 2010-11
Request Title:	Medicaid Payment Timing		
Department:	Health Care Policy and Financing	Dept. Approval by: John Bartholomew	Date: November 2, 2009 10/28/09
Priority Number:	BRI-5	OSPB Approval:	Date: 11/2/09

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,528,767,696	2,544,655,371	0	2,750,090,382	3,002,644,591	(188,101,520)	3,047,954,890	0	3,047,954,890	34,714,989
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	929,233,912	773,238,343	0	867,501,647	1,144,814,023	(93,822,636)	1,151,384,986	0	1,151,384,986	16,530,560
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	168,808,635	0	177,242,277	334,288,427	(5,227,680)	360,340,549	0	360,340,549	798,617
	CFE/RF	2,631,068	2,739,519	0	2,748,535	2,736,160	(77,508)	2,667,602	0	2,667,602	16,237
	FF	1,448,017,385	1,599,868,874	0	1,702,597,923	1,520,805,981	(88,973,696)	1,533,561,753	0	1,533,561,753	17,369,575
(2) Medical Services Premiums	Total	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(166,645,996)	2,834,267,066	0	2,834,267,066	36,845,812
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,968	1,037,363,033	0	1,037,363,033	1,140,610,858	(79,070,398)	1,061,540,460	0	1,061,540,460	17,505,773
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	(4,143,069)	348,406,494	0	348,406,494	888,560
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	(76,485)	2,659,675	0	2,659,675	16,341
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(83,356,044)	1,421,660,437	0	1,421,660,437	18,435,138
(2) Medical Services Premiums; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	(4,910,335)	(4,910,335)	0	(4,910,335)	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	(196,724)	(196,724)	0	(196,724)	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	5,107,059	5,107,059	0	5,107,059	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐	**Base Reduction Item FY 2010-11** ☑	**Supplemental FY 2009-10** ☐	**Budget Amendment FY 2010-11** ☐	
Request Title:	Medicaid Payment Timing			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 2, 2009
Priority Number:	BRI-5	**OSPB Approval:**		**Date:**

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)
	Fund	FY 2008-09	FY 2009-10	FY 2009-10	FY 2009-10	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2010-11	FY 2011-12
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	**Total**	215,860,937	205,435,011	0	205,435,011	233,411,819	(21,320,366)	212,091,453	0	212,091,453	(2,159,753)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	86,769,471	94,262,892	0	94,262,892	103,726,456	(9,769,781)	93,956,675	0	93,956,675	(989,678)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	5,219,083	8,434,054	0	8,434,054	13,018,666	(887,887)	12,130,779	0	12,130,779	(89,943)
	CFE/RF	7,330	9,016	0	9,016	8,950	(1,023)	7,927	0	7,927	(104)
	FF	123,865,053	102,729,049	0	102,729,049	116,657,747	(10,661,675)	105,996,072	0	105,996,072	(1,080,028)
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Payments, Medicaid Mental Health Fee for Services Payments	**Total**	1,776,253	1,731,529	0	1,731,529	1,731,529	(135,158)	1,596,371	0	1,596,371	28,930
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	730,829	865,765	0	865,765	865,765	(67,579)	798,186	0	798,186	14,465
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,045,424	865,764	0	865,764	865,764	(67,579)	798,185	0	798,185	14,465
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(22,471,323)	0	(22,471,323)	0	(4,543)	(4,543)	0	(4,543)	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(1,950,368)	0	(1,950,368)	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	24,421,691	0	24,421,691	0	4,543	4,543	0	4,543	0

Non-Line Item Request:	None.
Letternote Revised Text:	See Table F.1 and F.2 for Revised Letternote Totals.
Cash or Federal Fund Name and COFRS Fund Number:	FF: Title XIX; See Tables F.1 and F.2 for Cash Fund Names and COFRS Numbers.
Reappropriated Funds Source, by Department and Line Item Name:	None.
Approval by OIT?	**Yes:** ☐ **No:** ☐ **N/A:** ☑
Schedule 13s from Affected Departments:	None.

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-5
Change Request Title:	Medicaid Payment Timing

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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:

The Department requests a reduction of $188,101,520 total funds and $93,822,636 General Fund in FY 2010-11. To achieve these savings, the Department proposes to shift the final two weeks of payments processed through the Medicaid Management Information System (MMIS) in FY 2009-10 into FY 2010-11 as well as shift the final four week's worth of payments from FY 2010-11. In order to reduce the impact of the out-year expenditure due to the payment delays, the Department also proposes to delay the final three weeks of payments in FY 2011-12, the final two weeks of payments in FY 2012-13, and the final week of payments in FY 2013-14. This "step down" approach to the delayed payments would result in FYs 2011-12 through 2014-15 each paying 53 weeks worth of expenditure rather than having FY 2011-12 pay off 56 weeks. These savings figures represent the incremental change from the payments shift already required by SB 09-265 and also reflect the enhanced Federal Medicaid Assistance Percentage (FMAP) that the State is receiving as a result of the American Recovery and Reinvestment Act of 2009 (ARRA).

Background and Appropriation History:

SB 09-265 requires the Department to delay one week of payments as processed through the MMIS at the end of FY 2009-10. That delayed payment will currently result in an extra week's worth of payments in the following year, FY 2010-11, resulting in a savings in FY 2009-10 of approximately $44.7 million total funds and a net increase in FY 2010-11 of the same amount.

The Department's request would effectively double the savings from SB 09-265 for FY 2009-10 and produce additional savings in FY 2010-11.

General Description of Request:

The Department requests a reduction of $188,101,520 total funds and $93,822,636 General Fund in FY 2010-11. To achieve these savings, the Department proposes to shift the final two weeks of payments processed through the Medicaid Management Information System (MMIS) in FY 2009-10 into FY 2010-11 as well as shift the final four week's worth of payments from FY 2010-11. In order to reduce the impact of the out-year expenditure due to the payment delays, the Department also proposes to delay the final three weeks of payments in FY 2011-12, the final two weeks of payments in FY 2012-13, and the final week of payments in FY 2013-14. This "step down" approach to the delayed payments would result in FYs 2011-12 through 2014-15 each paying 53 weeks worth of expenditure rather than having FY 2011-12 pay off 56 weeks. These savings figures represent the incremental change from the payments shift already required by SB 09-265 and also reflect the enhanced Federal Medicaid Assistance Percentage (FMAP) that the State is receiving as a result of the American Recovery and Reinvestment Act of 2009 (ARRA).

The Department proposes to: 1) delay the final two weeks of MMIS processed payments in FY 2009-10, allowing those payments to be made in FY 2010-11; 2) delay the final four weeks of MMIS processed payments in FY 2010-11; and 3) delay the final three weeks of payments in FY 2011-12, the final two weeks of payments in FY 2012-13, and the final week of payments in FY 2013-14. The Department estimates that this proposal would

result in the savings figures provided, above, and an increase of $34,714,989 total funds and $16,530,560 General Fund in FY 2011-12.[1]

The calculations for this request provide the total incremental change to the Department's budget. In those calculations, for FY 2010-11 the estimated expenditure from the prior year due to the fee-for-service shifted payment is overstated, as a portion is already included in the Department's Budget Request (DI-1 and DI-2) in order to account for SB 09-265. In order to calculate the incremental total, the Department backs out the amount of the shifted payment that is already included in its budget.

Additionally, SB 09-265 created a permanent savings in FY 2009-10 by having managed care payments made in the month following services, rather than the former practice of paying concurrently in the month of service. The Department's request impacts managed care payments in FY 2010-11 and FY 2011-12, as either a four week delay in payment or a three week delay in payment would cause that week when managed care payments are normally to be made to be delayed. However, there is no issue of double counting savings, as the delayed payment is fundamentally a different savings mechanism than the permanent shift required by SB 09-265.

The Department's estimates are based on the estimated expenditure for Medical Services Premiums and Mental Health Community Programs developed in Decision Items 1 and 2 in this November Budget Request. As part of DI-1 and DI-2, the Department has recalculated the impact of SB 09-265; those same estimates are used in this request to develop a consistent estimate.

The Department's request crosses the next six fiscal years, in the following ways:

- Delay the final two weeks of payments in FY 2009-10

[1] Please note that while the Department's request and calculations assumes that a supplemental request for FY 2009-10 is approved, this request does not officially request a change to FY 2009-10. The Department will submit a future budget request to officially request FY 2009-10, or, if necessary, revise this estimate.

- Delay the final four weeks of payments in FY 2010-11
- Delay the final three weeks of payments in FY 2011-12
- Delay the final two weeks of payments in FY 2012-13
- Delay the final week of payments in FY 2013-14
- Pay the delayed FY 2013-14 week in FY 2014-15

To implement the Department's request, the Department would need legislation to change section 25.5-4-401(1), C.R.S. (2009) to allow for a further delay in MMIS payments. Per section 25.5-4-401(1)(c), C.R.S. (2009), with the exception of FY 2009-10, the Department is prohibited from "intentionally interrupt[ing] the normal provider payment schedule unless notified… there is the possibility that adequate cash will not be available to make payments to providers and for other state expenses."

Delay the Final Two Weeks of Payments in FY 2009-10

By delaying the final two weeks of payments in FY 2009-10, the Department estimates that it would achieve $44,704,341 in total funds savings. This amount is in addition to the savings in SB 09-265. Those funds are in part subject to the ARRA enhanced FMAP, effectively reducing the magnitude of General Fund savings.

The final two weeks worth of payments, those payments regularly scheduled to be made in June 2010, will be paid at the beginning of FY 2010-11, in July 2010, generating an increase in expenditure for FY 2010-11 in the same amounts as were saved in FY 2010-11.

Delay the Final Four Weeks of Payments in FY 2010-11

By delaying four weeks of MMIS processed payments, those regularly scheduled to be paid in June 2011, the Department estimates that the request would result in a one-time savings of $188,101,520 total funds. Expenditure from June 2011 will be paid at the

beginning of FY 2011-12, generating an increase in expenditure for FY 2010-11 in the same amounts as were saved in FY 2010-11.

This amount includes both managed care capitation payments, including Health Maintenance Organizations (HMOs), Programs of All-Inclusive Care for the Elderly (PACE), Pre-paid Inpatient Health Plan (PIHP), and mental health capitation payments made to the Behavioral Health Organizations (BHOs); and all Medicaid fee-for-service providers. The Department's calculations for managed care are shown in tables B.1 through B.4. The Department's calculations for fee-for-service are shown in tables C.1 through C.4 and table D.

Fee-for-service savings from delaying the final four weeks of payments in the Medical Services Premiums line as well as the Medicaid Mental Health Community Programs lines would be partially offset by the increased expenditure of paying for the final two weeks of FY 2009-10 payments. The SB 09-265 requirement to pay for the final week of FY 2009-10 at the beginning of FY 2010-11 is already accounted for within the Department's base budget; the additional week's worth of delayed payment would result in an incremental increase for FY 2010-11.

The Department's managed care payments for May 2011 would normally be made in the first payment cycle in June 2011. Because the Department request that four weeks of payments be delayed, that period of time includes when managed care payments are made in June 2010; that payment, the payment made for services provided in May of 2010, would be shifted into FY 2011-12. During the payment shift in FY 2011-12 a similar impact to managed care payments would occur (discussed below). In subsequent fiscal years, the managed care payment would not be delayed; therefore, the proportion of the total delayed payments for FY 2010-11 and FY 2011-12 are larger than in the subsequent fiscal years.

Finally, because the final two weeks of FY 2009-10 are under the ARRA enhanced FMAP, and the final four weeks of FY 2010-11 are after the ARRA enhanced match

expires, the net ARRA impact is simply the reduced state funded expenditure when paying off the FY 2009-10 delayed expenditure. The Department estimates that this will further reduce General Fund expenditure by $4,914,878 in FY 2010-11. The Department's calculations are shown in tables E.1 and E.2.

Pay 53 Weeks in FY 2011-12 through FY 2014-15

As described, above, beginning in July 2011, the Department will pay for those expenses that were regularly scheduled to be made in June 2011.

In order to reduce the impact of the out-year expenditure due to the payment delays, the Department also proposes to delay the final three weeks of payments in FY 2011-12, the final two weeks of payments in FY 2012-13, and the final week of payments in FY 2013-14. This "step down" approach to the delayed payments would result in FYs 2011-12 through 2014-15 each paying 53 weeks worth of expenditure rather than having FY 2011-12 pay off 56 weeks.

FY 2011-12, normally paying 52 weeks, would now pay an additional four weeks, those carried over from FY 2010-11; delaying the final three weeks of FY 2011-12 would have a net result of one additional week, or a 53 payment week year.

The delay of three weeks of payments in FY 2011-12, as discussed above, would include both managed care capitation payments, including health maintenance organizations (HMOs), the Program of All-Inclusive Care for the Elderly (PACE), pre-paid inpatient health plans (PIHP), and mental health capitation payments made to the behavioral health organizations (BHOs); and all Medicaid fee-for-service providers.

FY 2012-13 would be affected by a similar set of mechanics, adding the three additional weeks carried over from FY 2011-12 and subtracting its own final two weeks. FY 2013-14 would have the final delayed week, to be paid off in FY 2014-15.

FY 2011-12 and FY 2012-13 would see a disproportionate share of expenditure from this "step down" delayed payment strategy as they are the only fiscal years in which delayed managed care payments would come due.

There are no additional ARRA impacts in FY 2011-12 or any of the out-years, as the incurred expenses being paid in FY 2010-11 are from the end of that year, after the expiration of the ARRA enhanced FMAP.

Federal Regulation

Federal regulations at 42 C.F.R. § 447.45(d)(2) require that the Department pay 90% of "claims from practitioners who are in individual or group practice or who practice in shared health facilities, within 30 days of receipt." Additionally, 42 C.F.R. § 447.45(d)(3) requires that the Department pay 99% of "claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

Currently, the Department averages 7.4 days from date of receipt to date of payment. Very few claims payments are made after 30 days. By delaying the processing of claims four weeks in FY 2010-11, 5 days worth of claims will be paid outside of the 30 day window. The MMIS pays claims on Tuesdays, for claims processed through the previous Friday. Should authority for this request be granted, in FY 2010-11, claims received on May 27, May 31, June 1, June 2, and June 3 of 2011 would be paid after 30 days. The Department estimates that these 5 days of claims comprise no more than 2.0% of total claims to be paid in FY 2010-11. Given the Department's precedence of prompt payment, the approximately 2.0% of claims estimated to be paid after 30 days should not prevent the Department from meeting the 90% requirement and should not impact the Department's overall compliance for the fiscal year.

Consequences if Not Funded: Not applicable.

Calculations for Request:

Summary of Impact FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($44,704,341)**	**($16,302,757)**	**($897,552)**	**($20,388)**	**($27,483,644)**
(2) Medical Services Premiums	($44,665,147)	($21,198,038)	($1,094,276)	($20,388)	($22,352,445)
(2) Medical Services Premiums; Long Bill Group Total	$0	$4,910,335	$196,724	$0	($5,107,059)
(3) Medicaid Mental Health Programs; (A) Mental Health Capitation Payments	$0	$0	$0	$0	$0
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Paymant; Medicaid Mental Health Fee for Service Payments	($39,194)	($19,597)	$0	$0	($19,597)
(3) Medicaid Mental Health Programs; Long Bill Group Total	$0	$4,543	$0	$0	($4,543)

Note: FY 2009-10 is shown for informational purposes only.

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($188,101,520)**	**($93,822,636)**	**($5,227,680)**	**($77,508)**	**($88,973,696)**
(2) Medical Services Premiums	($166,645,996)	($79,070,398)	($4,143,069)	($76,485)	($83,356,044)
(2) Medical Services Premiums; Long Bill Group Total	$0	($4,910,335)	($196,724)	$0	$5,107,059
(3) Medicaid Mental Health Programs; (A) Mental Health Capitation Payments	($21,320,366)	($9,769,781)	($887,887)	($1,023)	($10,661,675)
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Paymant; Medicaid Mental Health Fee for Service Payments	($135,158)	($67,579)	$0	$0	($67,579)
(3) Medicaid Mental Health Programs; Long Bill Group Total	$0	($4,543)	$0	$0	$4,543

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$34,714,989**	**$16,530,560**	**$798,617**	**$16,237**	**$17,369,575**
(2) Medical Services Premiums	$36,845,812	$17,505,773	$888,560	$16,341	$18,435,138
(3) Medicaid Mental Health Programs; (A) Mental Health Capitation Payments	($2,159,753)	($989,678)	($89,943)	($104)	($1,080,028)
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Paymant; Medicaid Mental Health Fee for Service Payments	$28,930	$14,465	$0	$0	$14,465

Cash Funds Projections: See Tables F.1 and F.2 for impact by cash fund.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Breast and Cervical Cancer Prevention and Treatment Fund	15D	$2,175,829	$10,291,636	$8,956,589	$8,487,913	$8,019,237
Colorado Autism Treatment Fund	18A	$608,665	$1,194,972	$1,632,742	$1,822,873	$1,271,300
Health Care Expansion Fund	18K	$94,003,143	$119,601,623	$81,320,908	$34,980,659	($22,674,568)
Coordinated Care for People with Disabilities Fund	19Z	$28,972	$1,038,307	$859,347	$679,865	$487,876
Medicaid Nursing Facility Cash Fund	22X	$16,410,618	$5,193,602	$5,193,602	$5,193,602	($9,023,209)
Hospital Provider Fee Cash Fund	-	-	-	-	-	-

Assumptions for Calculations: Where applicable, assumptions have been noted in the narrative, and in the accompanying tables. 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: Not applicable.

Cost Benefit Analysis: Not applicable.

Implementation Schedule:

The Department can implement this request within current resources.

Payment Timeline Summary:

- The final two weeks of June 2010 would be paid in the first week of July 2010
- The four weeks of June 2011 would be paid in the first week of July 2011
- The final three weeks of June 2012 would be paid in the first week of July 2012
- The final two weeks of June 2013 would be paid in the first week of July 2013
- The final week of June 2014 would be paid in the first week of July 2014

Statutory and Federal Authority:

25.5-4-401, C.R.S. (2009). Providers - payments - rules - repeal.

(c) The state department shall exercise its overexpenditure authority under section 24-75-109, C.R.S., and shall not intentionally interrupt the normal provider payment schedule unless notified jointly by the director of the office of state planning and budgeting and the state controller that there is the possibility that adequate cash will not be available to make payments to providers and for other state expenses. If it is determined that adequate cash is not available and the state department does interrupt the normal payment cycle, the state department shall notify the joint budget committee of the general assembly and any affected providers in writing of its decision to interrupt the normal payment schedule. Nothing in this paragraph (c) shall be interpreted to establish a right for any provider to be paid during any specific billing cycle.

(d) (I) Notwithstanding the provisions of paragraph (c) of this subsection (1), for the fiscal year commencing July 1, 2009, the state department shall delay the last normal provider payment cycle of the fiscal year until after July 1, 2010.

Performance Measures:

Not applicable.

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table A.1: Incremental Impact by Long Bill Group, Service Category, and Fiscal Year

Fund	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**
(2) Medical Services Premiums			
Health Maintenance Organizaitons	$0	($12,748,181)	($961,213)
Program of All-inclusive Care for the Elderly	$0	($7,222,930)	($894,199)
Prepaid Inpatient Health Plan	$0	($1,454,296)	($131,178)
Acute Care Fee-for-Service	($29,126,401)	($96,515,783)	$24,305,481
Community Based Long Term Care Fee-for-Service	($5,793,280)	($18,117,044)	$5,407,320
Long Term Care Fee-for-Service	($9,745,466)	($30,587,762)	$9,119,601
Medical Services Premiums Subtotal	**($44,665,147)**	**($166,645,996)**	**$36,845,812**
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	$0	$0	$0
Mental Health Capitation	**$0**	**($21,320,366)**	**($2,159,753)**
(3) Medicaid Mental Health Programs; (B) Other Medicaid Mental Health Payments; Medicaid	$0	$0	$0
Mental Health Fee-for-Service	**($39,194)**	**($135,158)**	**$28,930**
Total	**($44,704,341)**	**($188,101,520)**	**$34,714,989**

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table A.2
Cash Fund Splits
FY 2009-10

FY 2009-10	Total Funds	General Fund	Health Care Expansion Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Colorado Autism Treatment Fund	Hospital Provider Fee Fund	Nursing Facility Fund	Coordinated Care for People with Disabilities Fund	Reappropriated Funds	Federal Funds
Total Request	**($44,704,341)**	**($16,284,757)**	**($339,156)**	**($33,817)**	**($12,134)**	**($258,088)**	**($254,357)**	**$0**	**($20,388)**	**($27,501,644)**
(2) Medical Services Premiums	($44,665,147)	($21,198,038)	($448,546)	($43,690)	($15,642)	($332,041)	($254,357)	$0	($20,388)	($22,352,445)
(2) Medical Services Premiums; Long Bill Group Total	$0	$4,928,335	$109,390	$9,873	$3,508	$73,953	$0	$0	$0	($5,125,059)
(3) Medicaid Mental Health Programs; (A) Mental Health Capitation Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Payment; Medicaid Mental Health Fee for Service Payments	($39,194)	($19,597)	$0	$0	$0	$0	$0	$0	$0	($19,597)
(3) Medicaid Mental Health Programs; Long Bill Group Total	$0	$4,543	$0	$0	$0	$0	$0	$0	$0	($4,543)

Table A.3
Cash Fund Splits
FY 2010-11

FY 2010-11	Total Funds	General Fund	Health Care Expansion Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Colorado Autism Treatment Fund	Hospital Provider Fee Fund	Nursing Facility Fund	Coordinated Care for People with Disabilities Fund	Reappropriated Funds	Federal Funds
Total Request	**($188,101,520)**	**($93,840,636)**	**($2,529,957)**	**($176,200)**	**($52,424)**	**($1,469,733)**	**($986,859)**	**($12,507)**	**($77,508)**	**($88,955,696)**
(2) Medical Services Premiums	($166,645,996)	($79,070,398)	($1,684,119)	($163,896)	($48,916)	($1,246,772)	($986,859)	($12,507)	($76,485)	($83,356,044)
(2) Medical Services Premiums; Long Bill Group Total	$0	($4,928,335)	($109,390)	($9,873)	($3,508)	($73,953)	$0	$0	$0	$5,125,059
(3) Medicaid Mental Health Programs; (A) Mental Health Capitation Payments	($21,320,366)	($9,769,781)	($736,448)	($2,431)	$0	($149,008)	$0	$0	($1,023)	($10,661,675)
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Payment; Medicaid Mental Health Fee for Service Payments	($135,158)	($67,579)	$0	$0	$0	$0	$0	$0	$0	($67,579)
(3) Medicaid Mental Health Programs; Long Bill Group Total	$0	($4,543)	$0	$0	$0	$0	$0	$0	$0	$4,543

Table A.4
Cash Fund Splits
FY 2011-12

FY 2011-12	Total Funds	General Fund	Health Care Expansion Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Colorado Autism Treatment Fund	Hospital Provider Fee Fund	Nursing Facility Fund	Coordinated Care for People with Disabilities Fund	Reappropriated Funds	Federal Funds
Total Request	**$34,714,989**	**$16,530,560**	**$284,768**	**$34,770**	**$14,600**	**$250,924**	**$214,683**	**($1,128)**	**$16,237**	**$17,369,575**
(2) Medical Services Premiums	$36,845,812	$17,505,773	$359,370	$35,016	$14,600	$266,019	$214,683	($1,128)	$16,341	$18,435,138
(3) Medicaid Mental Health Programs; (A) Mental Health Capitation Payments	($2,159,753)	($989,678)	($74,602)	($246)	$0	($15,095)	$0	$0	($104)	($1,080,028)
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Payment; Medicaid Mental Health Fee for Service Payments	$28,930	$14,465	$0	$0	$0	$0	$0	$0	$0	$14,465

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table B.1: Delayed Payment Incremental Savings Calculation for Medical Services Premiums HMO Expenditure

Row	Description	FY 2010-11	FY 2011-12	Source
A	Estimated Acute Care Expenditure	$1,788,706,160	$1,923,574,604	FY 2010-11: DI-1, Exhibit F: Acute Care Base and Impacts Excluding SB 09-265; FY 2011-12: Table C.1, Row A
B	Proportion of FY 2008-09 Acute Care that is HMO Expenditure	8.55%	8.55%	DI-1: Exhibit N: Expenditure History
C	Estimated FY 2009-10 HMO Expenditure	$152,978,173	$164,512,727	Row A * Row B
D	Payment Months	12	12	Months in the fiscal year
E	Expenditure per Week	$12,748,181	$13,709,394	Row E / Row F
F	Months Delayed	1	1	Department's Request
G	Shifted Payment	($12,748,181)	($13,709,394)	-(Row E * Row F)
H	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$12,748,181	-(Row G, from Previous Year)
I	**Total Incremental HMO Expenditure**	**($12,748,181)**	**($961,213)**	**Additional Effect of the Request Beyond SB 09-265**

Table B.2: Delayed Payment Incremental Savings Calculation for Medical Services Premiums PACE Expenditure

Row	Description	FY 2010-11	FY 2011-12	Source
A	Estimated PACE Expenditure	$86,675,162	$97,405,547	FY 2010-11: DI-1, Exhibit H: PACE Base and Impacts Excluding SB 09-265; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, as presented in DI-1 Exhibit H, carried forward
B	Payment Months	12	12	Weeks in the Fiscal Year
C	Expenditure per Week	$7,222,930	$8,117,129	Row A / Row B
D	Months Delayed	1	1	Department's Request
E	Shifted Payment	($7,222,930)	($8,117,129)	-(Row D * Row E)
F	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$7,222,930	-(Row E, from Previous Year)
G	**Total Incremental PACE Expenditure**	**($7,222,930)**	**($894,199)**	**Additional Effect of the Request Beyond SB 09-265**

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table B.3: Delayed Payment Incremental Savings Calculation for Medical Services Premiums PIHP Expenditure

Row	Description	FY 2010-11	FY 2011-12	Source
A	Estimated PIHP Expenditure	$17,451,555	$19,025,685	FY 2010-11: DI-1, Exhibit I: PIHP Base and Impacts Excluding SB 09-265; FY 2011-12: The rate of change from FY 2007-08 to 2008-09, as presented in DI-1, Exhibit I, carried forward*
B	Payment Months	12	12	Weeks in the Fiscal Year
C	Expenditure per Week	$1,454,296	$1,585,474	Row A / Row B
D	Months Delayed	1	1	Department's Request
E	Shifted Payment	($1,454,296)	($1,585,474)	-(Row D * Row E)
F	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$1,454,296	-(Row E, from Previous Year)
G	**Total Incremental PIHP Expenditure**	**($1,454,296)**	**($131,178)**	**Additional Effect of the Request Beyond SB 09-265**

*The Department has used the trend from FY 2007-08 to 2008-09 as the change from 2008-09 to 2009-10 is estimated at over 230% due to the impact of the Department's Value-Based Care Coordination Initiative (DI-6).

Table B.4: Delayed Payment Incremental Savings Calculation for Medicaid Mental Health Capitation Expenditure

Row	Description	FY 2010-11	FY 2011-12	Source
A	Estimated Incurred Capitation Expenditure	$255,844,389	$281,761,426	FY 2010-11: DI-2, Exhibit BB: Capitation Expenditure Prior to Recoupments and Excluding SB 09-265; FY 2011-12: The rate of change from FY 2007-08 to 2008-09, as presented in DI-2, Exhibit D, carried forward*
B	Payment Months	12	12	Weeks in the Fiscal Year
C	Expenditure per Week	$21,320,366	$23,480,119	Row A / Row B
D	Months Delayed	1	1	Department's Request
E	Shifted Payment	($21,320,366)	($23,480,119)	-(Row D * Row E)
F	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$21,320,366	-(Row E, from Previous Year)
G	**Total Incremental Capitation Expenditure**	**($21,320,366)**	**($2,159,753)**	**Additional Effect of the Request Beyond SB 09-265**

*The Department has used the trend from FY 2007-08 to 2008-09 (10.13%) as the change from 2008-09 to 2009-10 is estimated at over 18% and the average year-to-year change since 2004-05 is also 10.13%; see the Department's November 2, 2009 DI-2 Request.

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table C.1: Delayed Payment Incremental Savings Calculation for Medical Services Premiums Acute Care

Row	Description	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Estimated Incurred Acute Care Expenditure	$1,663,241,217	$1,788,706,160	$1,923,574,604	FY 2009-10 and 2010-11: DI-1, Exhibit F: Acute Care Base and Impacts Excluding SB 09-265; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, carried forward
B	Proportion of FY 2008-09 Acute Care that is HMO Expenditure	8.55%	8.55%	8.55%	DI-1: Exhibit N: Expenditure History
C	Estimated FY 2009-10 HMO Expenditure	$142,247,848	$152,978,173	$164,512,727	Row A * Row B
D	Estimated FY 2009-10 Supplemental Physician Payments	$6,420,530	$2,379,581	$2,559,001	FY 2009-10 and 2010-11: November Request, Exhibit F: Bottom Line Impacts, S-8; FY 2011-12: The rate of change from Row A, FY 2009-10 to 2010-11, carried forward
E	Estimated Current Year Incurred Expenditure to be Affected by Shifted Payment	$1,514,572,839	$1,633,348,406	$1,756,502,876	Row A - Row C - Row D
F	Payment Weeks	52	52	52	Weeks in the fiscal year
G	Expenditure per Week	$29,126,401	$31,410,546	$33,778,901	Row E / Row F
H	Weeks Delayed	2	4	3	Department's Request
I	Shifted Payment	($58,252,802)	($125,642,184)	($101,336,703)	-(Row G * Row H)
J	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$58,252,802	$125,642,184	-(Row I, from Previous Year)
K	**Total Estimated Expenditure Shift**	**($58,252,802)**	**($67,389,382)**	**$24,305,481**	**Row I + Row J**
L	Amounts Already Included in the Department's Budget due to SB 09-265	$29,126,401	($29,126,401)	-	SB 09-265 Currently Delays One Week from FY 2009-10. *See Note, Below.
M	**Total Incremental Expenditure**	**($29,126,401)**	**($96,515,783)**	**$24,305,481**	**Additional Effect of the Request Beyond SB 09-265**

* For FY 2010-11, the estimated expenditure from the prior year due to the shifted payment is overstated, as a portion is already included in the Department's Budget Request (DI-1) to account for SB 09-265. In order to calculate the incremental total, the Department backs out the amount of the shifted payment that is already included in its budget.

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table C.2: Delayed Payment Incremental Savings Calculation for Medical Services Premiums Community Based Long Term Care

Row	Description	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Estimated Current Year Expenditure to be Affected by Shifted Payment	$301,250,566	$310,834,186	$320,718,713	FY 2009-10 and 2010-11: DI-1, Exhibit G: Community Based Long Term Care Base and Impacts Excluding SB 09-265; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, carried forward
B	Payment Weeks	52	52	52	Weeks in the fiscal year
C	Expenditure per Week	$5,793,280	$5,977,581	$6,167,668	Row A / Row B
D	Weeks Delayed	2	4	3	Department's Request
E	Shifted Payment	($11,586,560)	($23,910,324)	($18,503,004)	-(Row C * Row D)
G	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$11,586,560	$23,910,324	-(Row E, from Previous Year)
H	**Total Estimated Expenditure Shift**	**($11,586,560)**	**($12,323,764)**	**$5,407,320**	**Row E + Row G**
I	Account for SB 09-265	$5,793,280	($5,793,280)	-	SB 09-265 Currently Delays One Week from FY 2009-10. *See Note, Below.
J	**Total Incremental Expenditure**	**($5,793,280)**	**($18,117,044)**	**$5,407,320**	**Additional Effect of the Request Beyond SB 09-265**

* For FY 2010-11, the estimated expenditure from the prior year due to the shifted payment is overstated, as a portion is already included in the Department's Budget Request (DI-1) to account for SB 09-265. In order to calculate the incremental total, the Department backs out the amount of the shifted payment that is already included in its budget.

Table C.3: Delayed Payment Incremental Savings Calculation for Medical Services Premiums Long Term Care

Row	Description	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Shifted Payment	($19,490,931)	($40,333,228)	($31,213,627)	Table C.4, Row K
B	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$19,490,931	$40,333,228	-(Row A, from Previous Year)
C	**Total Estimated Expenditure Shift**	**($19,490,931)**	**($20,842,297)**	**$9,119,601**	**Row A + Row B**
D	Account for SB 09-265	$9,745,465	($9,745,465)	-	SB 09-265 Currently Delays One Week from FY 2009-10. *See Note, Below.
E	**Total Incremental Expenditure**	**($9,745,466)**	**($30,587,762)**	**$9,119,601**	**Additional Effect of the Request Beyond SB 09-265**

* For FY 2010-11, the estimated expenditure from the prior year due to the shifted payment is overstated, as a portion is already included in the Department's Budget Request (DI-1) to account for SB 09-265. In order to calculate the incremental total, the Department backs out the amount of the shifted payment that is already included in its budget.

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table C.4: Delayed Payment Per Week Savings Calculation for FY 2009-10 Medical Services Premiums Long Term Care

Row	Description	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Estimated Patient Days for FY 2009-11	3,385,605	3,375,987	3,366,535	FY 2009-10 and 2010-11: DI-1, Exhibit H: Class I Nursing Home Calculations Footnotes; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, carried forward
B	Estimated June 2010 Patient Days	274,241	271,555	268,894	FY 2009-10 and 2010-11: DI-1, Exhibit H: Class I Nursing Home Calculations Footnotes; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, carried forward
C	Estimated Patient Days per week (Estimated June 2010 Patient Days multiplied by 12 and divided by 52)	63,286	62,666	62,052	(Row B * 12) / 52
D	Estimated Patent Weeks Affected by the MMIS Payment Shift	2	4	3	Department's Request
E	Estimated Patient Days Affected by the MMIS Payment Shift	126,573	250,664	186,156	Row C * Row D
F	**Percentage of Estimated Patient Days Affected by MMIS Payment Shift to Total FY 2009-10 Patient Days**	**3.7%**	**7.4%**	**5.5%**	(Row E / Row A)
G	Expenditures Excluding Bottom Line Adjustments	$521,200,054	$541,246,701	$562,084,699	FY 2009-10 and 2010-11: DI-1, Exhibit H: Class I Nursing Home Calculations; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, carried forward
H	Hospital Back Up Program Expenditures	$7,489,401	$8,104,525	$8,769,907	FY 2009-10 and 2010-11: DI-1, Exhibit H: Class I Nursing Home Calculations; FY 2011-12: The rate of change from FY 2009-10 to 2010-11, carried forward
I	Impact of ES-2: Medicaid Program Reductions on Expenditure	($1,907,528)	($6,136,136)	($6,372,377)	FY 2009-10 and 2010-11: DI-1, Exhibit H: Class I Nursing Home Calculations; FY 2011-12: The rate of change from Row G, FY 2009-10 to 2010-11, carried forward
J	Total Expenditure (excluding recoveries)	$526,781,927	$543,215,090	$564,482,228	Row G + Row H + Row I
K	**Amount of Adjustment to Expenditure**	**($19,490,931)**	**($40,333,228)**	**($31,213,627)**	-(Row F * Row J)

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table D: Delayed Payment Incremental Savings Calculation for Mental Health Fee-for-Service

Row	Description	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Estimated Current Year Incurred Expenditure to be Affected by Shifted Payment	$2,038,098	$2,266,569	$2,520,651	DI-2, Exhibit KK: Base and Impacts Excluding SB 09-265
B	Payment Weeks	52	52	52	Weeks in the Fiscal Year
C	Expenditure per Week	$39,194	$43,588	$48,474	Row A / Row B
D	Weeks Delayed	2	4	3	Department's Request
E	Shifted Payment	($78,388)	($174,352)	($145,422)	-(Row C * Row D)
F	Account for SB 09-265	$39,194	($39,194)	$0	SB 09-265 Currently Delays One Week from FY 2009-10
G	Estimated Expenditure from Prior Year due to Shifted Payment	$0	$78,388	$174,352	-(Row E, from Previous Year)
H	**Total Incremental Expenditure**	**($39,194)**	**($135,158)**	**$28,930**	**Additional Effect of the Request Beyond SB 09-265**

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table E.1: FY 2009-10 Adjustments for the American Recovery and Reinvestment Act (ARRA)

Expenditure by Fund and Category of Federal Matching Percentage for FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Enhanced Match
Acute Care Services						
Base Acute Care (Fee For Service Only)	$0	$3,130,924	$193,203	$0	($3,324,127)	11.59%
Breast and Cervical Cancer Program	$0	$0	$0	$0	$0	0.00%
Family Planning	$0	$0	$0	$0	$0	0.00%
Indian Health Services	$0	$0	$0	$0	$0	0.00%
Community Based Long Term Care Fee For Service						
Community Based Long Term Care Base and Waiver Services (Fee For Service)	$0	$667,911	$3,521	$0	($671,432)	11.59%
Hospital Provider Fee Fund Split Adjustment	$0	$0	$0	$0	$0	0.00%
Long Term Care Fee For Service						
Class I Nursing Facilities Base	$0	$1,129,500	$0	$0	($1,129,500)	11.59%
Class I Nursing Facilities Cash Fund	$0	$0	$0	$0	$0	0.00%
Total Medical Services Premiums Fee For Service Adjustment	**$0**	**$4,928,335**	**$196,724**	**$0**	**($5,125,059)**	
Mental Health Fee For Service	$0	$4,543	$0	$0	($4,543)	11.59%
Total Fee For Service Adjustment	**$0**	**$4,932,878**	**$196,724**	**$0**	**($5,129,602)**	
Managed Care (HMO, PACE, PIHP, Mental Health Capitation)	$0	$0	$0	$0	$0	11.59%
Total Expenditure Adjustment	**$0**	**$4,932,878**	**$196,724**	**$0**	**($5,129,602)**	

Table E.2: FY 2009-10 Net Impact Including ARRA

Expenditure by Fund and Category of Federal Matching Percentage for FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Enhanced Match
Acute Care Services						
Base Acute Care (Fee For Service Only)	($28,680,988)	($13,507,004)	($833,490)	$0	($14,340,494)	11.59%
Breast and Cervical Cancer Program	($162,401)	$0	($39,815)	($17,025)	($105,561)	0.00%
Family Planning	($251,637)	($25,164)	$0	$0	($226,473)	0.00%
Indian Health Services	($31,375)	$0	$0	$0	($31,375)	0.00%
Community Based Long Term Care Fee For Service						
Community Based Long Term Care Base, Autism Waiver, and Health Care Expansion Fund Services (Fee For Service)	($5,793,197)	($2,881,409)	($15,189)	$0	($2,896,599)	11.59%
Children With Autism Waiver Services	($30,271)		($15,135)		($15,136)	
Health Care Expansion Fund Programs	($108)		($54)		($54)	
Hospital Provider Fee Fund Split Adjustment	($83)	$0	($41)	$0	($42)	0.00%
Long Term Care Fee For Service						
Class I Nursing Facilities Base	($9,745,466)	($4,872,733)	$0	$0	($4,872,733)	11.59%
Class I Nursing Facilities Cash Fund	$0	$0	$0	$0	$0	0.00%
Total Medical Services Premiums Fee For Service	**($44,665,147)**	**($21,286,310)**	**($888,535)**	**($17,025)**	**($22,473,277)**	
Mental Health Fee For Service	($39,194)	($19,597)	$0	$0	($19,597)	11.59%
Total Fee For Service	**($44,704,341)**	**($21,305,907)**	**($888,535)**	**($17,025)**	**($22,492,874)**	
Managed Care (HMO, PACE, PIHP, Mental Health Capitation)	$0	$0	$0	$0	$0	11.59%
Total Expenditure	**($44,704,341)**	**($21,305,907)**	**($888,535)**	**($17,025)**	**($22,492,874)**	

Base Reduction Item - 5: Medicaid Payment Timing
Appendix A

Table F.1: New Letternote Totals for Medical Services Premiums

Long Bill Group	Line Item	Cash Fund	Appropriation Type	COFRS Number	Total
(2) Medical Services Premiums	Medical Services Premiums	Health Care Expansion Fund	Cash Fund	18K	$84,968,222
(2) Medical Services Premiums	Medical Services Premiums	Colorado Autism Treatment Fund	Cash Fund	18A	$769,233
(2) Medical Services Premiums	Medical Services Premiums	Hospital Provider Fee Cash Fund	Cash Fund	-	($332,041)
(2) Medical Services Premiums	Medical Services Premiums	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	$1,681,789
(2) Medical Services Premiums	Medical Services Premiums	Coordinated Care for People with Disabilities Fund	Cash Fund	19Z	$250,000
(2) Medical Services Premiums	Medical Services Premiums	Nursing Facility Cash Fund	Cash Fund	22X	$26,786,497

Table F.2: New Letternote Totals for Medicaid Mental Health Community Programs

Long Bill Group	Line Item	Cash Fund	Appropriation Type	COFRS Number	Total
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Health Care Expansion Fund	Cash Fund	18K	$8,904,928
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Hospital Provider Fee Cash Fund	Cash Fund	-	$0
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	$20,056

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Joan Henneberry
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting ***November 2009***

BRI-5 Medicaid Payment Timing

Request: The Department requests a reduction of $188,101,520 total funds and $93,822,636 General Fund in FY 2010-11. To achieve these savings, the Department proposes to shift the final two weeks of payments processed through the Medicaid Management Information System (MMIS) in FY 2009-10 into FY 2010-11 as well as shift the final four week's worth of payments from FY 2010-11.

Highlights: The Department requests the ability to mitigate the impact of the current economic climate by spreading the impacts of payments out over future years by shifting the final two weeks of payments processed through the MMIS in FY 2009-10 into FY 2010-11 as well as shifting the final four weeks worth of payments from FY 2010-11. In order to reduce the impact of the out-year expenditure due to the payment delays, the Department also proposes to delay the final three weeks of payments in FY 2011-12, the final two weeks of payments in FY 2012-13, and the final week of payments in FY 2013-14. This "step down" approach to the delayed payments would result in FYs 2011-12 through 2014-15 each paying 53 weeks worth of expenditure.

In SB 09-265, the Department indicated that system changes to the Medicaid Management Information System (MMIS) would not be necessary to implement a payment delay. However, federal regulations at 42 C.F.R. § 447.45(d)(2) require that the Department pay 90% of "claims from practitioners who are in individual or group practice or who practice in shared health facilities, within 30 days of receipt." Additionally, 42 C.F.R. § 447.45(d)(3) requires that the Department pay 99% of "claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt." The Department is currently exploring what will be required to maintain compliance with federal regulations, and whether the proposed delayed payment process will require system changes or additional staff as a result of maintaining compliance with the federal regulation

Summary of Request FY 2009-10*	Total Funds	General Fund	Cash Funds	Reappro-priated Funds	Federal Funds
Total Request	**($44,704,341)**	**($16,302,757)**	**($897,552)**	**($20,388)**	**($27,483,644)**
(2) Medical Services Premiums	($44,665,147)	($21,198,038)	($1,094,276)	($20,388)	($22,352,445)
ARRA Adjustment	$0	$4,910,335	$196,724	$0	($5,107,059)
(3) Medicaid Mental Health Fee for Service Payments	($39,194)	($19,597)	$0	$0	($19,597)
ARRA Adjustment	$0	$4,543	$0	$0	($4,543)

**FY 2009-10 is shown for informational purposes only*

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappro-priated Funds	Federal Funds
Total Request	**($188,101,520)**	**($93,822,636)**	**($5,227,680)**	**($77,508)**	**($88,973,696)**
(2) Medical Services Premiums	($166,645,996)	($79,070,398)	($4,143,069)	($76,485)	($83,356,044)
ARRA Adjustment	$0	($4,910,335)	($196,724)	$0	$5,107,059
(3) Medicaid Mental Health Capitation Payments	($21,320,366)	($9,769,781)	($887,887)	($1,023)	($10,661,675)
(3) Medicaid Mental Health Fee for Service Payments	($135,158)	($67,579)	$0	$0	($67,579)
ARRA Adjustment	$0	($4,543)	$0	$0	$4,543

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappro-priated Funds	Federal Funds
Total Request	**$34,714,989**	**$16,530,560**	**$798,617**	**$16,237**	**$17,369,575**
(2) Medical Services Premiums	$36,845,812	$17,505,773	$888,560	$16,341	$18,435,138
(3) Medicaid Mental Health Capitation Payments	($2,159,753)	($989,678)	($89,943)	($104)	($1,080,028)
(3) Medicaid Mental Health Fee for Service Payments	$28,930	$14,465	$0	$0	$14,465

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

Media inquires should be directed to Joanne Lindsay at 303-866-3144.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10	Budget Amendment FY 2010-11

Request Title: Medicaid Program Reductions
Department: Health Care Policy and Financing
Priority Number: BRI-6
Dept. Approval by: John Bartholomew for Date: November 2, 2009 10/20/09
OSPB Approval: Date: 11-2-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,742,852,380	2,748,358,853	0	2,748,358,853	3,234,324,881	(35,234,040)	3,199,090,841	0	3,199,090,841	(36,222,439)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,006,479,429	844,164,559	0	844,164,559	1,244,337,314	(27,963,869)	1,216,373,445	0	1,216,373,445	(17,041,795)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	114,852,622	175,291,909	0	175,291,909	365,568,229	11,350,706	376,918,935	0	376,918,935	(1,062,996)
	CFE/RF	2,638,398	2,748,535	0	2,748,535	2,745,110	(214)	2,744,896	0	2,744,896	(279)
	FF	1,579,630,139	1,726,153,850	0	1,726,153,850	1,621,674,228	(18,620,663)	1,603,053,565	0	1,603,053,565	(18,117,369)
(2) Medical Services Premiums	Total	2,526,991,443	2,542,923,842	0	2,542,923,842	3,000,913,062	(31,111,229)	2,969,801,833	0	2,969,801,833	(30,842,996)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	1,037,363,033	0	1,037,363,033	1,140,610,858	(28,053,217)	1,112,557,641	0	1,112,557,641	(14,624,904)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	0	226,708,414	352,549,563	11,502,201	364,051,764	0	364,051,764	(790,848)
	CFE/RF	2,631,068	2,739,519	0	2,739,519	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,276,112,876	0	1,276,112,876	1,505,016,481	(14,560,213)	1,490,456,268	0	1,490,456,268	(15,427,244)
(2) Medical Services Premiums; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	1,645,687	1,645,687	0	1,645,687	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	41,309	41,309	0	41,309	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	(1,686,996)	(1,686,996)	0	(1,686,996)	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐		**Base Reduction Item FY 2010-11**	☑		**Supplemental FY 2009-10**	☐		**Budget Amendment FY 2010-11**	☐	
Request Title:	Medicaid Program Reductions										
Department:	Health Care Policy and Financing				**Dept. Approval by:**	John Bartholomew			**Date:**	November 2, 2009	
Priority Number:	BRI-6				**OSPB Approval:**				**Date:**		

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	**Total**	215,860,937	205,435,011	0	205,435,011	233,411,819	(4,122,811)	229,289,008	0	229,289,008	(5,379,443)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	86,769,471	94,262,892	0	94,262,892	103,726,456	(1,852,307)	101,874,149	0	101,874,149	(2,416,891)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	5,219,083	8,434,054	0	8,434,054	13,018,666	(208,575)	12,810,091	0	12,810,091	(272,148)
	CFE/RF	7,330	9,016	0	9,016	8,950	(214)	8,736	0	8,736	(279)
	FF	123,865,053	102,729,049	0	102,729,049	116,657,747	(2,061,715)	114,596,032	0	114,596,032	(2,690,125)
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(22,471,323)	0	(22,471,323)	0	295,968	295,968	0	295,968	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(1,950,368)	0	(1,950,368)	0	15,771	15,771	0	15,771	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	24,421,691	0	24,421,691	0	(311,739)	(311,739)	0	(311,739)	0

Non-Line Item Request:	None.			
Letternote Revised Text:	See Appendix A, Tables 4.1 - 4.3			
Cash or Federal Fund Name and COFRS Fund Number:	CF: Breast and Cervical Cancer Prevention and Treatment Fund 15D, Health Care Expansion Fund 18K; Hospital Provider Fee Cash Fund; Nursing Facility Cash Fund 22X. FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund			
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑	
Schedule 13s from Affected Departments:	None.			

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-6
Change Request Title:	Medicaid Program Reductions

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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:

In response to the state's current fiscal situation, the Department requests a reduction of $35,234,040 total funds, $27,963,869 General Fund in FY 2010-11, and a reduction of $36,222,439 total funds, $17,041,795 General Fund in FY 2011-12 in order to: reduce Medicaid physical health provider rates by 1%; reduce capitation rates paid to behavioral health organizations; reduce reimbursement to mid-level practitioners; impose restrictions on certain durable medical equipment; restrict nursing facility per diem growth to 0% in FY 2010-11; and, refinance a portion of Medical Services Premiums with an existing cash fund appropriation. Reductions would be effective July 1, 2010.

Background and Appropriation History:

Not applicable.

General Description of Request:

In response to the state's current fiscal situation, the Department requests a reduction of $35,234,040 total funds, $27,963,869 General Fund in FY 2010-11, and a reduction of $36,222,439 total funds, $17,041,795 General Fund in FY 2011-12 in order to: reduce Medicaid physical health provider rates by 1%; reduce capitation rates paid to behavioral health organizations; reduce reimbursement to mid-level practitioners; impose restrictions on certain durable medical equipment; restrict nursing facility per diem growth to 0% in FY 2010-11; and, refinance a portion of Medical Services Premiums with an existing cash fund appropriation. Reductions would be effective July 1, 2010.

Provider Rate Reductions:

As part of this request, the Department proposes to reduce rates paid to Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2010. This reduction would affect all providers and services paid within the Department's Medical Services Premiums line item, with the following exceptions: prescription drugs; federally qualified health centers; rural health centers; and, prepaid inpatient health plan (PIHP) administration. Rates paid to managed care organizations, including PACE, would also include corresponding decreases, as the Department pays rates based on fee-for-service expenditure. However, any managed care rates which fall outside the current actuarially sound rate ranges may require additional actuarial certification. The proposed rate change to nursing facilities would require a statute change.

Due to cash accounting, savings estimates are calculated under the assumption that there will be a constant one month lag between the time the cuts are implemented and the time savings are achieved. This gap incorporates the approximate time between a claim is incurred and the time that the claim is paid by the Department.

The Department estimates that the proposed rate reductions will reduce expenditures by approximately $22,337,320 total funds, $9,337,445 General Fund, and $532,169 cash funds in FY 2010-11.[1] The rate reductions annualize to savings of $26,241,374 total

[1] Note that the Department's calculations in table A.1 includes the effect and annualization of the proposed FY 2009-10 rate cut, announced October 28, 2009, although those totals are not shown in this request. The Department intends to submit a separate Supplemental request to fully account for the FY 2009-10 at a later date.

funds and $12,438,708 General Fund in FY 2011-12. The Department's calculations are shown in Appendix B, Tables A.1 and A.2.

Behavioral Health Organization Reduction

As part of this request, the Department proposes to reduce rates paid to behavioral health organizations by 2%. Currently, rates are paid at 2.5% below the midpoint of an actuarially-sound rate range developed during the rate-setting process. This reduction would place rates at approximately 95.55% of the midpoint of the rate range. The minimum level required to maintain an actuarially sound rate is 95% of the midpoint rate. The Department estimates that the proposed restrictions will reduce expenditure by $4,122,811 total funds and $1,556,339 General Fund in FY 2010-11. This proposal annualizes to a savings of $5,379,443 total funds and $2,416,891 General Fund in FY 2011-12. The Department's calculations are shown in Appendix B, Table B.

Reduction to Mid-Level Practitioner Reimbursement

As part of this request, the Department proposes to reduce rates paid to mid-level practitioners to 90% of the rate paid to physicians. Currently, the Department reimburses mid-level practitioners, including nurse practitioners, physician assistants, certified nurse midwives, and certified registered nurse anesthetists, at the same rate as physicians for the same services. This rate reduction would also impact risk-based physical health managed care organizations, and PACE.

The Department estimates that the proposed rate reductions will reduce expenditure by $1,417,613 total funds, $573,979 General Fund in FY 2010-11. This proposal annualizes to $1,810,562 total funds, $900,756 General Fund in FY 2011-12. The Department's calculations are shown in Appendix B, Table C.

Restrictions to Optional Durable Medical Equipment

As part of this request, the Department proposes to impose restrictions on certain optional durable medical equipment. In particular, the Department would impose a 210-unit limit

on incontinence products (down from the current limit of 240), and eliminate coverage for oral nutritional products for adults 21 years and older, although exceptions would be granted for individuals with innate errors of metabolism or malnourishment conditions. This rate reduction would also impact risk-based physical health managed care organizations, and PACE.

The Department estimates that the proposed rate reductions will reduce expenditure by $2,333,095 total funds, $944,651 General Fund in FY 2010-11. This proposal annualizes to $2,791,060 total funds, $1,285,440 General Fund in FY 2011-12. The Department's calculations are shown in Appendix B, Table E.

Reduction to Nursing Facility Per Diem General Fund Cap

As part of this request, the Department proposes to reduce the current limit on General Fund per diem growth in nursing facility rates from 5% to 0% in FY 2010-11. The Department's proposal assumes the limit is returned to the 5% level in FY 2011-12, and allowed to return to the 3% limit, in statute at 25.5-6-202 (9)(b)(I) and 25.5-6-202(9)(b.7), C.R.S. (2009), in FY 2012-13. A change to the General Fund limit would require a statute change. The Department estimates that the proposed rate reductions will reduce expenditure by $12,215,048 General Fund in FY 2010-11. This proposal annualizes to zero in FY 2011-12. The Department's calculations are shown in Appendix B, Table F.1.

In addition to affecting nursing facility rates, a reduction to the General Fund cap will also create a reduction to rates for the Program for All-Inclusive Care for the Elderly (PACE). The nursing facility component of PACE rates is based solely on the General Fund funded components of the nursing facility rates. Therefore, a reduction the cap will cause a corresponding decrease to PACE rates. The Department estimates that the proposed rate reductions will reduce expenditure by $3,023,201 total funds, $1,336,407 General Fund in FY 2010-11. This proposal annualizes to zero in FY 2011-12. The Department's calculations are shown in Appendix B, Table F.2.

The request further assumes that the Nursing Facility Cash Fund would be used to pay for any portion of the per diem which is unfunded due to an decrease to the General Fund limit, per 25.5-6-202(9)(b)(I), C.R.S. (2009). However, this would require an increase in provider fees; therefore, the Department will engage stakeholders to determine if an increase in the provider fee is appropriate before raising the provider fee. If the provider fee is raised, a statute change to 25.5-6-203(1)(a)(II), which limits the provider fee to $7.50 per patient day, may be required.

Refinance Medical Services Premiums with Disease Management Funding

As part of this proposal, the Department proposes to use $2,000,000 in cash funds, from the Prevention, Early Detection, and Treatment Fund to offset General Fund expenditure in the Medical Services Premiums line item. The Department's base request for Medical Services Premiums includes this $2,000,000, which typically funds the Department's Disease Management programs. Due to the current fiscal situation, in FY 2008-09 and for FY 2009-10, the Department ceased its Disease Management programs, and used this funding to offset fee-for-service claims "that address cancer, heart disease, and lung disease or the risk factors associated with such diseases" as allowed in 24-22-117(2)(d)(IV.5), C.R.S. (2009). Under this request, the Department would continue to use this funding to offset General Fund in FY 2010-11. The Department anticipates that it will resume its disease management program in FY 2011-12. This request would reduce total funds and General Fund expenditure by $2,000,000 in FY 2010-11.

Consequences if Not Funded: Not applicable.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($35,234,040)**	**($27,963,869)**	**$11,350,706**	**($214)**	**($18,620,663)**
(2) Medical Services Premiums	($31,111,229)	($28,053,217)	$11,502,201	$0	($14,560,213)
(2) Medical Services Premiums; Long Bill Group Total	$0	$1,645,687	$41,309	$0	($1,686,996)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	($4,122,811)	($1,852,307)	($208,575)	($214)	($2,061,715)
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	$0	$295,968	$15,771	$0	($311,739)

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($36,222,439)**	**($17,041,795)**	**($1,062,996)**	**($279)**	**($18,117,369)**
(2) Medical Services Premiums	($30,842,996)	($14,624,904)	($790,848)	$0	($15,427,244)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	($5,379,443)	($2,416,891)	($272,148)	($279)	($2,690,125)

Cash Funds Projections: See Appendix A, table 4.1 through table 4.3 for the impact to affected cash funds.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Breast and Cervical Cancer Prevention and Treatment Fund	15D	$2,175,829	$10,291,636	$8,956,589	$8,487,913	$8,019,237
Health Care Expansion Fund	18K	$94,003,143	$119,601,623	$81,320,908	$34,980,659	($22,674,568)
Medicaid Nursing Facility Cash Fund	22X	$16,410,618	$5,193,602	$5,193,602	$5,193,602	($9,023,209)
Hospital Provider Fee Cash Fund	-	-	-	-	-	-

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: Not applicable.

Cost Benefit Analysis: Not applicable.

Implementation Schedule: The Department would implement all reductions effective July 1, 2010.

Statutory and Federal Authority:

Except where noted below, the Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per 25.5-4-401 (1) (a), C.R.S. (2009).

25.5-4-401 (1) (a), C.R.S. (2009). Providers - payments - rules - repeal.
The state department shall establish rules for the payment of providers under this article and articles 5 and 6 of this title. Within the limits of available funds, such rules shall provide reasonable compensation to such providers, but no provider shall, by this section or any other provision of this article or article 5 or 6 of this title, be deemed to have any vested right to act as a provider under this article and articles 5 and 6 of this title or to receive any payment in addition to or different from that which is currently payable on behalf of a recipient at the time the medical benefits are provided by said provider.

25.5-6-202, C.R.S. (2009). Providers - nursing facility provider reimbursement - rules - repeal.
(9) *(b) (I) Except for changes in the number of patient days, the general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to subsections (1) to (4) of this section shall be limited to an annual increase of three percent. The state's share of the reimbursement rate components pursuant to subsections (1) to (4) of this section may be funded through the provider fee assessed pursuant to the provisions of section 25.5-6-203 and any associated federal funds. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, the general fund share of the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section shall be calculated using the rates that were effective on July 1 of that fiscal year.*

24-22-117, C.R.S. (2009). Tobacco tax cash fund - accounts - creation - legislative declaration - repeal.

(2)(d)(IV.5) For fiscal year 2008-09, and each fiscal year thereafter until and including fiscal year 2012-13, after the allocation and transfer required by subparagraphs (II) and (III) of this paragraph (d), of the moneys in the prevention, early detection, and treatment fund, two million dollars shall be transferred to the department of health care policy and financing for medicaid disease management and treatment programs, authorized by section 25.5-5-316, C.R.S., that address cancer, heart disease, and lung disease or the risk factors associated with such diseases.

Performance Measures: Not applicable.

Medicaid Program Reductions
Appendix A

Table 1.1
Summary of Request
FY 2010-11

FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($35,234,040)**	**($27,963,869)**	**$11,350,706**	**($214)**	**($18,620,663)**
(2) Medical Services Premiums	($31,111,229)	($28,053,217)	$11,502,201	$0	($14,560,213)
(2) Medical Services Premiums; Long Bill Group Total	$0	$1,645,687	$41,309	$0	($1,686,996)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	($4,122,811)	($1,852,307)	($208,575)	($214)	($2,061,715)
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	$0	$295,968	$15,771	$0	($311,739)

Table 1.2
Summary of Request
FY 2011-12

FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($36,222,439)**	**($17,041,795)**	**($1,062,996)**	**($279)**	**($18,117,369)**
(2) Medical Services Premiums	($30,842,996)	($14,624,904)	($790,848)	$0	($15,427,244)
(2) Medical Services Premiums; Long Bill Group Total	$0	$0	$0	$0	$0
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	($5,379,443)	($2,416,891)	($272,148)	($279)	($2,690,125)
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	$0	$0	$0	$0	$0

Medicaid Program Reductions
Appendix A

Table 2.1
Impact by Component: Base Fund Split
FY 2010-11

FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**($35,234,040)**	**($29,905,524)**	**$11,293,626**	**($214)**	**($16,621,928)**	
(2) Medical Services Premiums	**($31,111,229)**	**($28,053,217)**	**$11,502,201**	**$0**	**($14,560,213)**	
Provider Rate Cuts	($22,337,320)	($10,599,157)	($564,905)	$0	($11,173,258)	Table A
Reduction to Mid-Level Practitioner Reimbursement	($1,417,613)	($652,890)	($55,916)	$0	($708,807)	Table C
Restrictions to Optional Durable Medical Equipment	($2,333,095)	($1,074,521)	($92,026)	$0	($1,166,548)	Table D
Reduction to Nursing Facility Per Diem General Fund Cap	$0	($12,215,048)	$12,215,048	$0	$0	Table E.1
Reduction to Nursing Facility Per Diem General Fund Cap - PACE Impact	($3,023,201)	($1,511,601)	$0	$0	($1,511,600)	Table E.2
Refinance Medical Services Premiums with Disease Management Funding	($2,000,000)	($2,000,000)	$0	$0	$0	Narrative
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	**($4,122,811)**	**($1,852,307)**	**($208,575)**	**($214)**	**($2,061,715)**	
Reduce Mental Health Capitation Program Rates	($4,122,811)	($1,852,307)	($208,575)	($214)	($2,061,715)	Table B

Table 2.2
Impact by Component: Base Fund Split
FY 2011-12

FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**($36,222,439)**	**($17,041,795)**	**($1,062,996)**	**($279)**	**($18,117,369)**	
(2) Medical Services Premiums	**($30,842,996)**	**($14,624,904)**	**($790,848)**	**$0**	**($15,427,244)**	
Provider Rate Cuts	($26,241,374)	($12,438,708)	($676,233)	$0	($13,126,433)	Table A
Reduction to Mid-Level Practitioner Reimbursement	($1,810,562)	($900,756)	($4,525)	$0	($905,281)	Table C
Restrictions to Optional Durable Medical Equipment	($2,791,060)	($1,285,440)	($110,090)	$0	($1,395,530)	Table D
Reduction to Nursing Facility Per Diem General Fund Cap	$0	$0	$0	$0	$0	Table E.1
Reduction to Nursing Facility Per Diem General Fund Cap - PACE Impact	$0	$0	$0	$0	$0	Table E.2
Refinance Medical Services Premiums with Disease Management Funding	$0	$0	$0	$0	$0	Narrative
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	**($5,379,443)**	**($2,416,891)**	**($272,148)**	**($279)**	**($2,690,125)**	
Reduce Mental Health Capitation Program Rates	($5,379,443)	($2,416,891)	($272,148)	($279)	($2,690,125)	Table B

Medicaid Program Reductions
Appendix A

Table 3.1
Impact by Component: American Recovery and Reinvestment Act Adjustment
FY 2010-11

FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$0**	**$1,941,655**	**$57,080**	**$0**	**($1,998,735)**	
(2) Medical Services Premiums	**$0**	**$1,645,687**	**$41,309**	**$0**	**($1,686,996)**	
Provider Rate Cuts	$0	$1,261,712	$32,736	$0	($1,294,448)	Table A
Reduction to Mid-Level Practitioner Reimbursement	$0	$78,911	$3,240	$0	($82,151)	Table C
Restrictions to Optional Durable Medical Equipment	$0	$129,870	$5,333	$0	($135,203)	Table D
Reduction to Nursing Facility Per Diem General Fund Cap	$0	$0	$0	$0	$0	Table E.1
Reduction to Nursing Facility Per Diem General Fund Cap - PACE Impact	$0	$175,194	$0	$0	($175,194)	Table E.2
Refinance Medical Services Premiums with Disease Management Funding	$0	$0	$0	$0	$0	Narrative
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	**$0**	**$295,968**	**$15,771**	**$0**	**($311,739)**	
Reduce Mental Health Capitation Program Rates	$0	$295,968	$15,771	$0	($311,739)	Table B

Medicaid Program Reductions
Appendix A

Table 4.1 Cash Fund Splits FY 2010-11								
FY 2010-11	**Total Funds**	**General Fund**	**Breast and Cervical Cancer Prevention and Treatment Fund**	**Health Care Expansion Fund**	**Hospital Provider Fee Cash Fund**	**Nursing Facility Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Total Request	**($35,234,040)**	**($29,905,524)**	**($22,018)**	**($432,249)**	**($467,156)**	**$12,215,048**	**($214)**	**($16,621,928)**
(2) Medical Services Premiums	($31,111,229)	($28,053,217)	($21,517)	($287,248)	($404,083)	$12,215,048	$0	($14,560,213)
(3) Medicaid Mental Health Community Programs	($4,122,811)	($1,852,307)	($501)	($145,001)	($63,073)	$0	($214)	($2,061,715)

Notes:
- General Fund and cash fund sources are shown at the base FMAP level (50%).
- Health Care Expansion Fund is assumed to be transferred into the General Fund.

Table 4.2 Cash Fund Splits FY 2011-12								
FY 2011-12	**Total Funds**	**General Fund**	**Breast and Cervical Cancer Prevention and Treatment Fund**	**Health Care Expansion Fund**	**Hospital Provider Fee Cash Fund**	**Nursing Facility Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Total Request	**($36,222,439)**	**($17,041,795)**	**($26,421)**	**($507,088)**	**($529,487)**	**$0**	**$0**	**($18,117,369)**
(2) Medical Services Premiums	($30,842,996)	($14,624,904)	($25,768)	($317,891)	($447,189)	$0	$0	($15,427,244)
(3) Medicaid Mental Health Community Programs	($5,379,443)	($2,416,891)	($653)	($189,197)	($82,298)	$0	$0	($2,690,125)

Notes:
- General Fund and cash fund sources are shown at the base FMAP level (50%).
- Health Care Expansion Fund is assumed to be transferred into the General Fund.

Table 4.3 Cash Fund Splits: American Recovery and Reinvestment Act Adjustment FY 2010-11								
FY 2010-11	**Total Funds**	**General Fund**	**Breast and Cervical Cancer Prevention and Treatment Fund**	**Health Care Expansion Fund**	**Hospital Provider Fee Cash Fund**	**Nursing Facility Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Total Request	**$0**	**$1,941,655**	**$0**	**$28,154**	**$28,926**	**$0**	**$0**	**($1,998,735)**
(2) Medical Services Premiums	$0	$1,645,687	$0	$17,164	$24,145	$0	$0	($1,686,996)
(3) Medicaid Mental Health Community Programs	$0	$295,968	$0	$10,990	$4,781	$0	$0	($311,739)

Notes:
- General Fund and cash fund sources have been adjusted to account for the enhanced federal financial participation received as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The federal medical assistance percentage (FMAP) for

Table 4.4 Cash Fund Splits: American Recovery and Reinvestment Act Adjustment FY 2011-12								
FY 2011-12	**Total Funds**	**General Fund**	**Breast and Cervical Cancer Prevention and Treatment Fund**	**Health Care Expansion Fund**	**Hospital Provider Fee Cash Fund**	**Nursing Facility Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Total Request	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
(2) Medical Services Premiums	$0	$0	$0	$0	$0	$0	$0	$0
(3) Medicaid Mental Health Community Programs	$0	$0	$0	$0	$0	$0	$0	$0

Notes:
- General Fund and cash fund sources have been adjusted to account for the enhanced federal financial participation received as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The weighted federal medical assistance percentage

Base Reduction Item - 6: Medicaid Program Reductions
Appendix B

Table A.1
FY 2010-11 Provider Rate Reductions

Service Category	FY 2010-11 Estimate (1), (2),(3)	FY 2010-11 Appropriation Available for Rate Cut(4),(5)	Cut Level	FY 2010-11 Total Funds Reduction	FY 2010-11 Estimated GF Reduction	FY 2010-11 Estimated CF/RF Reduction	FY 2010-11 Estimated FF Reduction
ACUTE CARE							
Physician Services & EPSDT	$278,037,276	$253,568,024	1.00%	($2,535,680)	($1,167,823)	($100,017)	($1,267,840)
Emergency Transportation	$5,890,013	$5,399,179	1.00%	($53,992)	($24,866)	($2,130)	($26,996)
Non-emergency Medical Transportation	$10,372,432	$9,508,062	1.00%	($95,081)	($43,791)	($3,750)	($47,540)
Dental Services	$91,269,119	$83,663,359	1.00%	($836,634)	($385,317)	($33,000)	($418,317)
Family Planning	$381,309	$349,533	0.00%	$0	$0	$0	$0
Health Maintenance Organizations	$154,361,170	$141,497,740	0.80%	($1,126,817)	($518,963)	($44,446)	($563,408)
Inpatient Hospitals	$425,659,916	$390,188,256	1.00%	($3,901,883)	($1,797,037)	($153,905)	($1,950,941)
Outpatient Hospitals	$183,718,734	$168,408,839	1.00%	($1,684,088)	($775,617)	($66,427)	($842,044)
Lab & X-Ray	$33,947,377	$31,118,429	1.00%	($311,184)	($143,318)	($12,274)	($155,592)
Durable Medical Equipment	$91,932,111	$82,132,432	1.00%	($821,324)	($378,266)	($32,396)	($410,662)
Prescription Drugs	$281,448,592	$257,994,542	0.00%	$0	$0	$0	$0
Drug Rebate	($110,593,933)	($101,377,772)	0.00%	$0	$0	$0	$0
Rural Health Centers	$8,983,665	$8,235,026	0.00%	$0	$0	$0	$0
Federally Qualified Health Centers	$88,034,942	$80,698,697	0.00%	$0	$0	$0	$0
Co-Insurance (Title XVIII-Medicare)	$33,542,180	$30,746,998	1.00%	($307,470)	($141,607)	($12,128)	($153,735)
Breast and Cervical Cancer Treatment Program	$8,421,596	$7,719,797	0.80%	($61,477)	$0	($21,517)	($39,960)
Prepaid Inpatient Health Plan Services	$43,039,643	$39,453,006	0.80%	($314,184)	($144,699)	($12,393)	($157,092)
Other Medical Services	$56,546	$51,834	0.00%	$0	$0	$0	$0
Home Health	$175,871,543	$161,215,581	1.00%	($1,612,156)	($742,488)	($63,590)	($806,078)
Presumptive Eligibility	$0	$0	0.80%	$0	$0	$0	$0
Subtotal of Acute Care	$1,804,374,230	$1,650,571,562		($13,661,969)	($6,263,791)	($557,973)	($6,840,205)
COMMUNITY BASED LONG TERM CARE		$0					
HCBS - Elderly, Blind, and Disabled	$197,344,065	$180,898,727	1.00%	($1,808,987)	($899,972)	($4,521)	($904,494)
HCBS - Mental Illness	$25,672,898	$23,533,490	1.00%	($235,335)	($117,080)	($588)	($117,667)
HCBS - Disabled Children	$1,954,282	$1,791,425	1.00%	($17,914)	($8,912)	($45)	($8,957)
HCBS - Persons Living with AIDS	$662,813	$607,578	1.00%	($6,076)	($3,023)	($15)	($3,038)
HCBS - Consumer Directed Attendant Support	$4,613,716	$4,229,239	1.00%	($42,292)	($21,040)	($106)	($21,146)
HCBS - Brain Injury	$13,450,128	$12,329,284	1.00%	($123,293)	($61,339)	($308)	($61,646)
HCBS - Children with Autism	$1,446,892	$1,326,318	1.00%	($13,263)	($6,598)	($33)	($6,632)
HCBS - Pediatric Hospice	$32,777	$30,046	1.00%	($300)	($149)	($1)	($150)
Private Duty Nursing	$23,875,418	$21,885,800	1.00%	($218,858)	($108,882)	($547)	($109,429)
Hospice	$44,724,975	$30,748,420	1.00%	($307,484)	($152,974)	($768)	($153,742)
Subtotal of Community Based Long Term Care	$313,777,964	$277,380,327		($2,773,803)	($1,379,970)	($6,932)	($1,386,901)
LONG TERM CARE and INSURANCE		$0					
Class I Nursing Facilities	$558,617,741	$498,472,139	1.00%	($4,984,721)	($2,492,360)	$0	($2,492,361)
Class II Nursing Facilities	$2,322,371	$2,128,840	1.00%	($21,288)	($10,644)	$0	($10,644)
Program for All-Inclusive Care for the Elderly	$86,293,376	$79,102,261	0.84%	($664,459)	($332,230)	$0	($332,229)
Subtotal Long Term Care	$647,233,488	$579,703,240		($5,670,469)	($2,835,235)	$0	($2,835,234)
Supplemental Medicare Insurance Benefit	$104,272,632	$95,583,246	0.00%	$0	$0	$0	$0
Health Insurance Buy-In Program	$1,368,657	$1,254,602	0.00%	$0	$0	$0	$0
Subtotal Insurance	$105,641,289	$96,837,848		$0	$0	$0	$0
Subtotal of Long Term Care and Insurance	$752,874,777	$676,541,089		($5,670,469)	($2,835,235)	$0	($2,835,234)
SERVICE MANAGEMENT		$0					
Single Entry Points	$25,208,602	$23,107,885	1.00%	($231,079)	($120,161)	$0	($110,918)
Disease Management	$4,000,000	$3,666,667	0.00%	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$18,356,837	$16,827,101	0.00%	$0	$0	$0	$0
Subtotal Service Management	$47,565,439	$43,601,652		($231,079)	($120,161)	$0	($110,918)
Total	**$2,918,592,410**	**$2,648,094,630**		**($22,337,320)**	**($10,599,157)**	**($564,905)**	**($11,173,258)**

(1) Does not include any supplemental payment expenditure to either hospitals or nursing facilities
(2) Base is estimated in DI-1, and service category totals are estimated using FY 2008-09 expenditure patterns.
(3) This amount has been reduced for the Department's December 2009 reductions, and required annualizations.
(4) This amount has been reduced for other reductions in this proposal. If additional reductions are required, the figures in this calculation will change.
(5) Estimated implementation date: July 1, 2010 Only 11 months of savings are assumed in FY 2010-11 to account for cash accounting.

Base Reduction Item - 6: Medicaid Program Reductions
Appendix B

Table A.2
FY 2011-12 Provider Rate Reductions (Annualizations)

Service Category	FY 2010-11 Total Fund Reduction	Effective Months in FY 2010-11	Estimated Trend[1]	FY 2011-12 Total Funds Reduction	FY 2011-12 Estimated GF Reduction	FY 2011-12 Estimated CF/RF Reduction	FY 2011-12 Estimated FF Reduction
ACUTE CARE							
Physician Services & EPSDT	($2,535,680)	11.00	9.78%	($3,036,592)	($1,398,521)	($119,775)	($1,518,296)
Emergency Transportation	($53,992)	11.00	9.78%	($64,658)	($29,778)	($2,551)	($32,329)
Non-emergency Medical Transportation	($95,081)	11.00	9.78%	($113,863)	($52,441)	($4,491)	($56,931)
Dental Services	($836,634)	11.00	9.78%	($1,001,907)	($461,434)	($39,519)	($500,954)
Family Planning	$0	11.00	9.78%	$0	$0	$0	$0
Health Maintenance Organizations	($1,126,817)	11.00	9.78%	($1,349,414)	($621,482)	($53,226)	($674,706)
Inpatient Hospitals	($3,901,883)	11.00	9.78%	($4,672,682)	($2,152,033)	($184,308)	($2,336,341)
Outpatient Hospitals	($1,684,088)	11.00	9.78%	($2,016,772)	($928,837)	($79,549)	($1,008,386)
Lab & X-Ray	($311,184)	11.00	9.78%	($372,657)	($171,630)	($14,699)	($186,328)
Durable Medical Equipment	($821,324)	11.00	9.78%	($983,573)	($452,991)	($38,796)	($491,786)
Prescription Drugs	$0	11.00	9.78%	$0	$0	$0	$0
Drug Rebate	$0	11.00	9.78%	$0	$0	$0	$0
Rural Health Centers	$0	11.00	9.78%	$0	$0	$0	$0
Federally Qualified Health Centers	$0	11.00	9.78%	$0	$0	$0	$0
Co-Insurance (Title XVIII-Medicare)	($307,470)	11.00	9.78%	($368,209)	($169,580)	($14,524)	($184,105)
Breast and Cervical Cancer Treatment Program	($61,477)	11.00	9.78%	($73,621)	$1	($25,768)	($47,854)
Prepaid Inpatient Health Plan Services	($314,184)	11.00	9.78%	($376,249)	($173,283)	($14,841)	($188,125)
Other Medical Services	$0	11.00	9.78%	$0	$0	$0	$0
Home Health	($1,612,156)	11.00	9.78%	($1,930,630)	($889,163)	($76,152)	($965,315)
Presumptive Eligibility	$0	11.00	9.78%	$0	$0	$0	$0
Subtotal of Acute Care	($13,661,969)	11.00	9.78%	($16,360,827)	($7,501,172)	($668,199)	($8,191,456)
COMMUNITY BASED LONG TERM CARE							
HCBS - Elderly, Blind, and Disabled	($1,808,987)	11.00	6.25%	($2,096,781)	($1,043,150)	($5,240)	($1,048,391)
HCBS - Mental Illness	($235,335)	11.00	6.25%	($272,775)	($135,706)	($682)	($136,387)
HCBS - Disabled Children	($17,914)	11.00	6.25%	($20,764)	($10,330)	($52)	($10,382)
HCBS - Persons Living with AIDS	($6,076)	11.00	6.25%	($7,042)	($3,504)	($17)	($3,521)
HCBS - Consumer Directed Attendant Support	($42,292)	11.00	6.25%	($49,021)	($24,388)	($123)	($24,510)
HCBS - Brain Injury	($123,293)	11.00	6.25%	($142,908)	($71,097)	($357)	($71,454)
HCBS - Children with Autism	($13,263)	11.00	6.25%	($15,373)	($7,648)	($38)	($7,687)
HCBS - Pediatric Hospice	($300)	11.00	6.25%	($348)	($173)	($1)	($174)
Private Duty Nursing	($218,858)	11.00	6.25%	($253,676)	($126,204)	($634)	($126,838)
Hospice	($307,484)	11.00	6.25%	($356,402)	($177,311)	($890)	($178,201)
Subtotal of Community Based Long Term Care	($2,773,803)	11.00	6.25%	($3,215,090)	($1,599,511)	($8,034)	($1,607,545)
LONG TERM CARE and INSURANCE							
Class I Nursing Facilities	($4,984,721)	11.00	2.66%	($5,582,254)	($2,791,127)	$0	($2,791,127)
Class II Nursing Facilities	($21,288)	11.00	1.61%	($23,598)	($11,799)	$0	($11,799)
Program for All-Inclusive Care for the Elderly	($664,459)	11.00	9.65%	($794,814)	($397,408)	$0	($397,406)
Subtotal Long Term Care	($5,670,469)			($6,400,666)	($3,200,334)	$0	($3,200,332)
Supplemental Medicare Insurance Benefit	$0	11.00	5.47%	$0	$0	$0	$0
Health Insurance Buy-In Program	$0	11.00	3.98%	$0	$0	$0	$0
Subtotal Insurance	$0			$0	$0	$0	$0
Subtotal of Long Term Care and Insurance	($5,670,469)			($6,400,666)	($3,200,334)	$0	($3,200,332)
SERVICE MANAGEMENT							
Single Entry Points	($231,079)	11.00	5.04%	($264,791)	($137,691)	$0	($127,100)
Disease Management	$0	11.00	0.00%	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$0	11.00	9.02%	$0	$0	$0	$0
Subtotal Service Management	($231,079)			($264,791)	($137,691)	$0	($127,100)
Total	**($22,337,320)**			**($26,241,374)**	**($12,438,708)**	**($676,233)**	**($13,126,433)**

(1) Trend is based on average estimated percent increase from FY 2008-09 to FY 2010-11. Aggregate trends for Acute Care and Community Based Long Term Care are used. Trends for PACE, Disease Management, and PIHP Admin are based on different figures due to programmatic changes

Base Reduction Item - 6: Medicaid Program Reductions
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Table B.1 Reduce Behavioral Health Organization Capitation Rates				
		FY 2010-11	**FY 2011-12**	
A	Estimated BHO Incurred Cost	$258,807,959	$271,569,044	FY 2010-11: DI-2, Exhibit EE FY 2011-12: Table B.2.E
B	Proposed Reduction to Capitation Rates	-2.00%	-2.00%	See narrative; this figure reflects a reduction to approximately 95.55% of the median actuarially sound rate
C	Estimated Reduction to Expenditure in Fiscal Year	($5,176,159)	($5,431,381)	Row A * Row B
D	Estimated Percentage of Claims Paid in the Fiscal Year	79.65%	79.65%	DI-2, Exhibit EE.
E	Savings from Current Year	($4,122,811)	($4,326,095)	Row C * Row D
F	Savings from Prior Year	$0	($1,053,348)	FY 2011-12: Row C - Row E, FY 2010-11
G	**Total Estimated Savings**	**($4,122,811)**	**($5,379,443)**	**Row E + Row F**

Table B.2 Estimated FY 2011-12 Incurred Cost			
		FY 2011-12	
A	Estimated FY 2011-12 Per Capita	$467.80	DI-2, Exhibit DD
B	Estimated FY 2011-12 Caseload	587,272	DI-2, Exhibit CC
C	Estimated FY 2011-12 Expenditure	$274,728,421	Row A * Row B
D	Adjustment to Estimated Incurred Cost	98.85%	DI-2, Exhibit EE
E	Estimated FY 2011-12 Incurred Cost	$271,569,044	Row C * Row D

Base Reduction Item - 6: Medicaid Program Reductions
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Table C Reduction to Mid-Level Practitioner Reimbursement				
		FY 2010-11	**FY 2011-12**	
A	FY 2008-09 Reimbursment for Evaluation and Management (E&M) Codes for All Practitioners	$113,170,399	-	Based on MMIS claims data
B	FY 2008-09 Reimbursment for Evaluation and Management (E&M) Codes for Mid-Level Practitioners	$11,281,458	$15,464,314	FY 2010-11: FY 2008-09 value, based on MMIS claims data FY 2011-12: Row D
C	Estimated Trend	17.08%	17.08%	Average annual growth rate between FY 2005-06 and FY 2008-09
D	Estimated E&M Expenditure for Mid-Level Practitioners	$15,464,314	$18,105,619	FY 2010-11: Row B * (1 + Row C)^2 FY 2011-12: Row B * (1 + Row C)
E	Reduction to Mid-Level Practitioner Rates	-10.00%	-10.00%	Mid-Level Practitioners will be paid at 90% of the rate for a physician performing the same service.
F	Estimated Full Year Reduction to Expenditure	($1,546,431)	($1,810,562)	Row D * Row E
G	Savings Adjustment for Implementation Date	91.67%	100%	Estimated implementation date: July 1, 2010. Only 11 months of savings are assumed in FY 2010-11 to account for cash accounting.
H	Total Estimated Savings	($1,417,613)	($1,810,562)	Row F * Row G

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Table D.1 Summary of Durable Medical Equipment Reductions				
		FY 2010-11	**FY 2011-12**	
A	Limitations on Incontinence Products	($637,311)	($762,409)	Table D.2.J
B	Limitations on Oral Nutrition	($1,695,784)	($2,028,651)	Table D.3.L
C	**Total DME Reductions**	**($2,333,095)**	**($2,791,060)**	**Row A + Row B**

Table D.2 Limitation on Incontinence Products				
		FY 2010-11	**FY 2011-12**	
A	FY 2008-09 Expenditure on Incontinence Products	$10,021,457	-	Based on FY 2008-09 MMIS claims data
B	Total Units in FY 2008-09	13,674,186	-	Based on FY 2008-09 MMIS claims data
C	Estimated Number of Clients Above Proposed Limit	6,593	-	Based on FY 2008-09 MMIS claims data (Limit of 210 units per client per month)
D	Estimated Number of Units above Proposed Limit	791,992	-	Based on FY 2008-09 MMIS claims data
E	Average Cost Per Unit	$0.73	-	Based on FY 2008-09 MMIS claims data
F	Estimated Savings (in FY 2008-09 Dollars)	($578,154)	-	Row D * Row E * -1
G	Estimated Trend for Durable Medical Equipment	9.66%	-	Average expenditure growth in Durable Medical Equipment between FY 2005-06 and FY 2008-09
H	Estimated Full Year Savings	($695,248)	($762,409)	FY 2010-11: Row F * $(1 + \text{Row G})^2$ FY 2011-12: Row H * (1 + Row G)
I	Savings Adjustment for Implementation Date	91.67%	100%	Estimated implementation date: July 1, 2010. Only 11 months of savings are assumed in FY 2010-11 to account for cash accounting.
J	**Total Estimated Savings**	**($637,311)**	**($762,409)**	**Row H * Row I**

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Table D.3 Limitation on Oral Nutrition				
		FY 2010-11	**FY 2011-12**	
A	FY 2008-09 Expenditure for Oral Nutrition	$6,441,332	-	Based on FY 2008-09 MMIS claims data
B	FY 2008-09 Clients using Oral Nutrition	3,522	-	Based on FY 2008-09 MMIS claims data
C	FY 2008-09 Expenditure for Oral Nutrition for Clients Age 21 and Older	$1,922,973	-	Based on FY 2008-09 MMIS claims data
D	FY 2008-09 Clients Age 21 and Older using Oral Nutrition	1,895	-	Based on FY 2008-09 MMIS claims data
E	Average Expenditure Per Adult Client	$1,014.76	-	Row C / Row D
F	Estimated Number of Clients Meeting Exemption Requirements	379	-	Exemptions for clients with metabolic conditions and malnourishment, estimated at 20% of the total number of clients receiving services, based on a review of client diagnoses.
G	Estimated Number of Affected Clients	1,516	-	Row D - Row F
H	Estimated Savings (in FY 2008-09 Dollars)	($1,538,376)	-	Row E * Row G * -1
I	Estimated Trend for Durable Medical Equipment	9.66%	-	Average expenditure growth in Durable Medical Equipment between FY 2005-06 and FY 2008-09
J	Estimated Full Year Savings	($1,849,946)	($2,028,651)	FY 2010-11: Row H * $(1 + \text{Row I})^2$ FY 2011-12: Row J * (1 + Row I)
K	Savings Adjustment for Implementation Date	91.67%	100%	Estimated implementation date: July 1, 2010. Only 11 months of savings are assumed in FY 2010-11 to account for cash accounting.
L	**Total Estimated Savings**	**($1,695,784)**	**($2,028,651)**	**Row H * Row I**

Base Reduction Item - 6: Medicaid Program Reductions
Appendix B

Table E.1 Reduce Nursing Facilities General Fund Cap			
		FY 2010-11	
A	Estimated Maximum General Fund Per Diem Under Current Law	$75.91	DI-1, Exhibit H, Page EH-9, Row K
B	Estimated Maximum Per Diem at New Cap	$72.29	DI-1, Exhibit H, Page EH-9, Row K (FY 2009-10 General Fund value)
C	Incremental Reduction to Cap	($3.62)	Row B - Row A
D	Estimated Patient Days	3,376,689	DI-1, Exhibit H, Page EH-9, Row E
E	**Estimated Decrease to General Fund Nursing Facilities Expenditure**	**($12,215,048)**	**Row C * Row D**
F	Estimated Effective Per Diem Adjusted for ARRA at Current Cap	$67.11	DI-1, Exhibit H, Page EH-9, Row R
G	Estimated Effective Per Diem Adjusted for ARRA at Adjusted Cap	$63.91	(Row B * 2 * (1-55.975%)) Estimates the state share of the per diem after ARRA
H	Incremental Reduction to Cap	($3.20)	Row G - Row F
I	**Estimated Adjusted Decrease to General Fund Nursing Facilities Expenditure[(1)]**	**($10,803,795)**	**Row H * Row D**
J	Estimated Incremental Impact of ARRA	$1,411,253	Row I - Row J

(1) This figure is the estimated actual decrease to General Fund. The negative of this row is the estimated impact to the Nursing Facility Cash Fund.

Table E.2 Estimated PACE Impact of Reducing Nursing Facilities General Fund Cap			
		FY 2010-11	
A	Estimated FY 2010-11 General Fund Nursing Facilities Expenditure	$226,608,012	DI-1, Exhibit H, Page EH-9, Row V
B	Estimated FY 2010-11 General Fund Nursing Facilities Expenditure After Decrease	$215,804,217	Row A + Table E.1.I
C	Estimated Percentage Decrease to General Fund Nursing Facilities Expenditure	-4.77%	(Row B / Row A) - 1
D	Estimated FY 2010-11 PACE Expenditure	$86,675,162	DI-1, Exhibit H, Page EH-1
E	Estimated Proportion of PACE Rate due to Nursing Facility Fee-for-Service Claims	73.16%	Assumed, based on the relative percentage of nursing facility expenditure to total expenditure included in the PACE rate development.
F	Estimated Reduction to PACE Expenditure	($3,023,201)	Row C * Row D * Row E

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Executive Director Name
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting ***November 2009***

BRI-6 Medicaid Program Reductions

Request: In response to the State's current fiscal situation, the Department requests a reduction of $35.2 million total funds, $28.0 million General Fund in FY 2010-11, and a reduction of $36.2 million total funds, $17.0 General Fund in FY 2011-12 in order to: reduce Medicaid physical health provider rates by 2%; reduce capitation rates paid to behavioral health organizations; reduce reimbursement to mid-level practitioners; impose restrictions on certain durable medical equipment; restrict nursing facility per diem growth to 0% in FY 2010-11; and, refinance a portion of Medical Services Premiums with an existing cash fund appropriation. Reductions would be effective July 1, 2010.

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappro-priated Funds	Federal Funds
Total Request	**($35,234,040)**	**($27,963,869)**	**$11,350,706**	**($214)**	**($18,620,663)**
Provider Rate Cuts*	($22,337,320)	($9,337,445)	($532,169)	$0	($12,467,706)
Reduction to Mid-Level Practitioner Reimbursement*	($1,417,613)	($573,979)	($52,676)	$0	($790,958)
Restrictions to Optional Durable Medical Equipment*	($2,333,095)	($944,651)	($86,693)	$0	($1,301,751)
Reduction to Nursing Facility Per Diem General Fund Cap*	$0	($12,215,048)	$12,215,048	$0	$0
Reduction to Nursing Facility Per Diem General Fund Cap - PACE Impact*	($3,023,201)	($1,336,407)	$0	$0	($1,686,794)
Refinance Medical Services Premiums with Disease Management Funding*	($2,000,000)	($2,000,000)	$0	$0	$0
Reduce Mental Health Capitation Program Rates*	($4,122,811)	($1,556,339)	($192,804)	($214)	($2,373,454)

** Rows show costs by initiative not budget line item.*

Highlights:

- The Department proposes to reduce rates paid to Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2010. This reduction would affect all providers and services paid within the Department's Medical Services Premiums line item, with certain exceptions. Rates paid to managed care organizations, including PACE, would also include corresponding decreases, as the Department pays rates based on fee-for-service expenditure.
- The Department proposes to reduce rates paid to behavioral health organizations by 2%. Currently, rates are paid at 2.5% below the midpoint of an actuarially-sound rate range developed during the rate-setting process. This reduction would place rates at approximately 95.55% of the midpoint of the rate range.
- The Department proposes to reduce rates paid to mid-level practitioners to 90% of the rate paid to physicians. Currently, the Department reimburses mid-level practitioners, including nurse practitioners, physician assistants, certified nurse midwives, and certified registered nurse anesthetists, at the same rate as physicians for the same services.
- The Department proposes to impose restrictions on certain optional durable medical equipment. In particular, the Department would impose a 210-unit limit on incontinence products (down from the current limit of 240), and eliminate coverage for oral nutritional products for adults 21 years and older, although exceptions would be granted for individuals with innate errors of metabolism or malnourishment conditions.
- The Department proposes to reduce the current limit on General Fund per diem growth in nursing facility rates from 5% to 0% in FY 2010-11. The Department's proposal assumes the limit is returned to the 5% level in FY 2011-12, and allowed to return to the 3% limit, in statute at 25.5-6-202 (9)(b)(I) and 25.5-6-202(9)(b.7), C.R.S. (2009), in FY 2012-13.
- The Department proposes to use $2 million in cash funds, from the Prevention, Early Detection, and Treatment Fund to offset General Fund expenditure in the Medical Services Premiums line item. The Department's base request for Medical Services Premiums includes this $2 million, which typically funds the Department's Disease Management programs. Under this request, the Department would continue to use this funding to offset General Fund in FY 2010-11. The Department anticipates that it will resume its disease management program in FY 2011-12. This request would reduce total funds and General Fund expenditure by $2.0 million in FY 2010-11.

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

Media inquires should be directed to Joanne Lindsay at 303-866-3144.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10	Budget Amendment FY 2010-11

Request Title: Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage
Department: Health Care Policy and Financing
Dept. Approval by: John Bartholomew **Date:** November 2, 2009 10/29/09
Priority Number: BRI-8
OSPB Approval: **Date:** 11/2/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(335,939,125)	0	(335,939,125)	0	(192,394,435)	(192,394,436)	0	(192,394,435)	0
	GFE	0	0	0	0	0	(5,229)	(5,229)	0	(5,229)	0
	CF	0	(100,625,224)	0	(100,625,224)	0	(30,506,863)	(30,506,863)	0	(30,506,863)	0
	CFE/RF	0	(833,989)	0	(833,989)	0	(440,258)	(440,258)	0	(440,258)	0
	FF	0	437,398,338	0	437,398,338	0	223,346,785	223,346,785	0	223,346,785	0
(2) Medical Services Premiums; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	0	(264,990,043)	0	(155,589,245)	(155,589,245)	0	(155,589,245)	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	0	(57,900,191)	0	(20,127,432)	(20,127,432)	0	(20,127,432)	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	0	322,890,234	0	175,716,677	175,716,677	0	175,716,677	0
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(22,471,323)	0	(22,471,323)	0	(13,455,913)	(13,455,913)	0	(13,455,913)	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(1,950,368)	0	(1,950,368)	0	(1,042,913)	(1,042,913)	0	(1,042,913)	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	24,421,691	0	24,421,691	0	14,498,826	14,498,826	0	14,498,826	0
(4) Indigent Care Programs; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(3,474,797)	0	(3,474,797)	0	(1,129,996)	(1,129,996)	0	(1,129,996)	0
	GFE	0	0	0	0	0	(5,229)	(5,229)	0	(5,229)	0
	CF	0	(38,527,874)	0	(38,527,874)	0	(8,213,616)	(8,213,616)	0	(8,213,616)	0
	CFE/RF	0	0	0	0	0	(52,767)	(52,767)	0	(52,767)	0
	FF	0	42,002,671	0	42,002,671	0	9,401,608	9,401,608	0	9,401,608	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☑	**Supplemental FY 2009-10**	☐	**Budget Amendment FY 2010-11**	☐

Request Title:	Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 2, 2009
Priority Number:	BRI-8	**OSPB Approval:**		**Date:**

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
(5) Other Medical Services; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(531,252)	0	(531,252)	0	(254,429)	(254,429)	0	(254,429)	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(2,110,546)	0	(2,110,546)	0	(1,055,273)	(1,055,273)	0	(1,055,273)	0
	CFE/RF	0	(348,859)	0	(348,859)	0	(174,430)	(174,430)	0	(174,430)	0
	FF	0	2,990,657	0	2,990,657	0	1,484,132	1,484,132	0	1,484,132	0
(6) Department of Human Services Medicaid-Funded Programs; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(44,471,710)	0	(44,471,710)	0	(21,964,852)	(21,964,852)	0	(21,964,852)	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(136,245)	0	(136,245)	0	(67,629)	(67,629)	0	(67,629)	0
	CFE/RF	0	(485,130)	0	(485,130)	0	(213,061)	(213,061)	0	(213,061)	0
	FF	0	45,093,085	0	45,093,085	0	22,245,542	22,245,542	0	22,245,542	0

Non-Line Item Request:	None.		
Letternote Revised Text:	See Appendix A for cash funds and reappropriated funds totals		
Cash or Federal Fund Name and COFRS Fund Number:	FF: Title XIX; See Appendix A for source of cash funds and reappropriated funds.		
Reappropriated Funds Source, by Department and Line Item Name:	See Appendix A for reappropriated fund sources.		
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑
Schedule 13s from Affected Departments:	None.		

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	BRI-8
Change Request Title:	Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☒ Base Reduction Item FY 2010-11
☐ Supplemental Request FY 2009-10
☐ Budget Request Amendment FY 2010-11

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:

The Department requests a net zero total funds adjustment to all line items affected by the enhanced Federal Medicaid Assistance Percentage in its FY 2010-11 budget request that includes reductions of $192,394,435 General Fund, $30,506,863 cash funds, and $440,258 reappropriated funds. There is a corresponding increase of $223,346,785 federal funds. These changes reflect the enhanced Federal Medicaid Assistance Percentage (FMAP) that the State is receiving as a result of the American Recovery and Reinvestment Act of 2009 (ARRA).

Background and Appropriation History:

Not applicable.

General Description of Request:

This Request adjusts the Department's FY 2010-11 Base Request to account for the estimated level of enhanced federal funding the Department will receive as a result of the American Recovery and Reinvestment Act of 2009 (ARRA). The Department estimates that it will receive an enhanced federal medical assistance percentage (FMAP) of 61.59% for the first two quarters of FY 2010-11.

This request and all Department change requests that are impacted by the enhanced FMAP use an adjustment to the Long Bill Group total to account for the decrease in State funds and the increase in federal funds. This methodology was first used to request adjustments to the FY 2009-10 appropriations in the August 25th, 2009 budget requests. Because of the difficulty and time required to incorporate the enhanced FMAP into each line item, the previous methodology has been continued for the FY 2010-11 budget request. The Department will submit a budget amendment in accordance with required timelines in order to account for the enhanced FMAP at the line item level. The Department's current methodology correctly accounts for the total General Fund request. There will be no change to the total General Fund request as a result of the budget amendment. Appendix B details the estimated funding change by line item.

Through the proposed methodology the Department has estimated the amount of enhanced federal funding for each line item based on the actual amount of federal funding the Department has received for medical assistance. However, the estimate is based on FY 2007-08 actual expenditures, as actual expenditures for FY 2008-09 reflect a combination of three different federal financial participation rates because of the ARRA enhanced FMAP. Because the FY 2010-11 base request is set in aggregate at the line item level and contains many areas of expenditures with varying federal rates, it is not as accurate of a starting point as the use of actual expenditures in developing the estimate in this proposal. As part of the budget update discussed in the previous paragraph, the Department will apply the enhanced FMAP to the individual components of each appropriation.

In order to prevent double counting, this request supersedes the enhanced FMAP-related annualizations of the following budget requests:

- ES-1, "Enhanced Federal Funding Adjustments"
- ES-2, "Medicaid Program Reductions"
- ES-4, "Reduce Funding for Indigent Care Programs"
- ES-5, "Reduce Appropriation for Enhanced Federal Funds"
- FY 2009-10 NP-ES#3, "DHS - Increase State Capacity to 120% at State Commitment Facilities"
- FY 2009-10 NP-ES#5, "DHS - Close 59 beds at the Colorado Mental Health Institute at Fort Logan"
- FY 2009-10 NP-ES#6, "DHS - Reclassification of Licensing Category of Ridgeview Youth Services Center for Medicaid Billing"
- FY 2009-10 NP-ES#7, "DHS - DDD Medicaid Waivers Provider Rate Retraction"
- FY 2009-10 NP-ES#8, "DHS - Closure of 32 bed Nursing Facility at Grand Junction Regional Center"
- FY 2009-10 NP-ES#9, "DHS - Reduction to the Child Welfare Services Block"

In each case, the requested reduction is included as a base request for each line item. Because the Department's calculations in Appendix B are based on the base request, counting the annualization value and this request would double count the reduction to state funds. The Department's Reconciliation Table accounts for the FMAP-related totals by annualizing the totals to zero.

Further, because of the complexity of the calculations, the estimates in this request for the Department's Long Bill Groups (2) Medical Services Premiums and (3) Medicaid Mental Health Community Programs are included in the Department's requests for those programs (see Decision Item 1, Exhibit A, and Decision Item 2, Exhibit AA, respectively). The schedule 13s for those requests do not include any amount for the enhanced FMAP. While the total reductions are also shown in the exhibits for those requests, the reduction to state funds must only be taken once.

Finally, please note that this request does not include any amount related to the Department's other change requests. If other change requests are approved, the

incremental totals for enhanced FMAP from those requests should be added to the final appropriation.

Consequences if Not Funded: Not applicable.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$0**	**($192,394,435)**	**($5,229)**	**($30,506,863)**	**($440,258)**	**$223,346,785**
(2) Medical Services Premiums	$0	($155,589,245)	$0	($20,127,432)	$0	$175,716,677
(3) Medicaid Mental Health Programs	$0	($13,455,913)	$0	($1,042,913)	$0	$14,498,826
(4) Indigent Care Program	$0	($1,129,996)	($5,229)	($8,213,616)	($52,767)	$9,401,608
(5) Other Medical Services	$0	($254,429)	$0	($1,055,273)	($174,430)	$1,484,132
(6) Department of Human Services Medicaid-Funded Programs	$0	($21,964,852)	$0	($67,629)	($213,061)	$22,245,542

Cash Funds Projections: See Appendix A for impact by cash fund.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Colorado Autism Treatment Fund	18A	$608,665	$1,194,972	$1,632,742	$1,822,873	$1,271,300
Health Care Expansion Fund	18K	$94,003,143	$119,601,623	$81,320,908	$34,980,659	($22,674,568)
Medicaid Nursing Facility Cash Fund	22X	$16,410,618	$5,193,602	$5,193,602	$5,193,602	($9,023,209)
Hospital Provider Fee Cash Fund	-	-	-	-	-	-

Assumptions for Calculations: Where applicable, assumptions have been noted in the narrative, and in Appendix B. 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: Not applicable. The Department will transfer less General Fund to the Departments of Human Services and the Department of Public Environment as a result of the enhanced FMAP. The Department's calculations by line item are contained in Appendix B.

Cost Benefit Analysis: Not applicable.

Implementation Schedule: Not applicable

Statutory and Federal Authority:

24-1-107, C.R.S. (2009). Internal organization of department - allocation and reallocation of powers, duties, and functions - limitations.

In order to promote economic and efficient administration and operation of a principal department and notwithstanding any other provisions of law, except as provided in section 24-1-105, the head of a principal department, with the approval of the governor, may establish, combine, or abolish divisions, sections, and units other than those specifically created by law and may allocate and reallocate powers, duties, and functions to divisions, sections, and units under the principal department, but no substantive function vested by law in any officer, department, institution, or other agency within the principal department shall be removed from the jurisdiction of such officer, department, institution, or other agency under the provisions of this section.

25.5-1-104 (2) (4), C.R.S. (2009). Department of health care policy and financing created - executive director - powers, duties, and functions…

(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director … (4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in part 2 of this article.

Performance Measures:

Not applicable.

Base Reduction Item - 8: Reduce Appropriation for Enhanced FMAP

Appendix A
Impact to Cash Funds and Reappropriated Funds

Long Bill Group	Line Item	Cash Fund	Appropriation Type	COFRS Number	Total
(2) Medical Services Premiums	**Total**				**($20,127,432)**
(2) Medical Services Premiums	Medical Services Premiums	Health Care Expansion Fund	CF	18K	($3,396,686)
(2) Medical Services Premiums	Medical Services Premiums	Colorado Autism Treatment Fund	CF	18A	($90,967)
(2) Medical Services Premiums	Medical Services Premiums	Hospital Provider Fee Cash Fund	CF	-	($15,031,441)
(2) Medical Services Premiums	Medical Services Premiums	Certification of Public Expenditure	CF	-	$0
(2) Medical Services Premiums	Medical Services Premiums	Nursing Facility Cash Fund	CF	22X	($1,608,338)
(3) Medicaid Mental Health Programs	**Total**				**($1,042,913)**
(3) Medicaid Mental Health Programs	(A) Mental Health Capitation Payments for Medicaid Eligible Clients	Health Care Expansion Fund	CF	18K	($1,042,913)
(4) Indigent Care Program	**Total**				**($8,266,383)**
(4) Indigent Care Program	Safety Net Provider Payments	Certified Funds	CF	-	($8,177,180)
(4) Indigent Care Program	Comprehensive Primary and Preventive Care Rural and Public Hospital Grant Program	Comprehensive Primary and Preventive Care Fund	CF	14B	$0
(5) Other Medical Services	**Total**				**($1,229,703)**
(5) Other Medical Services	Nurse Home Visitor Program	-	RF (DPHE)	-	($174,430)
(5) Other Medical Services	Public School Health Services	Certified Funds	CF	-	($1,055,273)
(6) Department of Human Services Medicaid-Funded Programs	**Total**				**($280,690)**
(6) Department of Human Services Medicaid-Funded Programs	(E) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Residential Treatment for Youth (H.B. 99-1116)	Tobacco Litigation Settlement Fund	CF	-	($2,795)
(6) Department of Human Services Medicaid-Funded Programs	(F) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Program Costs	Health Care Expansion Fund	CF	18K	($64,834)
(6) Department of Human Services Medicaid-Funded Programs	(F) Services for People with Disabilities - Medicaid Funding; Regional Centers	Service fees from regional centers for people with developmental disabilities	RF	-	($213,061)

Acronyms:
CF: Cash Funds; RF: Reappropriated Funds; HCPF: Department of Health Care Policy and Financing; DPHE: Department of Public Health and Environment

Base Reduction Item - 8: Reduce Appropriation for Enhanced FMAP
Appendix B
Impact of Enhanced Federal Medical Assistance Percentage by Line Item

(2) Medical Services Premiums

Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Medical Services Premiums	$0	($155,589,245)	$0	($20,127,432)	$0	$175,716,677
Total	**$0**	**($155,589,245)**	**$0**	**($20,127,432)**	**$0**	**$175,716,677**

(3) Medicaid Mental Health Programs

Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) Mental Health Capitation Payments for Medicaid Eligible Clients	$0	($13,322,294)	$0	($1,042,913)	$0	$14,365,207
(B) Other Medicaid Mental Health Payments	$0	($133,619)	$0	$0	$0	$133,619
Total	**$0**	**($13,455,913)**	**$0**	**($1,042,913)**	**$0**	**$14,498,826**

(4) Indigent Care Program

Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Safety Net Provider Payments	$0	$0	$0	($8,177,180)	$0	$8,177,180
Colorado Health Care Services Fund	$0	$0	$0	$0	$0	$0
The Children's Hospital, Clinic Based Indigent Care	$0	($354,640)	$0	$0	$0	$354,640
Health Care Services Fund Programs	$0	$0	$0	$0	$0	$0
Pediatric Specialty Hospital	$0	($775,356)	($5,229)	($36,436)	($52,767)	$869,788
H.B. 05-1262 Appropriation from General Fund to Pediatic Specialty Hospital Fund	$0	$0	$0	$0	$0	$0
H.B. 05-1262 Appropriation from Tobacco Tax Cash Fund to the General Fund	$0	$0	$0	$0	$0	$0
Primary Care Fund Program	$0	$0	$0	$0	$0	$0
H.B. 97-1304 Children's Basic Health Plan Trust	$0	$0	$0	$0	$0	$0
Children's Basic Health Plan Administration	$0	$0	$0	$0	$0	$0
Children's Basic Health Plan Premium Costs	$0	$0	$0	$0	$0	$0
Children's Basic Health Plan Dental Benefits Costs	$0	$0	$0	$0	$0	$0
Comprehensive Primary and Preventive Care Grants Program	$0	$0	$0	$0	$0	$0
Comprehensive Primary and Preventive Care Rural and Public Hospital Grant Program	$0	$0	$0	$0	$0	$0
Total	**$0**	**($1,129,996)**	**($5,229)**	**($8,213,616)**	**($52,767)**	**$9,401,608**

(5) Other Medical Services

Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Services for Old Age Pension State Medical Program clients	$0	$0	$0	$0	$0	$0
Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pension State Medical Fund	$0	$0	$0	$0	$0	$0
Commission on Family Medicine Residency Treatment Programs	$0	($100,766)	$0	$0	$0	$100,766
State University Teaching Hospitals - Denver Health and Hospital Authority	$0	($106,148)	$0	$0	$0	$106,148
State University Teaching Hospitals - University of Colorado Hospital Authority	$0	($40,619)	$0	$0	$0	$40,619
Enhanced Prenatal Care Training and Technical Assistance	$0	($6,896)	$0	$0	$0	$6,896
Nurse Home Visitor Program	$0	$0	$0	$0	($174,430)	$174,430
Medicaid Modernization Act of 2003 State Contribution Payment	$0	$0	$0	$0	$0	$0
Public School Health Services	$0	$0	$0	($1,055,273)	$0	$1,055,273
Total	**$0**	**($254,429)**	**$0**	**($1,055,273)**	**($174,430)**	**$1,484,132**

Base Reduction Item - 8: Reduce Appropriation for Enhanced FMAP
Appendix B
Impact of Enhanced Federal Medical Assistance Percentage by Line Item

(6) Department of Human Services Medicaid-Funded Programs

Line Item	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) Executive Director's Office - Medicaid Funding	$0	($298,196)	$0	$0	$0	$298,196
(B) Office of Information Technology Services - Medicaid Funding; Colorado Benefits Management System	$0	$0	$0	$0	$0	$0
(B) Office of Information Technology Services - Medicaid Funding; CBMS SAS-70 Audit	$0	$0	$0	$0	$0	$0
(B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line items	$0	($22,881)	$0	$0	$0	$22,881
(C) Office of Operations - Medicaid Funding	$0	($300,715)	$0	$0	$0	$300,715
(D) Division of Child Welfare - Medicaid Funding; Administration	$0	$0	$0	$0	$0	$0
(D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	$0	($840,752)	$0	$0	$0	$840,752
(E) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Administration	$0	$0	$0	$0	$0	$0
(E) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Residential Treatment for Youth (H.B. 99-1116)	$0	($4,114)	$0	($2,795)	$0	$6,909
(E) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Mental Health Institutes	$0	($170,174)	$0	$0	$0	$170,174
(E) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Alcohol and Drug Abuse Division, Administration	$0	$0	$0	$0	$0	$0
(E) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	$0	($118,214)	$0	$0	$0	$118,214
(F) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Administration	$0	$0	$0	$0	$0	$0
(F) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Program Costs	$0	($17,596,380)	$0	($64,834)	$0	$17,661,214
(F) Services for People with Disabilities - Medicaid Funding; Regional Centers	$0	($2,467,860)	$0	$0	($213,061)	$2,680,921
(F) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$0	$0	$0	$0	$0	$0
(G) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	$0	$0	$0	$0	$0	$0
(H) Division of Youth Corrections - Medicaid Funding	$0	($145,566)	$0	$0	$0	$145,566
(I) Other Contractual Services; Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	$0	$0	$0	$0	$0	$0
(I) Other Contractual Services; Transfer to the Department of Human Services for Related Administration	$0	$0	$0	$0	$0	$0
Total	**$0**	**($21,964,852)**	**$0**	**($67,629)**	**($213,061)**	**$22,245,542**

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

A Fact Sheet

Executive Director Name
Executive Director

Todd Saliman
Director, OSPB

Office of State Planning and Budgeting ***November 2009***

BRI-8 Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage

Request: The Department requests a net zero total funds adjustment to its FY 2010-11 appropriation that includes reductions of $192.4 million General Fund, $30.5 million cash funds, and $0.4 million reappropriated funds. There is a corresponding increase of $223.3 million federal funds. These changes reflect the enhanced Federal Medicaid Assistance Percentage (FMAP) that the State is receiving as a result of the American Recovery and Reinvestment Act of 2009 (ARRA).

Summary of Request FY 2010-11	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$0**	**($192,394,435)**	**($5,229)**	**($30,506,863)**	**($440,258)**	**$223,346,785**
(2) Medical Services Premiums	$0	($155,589,245)	$0	($20,127,432)	$0	$175,716,677
(3) Medicaid Mental Health Programs	$0	($13,455,913)	$0	($1,042,913)	$0	$14,498,826
(4) Indigent Care Program	$0	($1,129,996)	($5,229)	($8,213,616)	($52,767)	$9,401,608
(5) Other Medical Services	$0	($254,429)	$0	($1,055,273)	($174,430)	$1,484,132
(6) Department of Human Services Medicaid-Funded Programs	$0	($21,964,852)	$0	($67,629)	($213,061)	$22,245,542

Highlights:

- This Request adjusts the Department's FY 2010-11 Base Request to account for the estimated level of enhanced federal funding the Department will receive as a result of the American Recovery and Reinvestment Act of 2009 (ARRA). The Department estimates that it will receive an enhanced federal medical assistance percentage (FMAP) of 61.59% for the first two quarters of FY 2010-11.

- The Department and the Office of State Planning and Budgeting will continue to work with the General Assembly and legislative staff to develop the best solution for this issue in preparing for the Long Bill.

For more information about this Department and its programs, please call Ginny Brown at 303-866-3972 or Nicole Storm at 303-866-3180.

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