

**Schedule 13**  
**Funding Request for the 2012-13 Budget Cycle**

Department: Health Care Policy and Financing  
Request Title: Medicaid Budget Reductions  
Priority Number: R-6

Dept. Approval by: John Bartholomew *JB 10/26/11*  
Date

OSPB Approval by: *Govt. M. Schuler* 10/26/11  
Date

<input type="checkbox"/>	Decision Item FY 2012-13
<input checked="" type="checkbox"/>	Base Reduction Item FY 2012-13
<input type="checkbox"/>	Supplemental FY 2011-12
<input type="checkbox"/>	Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
<b>Total of All Line Items</b>	<b>Total</b>	\$3,551,534,588	\$0	\$3,567,597,651	(\$29,699,322)	(\$31,976,323)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$900,939,403	\$0	\$983,420,675	(\$30,471,105)	(\$31,592,518)
	GFE	\$284,175,417	\$0	\$284,175,417	\$0	\$0
	CF	\$608,377,712	\$0	\$534,630,271	\$15,496,446	\$15,479,358
	RF	\$6,388,059	\$0	\$3,101,708	\$0	\$0
	FF	\$1,751,653,997	\$0	\$1,762,269,580	(\$14,724,663)	(\$15,863,163)
<b>(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts</b>	<b>Total</b>	\$7,670,839	\$0	\$7,801,722	\$500,000	\$500,000
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$2,100,370	\$0	\$2,100,370	\$125,000	\$125,000
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$60,537	\$0	\$100,654	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$5,509,932	\$0	\$5,600,698	\$375,000	\$375,000
<b>(2) Medical Services Premiums</b>	<b>Total</b>	\$3,543,863,749	\$0	\$3,559,795,929	(\$30,199,322)	(\$32,476,323)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$898,839,033	\$0	\$981,320,305	(\$30,596,105)	(\$31,717,518)
	GFE	\$284,175,417	\$0	\$284,175,417	\$0	\$0
	CF	\$608,317,175	\$0	\$534,529,617	\$15,496,446	\$15,479,358
	RF	\$6,388,059	\$0	\$3,101,708	\$0	\$0
	FF	\$1,746,144,065	\$0	\$1,756,668,882	(\$15,099,663)	(\$16,238,163)

Letternote Text Revision Required? Yes:  No:  If yes, describe the Letternote Text Revision:  
 FY 2012-13: <sup>b</sup> Of this amount, \$379,420,151 \$394,941,574 shall be from the Hospital Provider Fee Cash Fund Created in Section 25.5-4-402.3  
 (4)....\$2,731,400 \$2,706,422 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I)  
 Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee Cash Fund (24A), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Title XIX  
 Reappropriated Funds Source, by Department and Line Item Name: None.  
 Approval by OIT? Yes:  No:  Not Required:   
 Schedule 13s from Affected Departments: None.  
 Other Information: None.



# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper  
Governor

Susan E. Birch  
Executive Director

*FY 2012-13 Funding Request  
November 1, 2011*

**Department Priority: R-6**  
**Request Title: Medicaid Budget Reductions**

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Medicaid Budget Reductions	(\$29,699,322)	(\$30,471,105)	0.0

## Request Summary:

As part of the Department's strategic objective to contain health care costs, the Department proposes to reduce Medicaid expenditure through a series of initiatives. The proposed initiatives will also assist in meeting budget balancing goals for FY 2012-13. These initiatives provide a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies to reduce Medicaid program expenditures by \$29,699,322 total funds and \$30,471,105 General Fund in FY 2012-13.

Department initiatives include the following:

- *Preterm Labor Prevention:* the Department is offering coverage of alpha hydroxyprogesterone caproate injections which reduces the occurrence of preterm labor.
- *Synagis PAR Review:* The Department will be increasing review of prior authorizations for Synagis to ensure only appropriate dosages are utilized of this drug.
- *Expansion of the Physician Administered Drug Rebate Program:* the Department has expanded the list of physician administered drugs for which it collects rebates as well as performed outreach to providers to ensure sufficient information is provided for the Department to claim rebates.
- *Reimbursement Rate Alignment for Developmental Screenings:* Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. Previously, the rate paid for developmental and depression screenings was well above the rates paid by Medicare and commercial insurance plans for these screenings.
- *Physician Administered Drug Pricing and Unit Limits:* the Department has realigned the pricing and unit limits on three physician administered drugs to achieve both consistency for billing and cost savings.
- *Public Transportation Utilization:* the Department has built incentives and expectations into the non emergent medical transportation program to increase the utilization of public transportation in the Denver-metro area.
- *Home Health Therapies Cap:* the Department is limiting the number of home health visits for therapy to 48 visits per calendar year.
- *Home Health Care Cap:* the Department has limited the number of hours of skilled care a patient can receive in the home health setting to eight per day.
- *Seroquel Restrictions:* the Department has implemented policies to prevent the utilization of Seroquel for off label use.
- *Dental Efficiencies:* the Department will clarify rules regarding eligibility for orthodontics. These clarifications are

expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion.

- *Augmentative Communication Devices:* the Department has implemented an initiative to provide access to less costly durable medical equipment for disabled clients that require the aid of augmentative communication devices.
- *Durable Medical Equipment Preferred Provider:* the Department initiated a competitive procurement process to acquire a sole source diabetic testing supply provider whereby the Department can leverage purchasing power to obtain significant rebates.
- *Continuation of Nursing Facility Reduction:* the Department proposes a continuation of the 1.5% rate reduction to nursing facility reimbursement current scheduled to end July 1, 2012.
- *Ambulatory Surgical Centers:* the Department has initiated a pilot project to shift outpatient surgery utilization from the outpatient hospital setting to the less costly ambulatory surgical setting.
- *Utilization Management Vendor Funding:* the Department is requesting additional funding for to expand the scope of work of the Department's contracted utilization management vendor to perform prior authorizations for the savings initiatives in this request.
- *Pharmacy Rate Methodology Transition:* to accommodate a change in available drug pricing information, the Department is changing the reimbursement methodology for pharmaceuticals. As part of the change in reimbursement methodology, reimbursement for ingredient costs will be decreased, the dispensing fee will be increased, and net savings of \$4,000,000 total funds will be achieved.
- *Hospital Provider Fee Financing:* the Department is utilizing hospital provider fee to offset lost federal funds associated with certification of public expenditure for outpatient hospital services. An annual amount of \$15,700,000 cash funds will be

used to offset General Fund in the Medical Services Premiums line.

#### **Anticipated Outcomes:**

If implemented, the initiatives described in this request will generate savings by reducing inefficiencies in billing processes, ensuring that services received are medically necessary, and encouraging utilization in the most cost effective/clinically effective setting.

#### **Assumptions for Calculations:**

A detailed description of each proposed initiative is contained in Appendix A. Summary totals for the request are shown in Appendix B. Detailed calculations and assumptions for individual proposals are shown in Appendix C.

#### **Consequences if not Funded:**

The proposed measures in this request are necessary in order for the Department to meet strategic goals and to achieve a balanced budget in FY 2012-13. If these measures are not approved, other reductions would be required to balance the budget.

#### **Cash Fund Projections:**

See Table 5.1 of Appendix A.

#### **Relation to Performance Measures:**

*HCPF Performance Measure 4: Contain Health Care Costs:* The initiatives contained in this request ensure care is both necessary and appropriate without sacrificing the integrity of clients' health.

#### **Supplemental, 1331 Supplemental, or Budget Amendment Criteria:**

New data has resulted in a substantive change in funding need.

#### **Current Statutory Authority or Needed Statutory Change:**

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. (2010).

## Appendix

### **Appendix A**

Appendix A contains a description of each of the fourteen initiatives proposed with this request as well as assumptions used in calculating fiscal impacts.

### **Appendix B**

Appendix B contains summary information including fund splits and cash fund projects.

### **Appendix C**

Tables containing detailed calculations are included in Appendix C.

<b>Proposal</b>	<b>Table</b>
Preterm Birth Prevention	Table A
Synagis Restrictions	Table B
Enhanced Physician Administered Drug Rebate Program	Table C
Reimbursement Rate Alignment for Developmental Screenings	Table D
Physician Administered Drug Pricing and Unit Limits	Table E
Increased Public Transportation Utilization	Table F
Home Health Therapies Limits	Table G
Home Health Personal Care Limits	Table H
Seroquel Restrictions	Table I
Dental Efficiencies	Table J
Augmentative Communication Devices	Table K
Durable Medical Equipment Preferred Provider	Table L
Continuation of Class I Nursing Facility Reduction	Table M
Increased Utilization of Ambulatory Surgical Centers	Appendix A
Utilization Management Vendor Funding	Appendix A

## Appendix A

The components of this request represent significant reductions in expenditure, and consequently impact stakeholders in a variety of ways. To the extent possible for each initiative, the Department has engaged stakeholders to collaboratively develop proposals. Stakeholders have provided invaluable feedback that allowed the Department to identify reductions and find efficiencies that will have the least negative consequences to Medicaid clients and providers while still achieving significant savings.

The Department is able to begin many of these initiatives prior to FY 2012-13. For those instances, the Department may submit a separate supplemental budget request to account for any additional savings.

### **Preterm Labor Prevention**

As of August 1, 2011, the Department has begun offering coverage of alpha hydroxyprogesterone caproate injections (also known as 17P) to pregnant women who meet certain criteria for being at risk of preterm birth.

Studies show that, on average, every five and a half individuals treated with 17P results in the prevention of one preterm birth.<sup>1</sup> Premature babies are at increased risk for newborn health complications such as respiratory system underdevelopment resulting in breathing problems. Most premature babies require care in a newborn intensive care unit (NICU), which has specialized medical staff and equipment that can deal with the multiple problems faced by premature infants. The higher level of newborn care represents a significant cost to the state; MMIS data shows that on average there is an additional expense of \$6,138 per preterm birth and \$9,274 per preterm birth when the baby's birth weight is low.

FY 2009-10 claims data shows 2,280 Medicaid newborns had a low birth weight diagnosis. National Vital Statistics show that 66% of low birth weight births are also premature births. This results in approximately 1,505 births that are both preterm and low birth weight. FY 2009-10 claims data also shows 655 newborns with a preterm labor diagnosis but no diagnosis of low birth weight. An additional qualifying criterion for use of 17P is a previous live preterm birth. Information from the Department of Public Health and Environment indicates that 62% of women that have a preterm birth, have had a previous live birth. Information on previous preterm live births was not available. Although the exact number cannot be calculated, given this information, the Department estimates approximately 1,000 clients will be eligible for this drug. Based on the statistics above, the Department estimates that approximately 70% are at risk of preterm labor and a low birth weight birth. The remaining 30% are at risk for preterm birth only.

Due to a six month delay between implementation of the program and demonstrated clinical effectiveness, the Department estimates an increase in FY 2011-12 expenditure equal to \$131,615 total funds, \$65,807 General Fund. The Department estimates a net reduction of expenditure equal to \$902,736 total funds, \$451,368 General Fund in FY 2012-13 and \$1,000,608 total funds, \$500,304 General Fund in FY 2013-14.

See tables A.1 through A.3 in Appendix C for detailed calculations.

### **Synagis PAR Restrictions**

Synagis is a commonly prescribed prophylactic for high risk children; the pharmaceutical reduces the likelihood of hospitalization from respiratory syncytial virus (RSV) infection.

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<sup>1</sup> 2003 New England Journal of Medicine, multicenter, randomized, placebo-controlled trial conducted by the National Institute of Child Health and Human Development.

The Department is in the process of implementing a more restrictive prior authorization process for Synagis; implementation is expected to be complete by November 1, 2011. By authorizing each dose individually, the Department will have greater control in limiting patients to the American Academy of Pediatrics (AAP) recommended number of doses per season. The Department will set up controls to ensure that a weight appropriate dose is authorized, that the client receives all authorized doses, that only the appropriate number of doses are given, and that the doses are given at the appropriate interval (28-30 days apart).

Based on the nature of the proposal, clinical data would be necessary to predict the fiscal impact with precision. Unfortunately, specific clinical data such as client weight is not available to the Department at this time. However, several studies have been done related to the pharmaceutical PAR process which allows the Department to estimate the fiscal impact of this proposal. Bernard Bloom and Jake Jacobs studied the effect of the prior authorization process of Cimetidine in the West Virginia Medicaid program. They found that utilization of the drug decreased by 84%. Walter Smalley and colleagues examined the effects of a prior authorization policy for nongeneric non-steroidal anti-inflammatory drugs in the Tennessee Medicaid program. Their results indicated a 53% decline in utilization resulting from the prior authorization process<sup>2</sup>.

It is important to note that there are several differences between the policies implemented in West Virginia and Tennessee. First, there currently exists a prior authorization process for Synagis; it is not reviewed or restricted to the levels proposed by this initiative. As a result, the reduction in utilization from physicians being unwilling to traverse the prior authorization process will not be experienced by Colorado. Second, Synagis is in a different drug class than either of the two studies. The Department does not anticipate substitution effects with Synagis such as those that likely drove much of the reduction in utilization in the studies. To account for these differences, the Department estimates 10% of the utilization reduction seen in the Tennessee program, or 5.3% as available savings from this initiative. Should savings prove to exceed this amount, the Department will request a change in funding through the normal budgetary process.

The Department estimates \$211,253 total funds, \$103,217 General Fund savings in FY 2011-12; \$419,772 total funds, \$205,100 General Fund savings in FY 2012-13; and \$486,552 total funds, \$237,729 General Fund savings in FY 2013-14 from the implementation of this policy.

See table B.1 in Appendix C for detailed calculations.

### **Physician Administered Drug Enhanced Rebate Program**

Many pharmaceuticals covered under the Medicaid program are eligible for manufacturer rebates. Physician administered drugs (also known as J-Code drugs) are also eligible for rebates. While the Department has historically collected rebates on some physician administered drugs, there was opportunity to expand the physician administered drug rebate program. Physician administered drugs are processed as a medical claim and not a pharmacy claim. This had resulted in insufficient information being supplied on these claims for the Department to claim rebates from the manufacturers. Department policy staff has been working with the provider community to clarify expectations regarding the submission of claims for physician administered drugs. Further, the Department has expanded the list of rebateable physician administered drugs by comparing the Department's rebateable drug list with other national lists to ensure all opportunities for rebate collection are identified. Because many of the physician administered drugs on the expanded drug rebate list are multisource generics for which the Department is unable to pursue

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<sup>2</sup> Soumerai, Stephen B. "Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid", Health Affairs, V.23 , January/February 2004

collection of rebates, the Department assumes that the percentage of collectable rebates for drugs recently added to the expanded list will be 50% lower than was achieved for drugs on the list prior to the expansion. The Department began implementation of this initiative September 2011. The Department is investigating the possibility of collecting rebates on claims paid prior to September 2011, but is unclear that this will be allowable under federal law; the Department has not scored savings for historical claims as a result. However, collection of rebates on these claims may yet be possible. The Department continues to investigate the possibility and will account for any additional savings achieved through the regular budget process.

The Department estimates a \$1,738,620 total funds, \$869,310 General Fund savings in FY 2011-12 from this initiative. This amount annualizes to \$2,418,276 total funds, \$1,209,138 General Fund in FY 2012-13 and \$2,803,032 total funds, \$1,401,516 General Fund in FY 2013-14.

See table C.1 in Appendix C for detailed calculations.

### **Reimbursement Rate Alignment for Developmental Screenings**

Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings. Previously, developmental and depression screenings were both billed with procedure code 96110 and the rate was set at \$36.10. This was well above the rates paid by Medicare and commercial insurance plans for these screenings.

The Department reduced the rate for developmental screenings to \$17.00 and continues to reimburse it using code 96110. The decision to reduce the rate to \$17.00 was reached in collaboration with the Colorado Chapter of the American Academy of Pediatrics (CO AAP), which compiled a document indicating that commercial rates for this type of screening range from \$16.00 to \$20.00. This range is still well above the Medicare rate of \$8.05 for this code, but the CO AAP maintained that Medicare rates do not accurately represent the pediatric population and urged the Department to set the rate to a commercial benchmark. The Department is also limiting reimbursement to three developmental screenings per year for children 0 to 24 months old and two developmental screenings per year for children 25 to 29 months old based on guidance from the CO AAP. Developmental screenings will not be a benefit available to children over the age of four. Exceptions to this age limit will be made if the provider shows medical justification; the Department anticipates that there will be very few exceptions and therefore did not include them in its analysis as it would not significantly change the results.

The Department has opened procedure code 99420 for adolescent depression screenings and reduced its reimbursement rate to \$10.08, which is equivalent to the rate for depression screenings in the Medicare Physician Fee Schedule. Further, the Department is limiting this benefit to clients 11 to 20 years old to reflect the adolescent age group within the EPSDT population that is consistent with national guidelines for depression screening. Any claims submitted for clients outside of this range will be denied. The Department will allow for an exception for children under the age of 11 in the case of a justified need. As with developmental screenings, the Department anticipates that there will be very few exceptions and therefore did not include them in its analysis.

The Department estimates that changing the reimbursement levels and age limits for these rates will generate savings of \$1,620,574 total funds, \$791,810 General Fund in FY 2011-12 and \$2,092,701 total funds, \$1,022,490 General Fund in FY 2012-13, and \$2,431,758 total funds, \$1,188,154 General Fund in FY 2013-14

See tables D.1, D.2, and D.3 in Appendix C for detailed calculations.

### **Physician Administered Drug Pricing and Unit Restrictions**

The Department has identified three physician administered drugs for which the pricing and unit limits are inconsistent with policy. The Department raised reimbursement to be equal with Medicare rates while also changing the unit limits for haloperidol decanoate (J1631) and fluphenazine decanoate (J2680) that ensures compensation is adequate; this provided consistency in billing, but ultimately results in savings for the Department. Reducing reimbursement of risperidone (J2794) brought reimbursement in line with the actual cost of the drug which is consistent with Department policy. All three drugs are used in the treatment of schizophrenia.

Claims data indicated that providers were frequently billing unit amounts that were inconsistent with standard dosages. Many claims appeared to be billing 1 unit = 1mg. The correct unit size is 1 unit = 50mg for J1631 and 1 unit = 25mg for J2680. For J2794, lowering the reimbursement to the same level as the Medicare rate generated savings for the Department as reimbursement for the drug significantly exceeded the Medicare rate. The Department has adjusted the Medicaid fee schedule to match the Medicare rate for these three office injected drugs and to change the unit limit to prevent billing incorrect units.

This change is estimated to result in \$359,305 total funds, \$175,555 General Fund savings in FY 2011-12; \$416,472 total funds, \$203,488 General Fund savings in FY 2012-13; and \$482,738 total funds, \$235,865 General Fund savings in FY 2013-14.

See tables E.1, E.2, E.3, and E.4 in Appendix C for detailed calculations.

### **Increased Utilization of Public Transportation**

Effective January 2012, the Department will be implementing a public transportation utilization incentive program in the Denver-metro area to increase the utilization of public transportation under the Department's non-emergent medical transportation program.

Through a survey and comparison of national best practices, the Department identified that public transportation is being underutilized relative to other states within the state's non-emergent medical transportation (NEMT) program. Public transportation represents a significantly cheaper alternative to private vehicles, but an equally effective way for the Department to provide transportation access to Medicaid clients. Other states have experienced levels of public transportation utilization nearing 30% whereas utilization in the Denver-Metro region of Colorado is historically between 9% and 10%.

For the Denver-metro counties, the Department utilizes a contractor for the coordination of NEMT trips. This administrative contract will be reprocured early in FY 2011-12. With the contract procurement, the Department will build in incentives in the form of additional compensation for achieving specific targets (see attached tables for additional detail) to ensure the contractor is encouraging clients to utilize public transportation when they are physically able and it will not result in undue hardship for the client. Over the first eighteen month period of the contract, the Department anticipates utilization of public transportation in the NEMT program for this region to increase from 9.5% to 17.5%. The Department incorporated this assumption into the NEMT contract; under this assumption the base amount of the contract is fixed at a lower rate than in FY 2010-11 which ensures the Department will capture savings from this initiative whether the contractor achieves the public transportation utilization target or not.

In addition to the savings generated by increasing public transportation utilization, there will be a one-time cash accounting savings as the Department transitions from a prospective reimbursement methodology to a retrospective reimbursement methodology.

The combined savings generated by increasing utilization of public transportation and the onetime cash accounting savings results in total fund savings of \$615,598 and \$300,780 General Fund savings in FY 2011-12. This annualizes to \$209,574 total fund, \$102,398 General Fund savings in FY 2012-13 and a like amount in FY 2013-14.

See table F.1 in Appendix C for detailed calculations.

### **Home Health Efficiencies**

The following initiatives proposed by the Department are aimed at ensuring appropriate utilization of home health services in the Medicaid program. Exemptions to limitation on services will be made for clients under the age of twenty as applicable and required by federal law.

#### *Unit Cap of 48 Units on Home Health Therapies*

The Department is limiting home health therapy to 48 visits per year. This policy would be consistent with the Department's current outpatient therapy limits.

Physical therapy, occupational therapy and speech therapy are services available to Medicaid recipients during the acute period of home health care (up to 60 days of care). For home health purposes, therapies should be rehabilitative and restorative in nature. In most cases, visits past the 48<sup>th</sup> visit are for maintenance, which is not covered as a home health benefit. The Department is placing a 48 visit cap per client per calendar year for all three home health therapies which will still allow a client to receive needed rehabilitative and restorative care while avoiding treatment that can no longer be considered restorative, but is instead maintenance. While the Department will allow exceptions when authorized for a medical need, it is unlikely that visits past the 48<sup>th</sup> would be restorative or rehabilitative in nature and would be approved.

This proposal may have a significant effect on those clients who would have received more than 48 units. In CY 2010, for clients that utilized services in excess of 48 unit cap, utilization would have to be reduced by approximately 36% with the unit limitation. While this reduction is large, the Department believes that any potential negative effects to clients will be mitigated through appropriate use of certified nursing aide services, and the aforementioned medical exemption process.

While some substitution may occur between home health therapy services and outpatient therapy services, the Department previously limited the number of outpatient therapy visits that can be utilized by a client (requested in FY 2011-12 BA-9: "Medicaid Reductions"). This acts to constrain, but does not eliminate completely, the substitution effect. As with the home health setting, if the therapies are no longer restorative as one would anticipate past the 48 visit point, it is unlikely the client would qualify for therapy in the outpatient setting. The Department therefore assumes no substitution effect to outpatient therapy as part of its calculations.

This initiative is estimated to save \$60,601 total funds and \$29,609 General Fund in FY 2011-12. This amount annualizes to \$382,453 total fund, \$186,866 General Fund in FY 2012-13, and \$402,407 total funds, \$196,615 General Fund in FY 2013-14

See table G.1 in Appendix C for detailed calculations.

### *Limit Home Health Care to Eight Hours per Day*

Home Health rules currently state that home health visits must be completed on an intermittent basis, but the rules do not define what is considered an intermittent basis. Medicare defines intermittent as less than 8 hours a day and less than 21 days a month. For this initiative, the Department is issuing a clarifying rule consistent with Medicare. However, as many Medicaid recipients need daily care, the Department believes the 21 day per month limitation cannot be safely applied; only the 8 hour per day limitation is being incorporated. Exemptions will be allowed when deemed medically necessary and are prior authorized.

For those clients that currently utilize more than 8 hours per day of home health services, the average number of hours utilized is 10.5. For this subset of home health 'high utilizers, the restriction results in an approximate 19.8% reduction in hours of service received. However, when accounting for all home health utilizers, the reduction in hours resulting from the cap is far less, approximately 4.1%. Meeting the eight hour limit without negatively impacting those clients whose utilization exceeds the cap will require home health agencies to be more efficient with time spent attending a client's needs. In cases where meeting the needs of the client within the hour limitations is not possible, documentation of medical necessity will need to be provided and reviewed.

The Department estimates FY 2011-12 savings equal to \$652,941 total funds, \$319,026 General Fund, FY 2012-13 savings of \$4,117,163 total funds, \$2,011,640 General Fund and FY 2013-14 savings of \$4,326,979 total funds, \$2,114,155 General Fund.

See table H.1 in Appendix C for detailed calculations.

### **Seroquel Restrictions**

Seroquel is a pharmaceutical that is prescribed to treat schizophrenia and mood disorders such as bipolar disorder. In low doses, this drug is sometimes used as a sleep aid or anxiety reducer. The Department believes this off-label use of an antipsychotic agent exposes clients to unnecessary risk of adverse reactions while driving additional expenditure for the state. Effective January 2012, the Department is restricting use of Seroquel to treatment of psychotic disorders through the Department's pharmacy prior authorization process. As a result of this policy change, the Department anticipates a shift in utilization away from Seroquel to cheaper and more appropriate medications for the treatment of sleep disorders and anxiety. In comparing the cost of Seroquel to generic Zolpiden, the Department estimates costs for off-label use of Seroquel in excess of four times what would be paid for a generic sedative.

Seroquel can be used in low doses to titrate to higher doses for use as an antipsychotic. The Department identified claims where a low dose of Seroquel was prescribed for lengths of time greater than one month. As titration should be complete within a month, this indicated that approximately 78% of low dosage Seroquel was likely to be off label use. To avoid an overestimation of savings, the Department conservatively assumes that 30% of the low dosage utilization is appropriate usage.

The Department estimates the impact of this policy change to equal \$694,210 total fund, \$339,190 General Fund in FY 2011-12. This amount annualizes to \$1,931,172 total funds, \$943,568 General Fund in FY 2012-13 and \$2,238,420 total fund, \$1,093,689 General Fund in FY 2013-14.

See Table I.1 in Appendix C for detailed calculations.

## **Dental Efficiencies**

Effective January 2012, the Department will be clarifying several policies regarding reimbursement for orthodontic services. Orthodontic services are covered by Medicaid when a client has a qualifying medical need. State rules do not clearly define the criteria under which a client is eligible. This proposal includes clarification of the definition of a 'severe handicapping malocclusion', which ensures procedures are reimbursed only when the procedure was medically necessary.

Under current policy, an entire procedure is paid in full up front. Under multiple circumstances, this results in overpayment by the Department. For example, if a client becomes ineligible for Medicaid or initiates but fails to complete treatment, the state incurs avoidable costs. The Department will be transitioning to a new payment methodology where payments are made in three equal installments. This will reduce expenditure for partially performed procedures.

To reduce spurious claims, the Department will restrict reimbursement for diagnostic casts, x-rays and other preparatory diagnostics associated with orthodontic procedures through the PAR process. The procedures will only be reimbursed when associated with a preapproved orthodontic procedure.

Because the Department has limited access to clinical data, it is difficult to predict the level of savings which can be achieved with precision. However, in comparing Colorado's expenditure on dental services to other states, the Department identified that states which have relatively stricter limitations on access to orthodontic procedures have significantly lower expenditure. For example, Rhode Island has a per member per month dental expenditure of approximately \$12.76 (after adjustments for administrative expenses) whereas Colorado has a per member per month of \$31.22 for clients under the age of 21. This represents a 59% difference in per member per month costs. While there are differences between programs other than the relative restrictiveness of medical necessity criteria, the indication is that more restrictive policies can achieve significant savings. Comparison of expenditure to North Carolina showed a similar relationship: North Carolina's orthodontic expenditure comprises approximately 8% of their total Medicaid dental expenditure. Colorado's orthodontic expenditure is 12% of total Medicaid dental expenditure. Dr. Mark Casey of the North Carolina Department of Health and Human Services surmised that one driving factor for Colorado's higher ratio of orthodontic expenditure is the orthodontics approval criteria. If Colorado were to achieve the same ratio of orthodontic expenditure to total dental expenditure as North Carolina through clarification of qualification criteria and other efficiencies enacted as part of this initiative, orthodontic expenditure would be reduced by approximately 32%. To account for programmatic differences between states, the Department assumes one third of this reduction, or 10% of total orthopedic expenditure, as attainable savings.

This initiative is estimated to save \$603,812 total funds, \$295,022 General Fund in FY 2011-12; \$1,641,594 total funds, \$802,081 General Fund in FY 2012-13; and \$1,859,598 total fund, \$908,597 General Fund in FY 2013-14.

See Table J.1 in Appendix C for detailed calculations.

## **Augmentative and Alternative Communication Devices**

Augmentative and alternative communication devices (AACD) aid individuals with impairments that hinder their ability to produce or comprehend verbal or visual communication. As a Medicaid benefit, clients are able to obtain these devices. On average, the Department provides approximately ten AACDs each month at an average cost of \$6,500 each. With the rapid progression of technology, alternatives to the traditional AACD have become available. A tablet computer with a specialized application can achieve

nearly the same functionality as the traditional AACD, and essentially serves as a step-down alternative to the traditional AACD. Further, tablet computers with the necessary applications cost approximately \$800. Unfortunately, tablet computers are not suitable for all clients that would use the traditional AACD. Some of the clients' disabilities limit their dexterity to the point of being unable to use a tablet computer. For these clients, the traditional AACD is still necessary. Based on information from a Colorado complex rehab durable medical equipment provider, the Department estimates that 80% of clients that would opt to obtain the traditional AACD are physically capable of utilizing a tablet computer instead.

Both current policy and systems capacity allow for reimbursement for tablet computers as part of the Department's durable medical equipment benefit. However, client and DME supplier outreach will be necessary to ensure access. Due to the low volume of clients with conditions that qualify for AACDs, the Department believes this outreach can be accomplished with existing resources.

The Department recognizes that some clients that qualify for an AACD based on their impairment do not opt to obtain one, but would likely opt for a tablet computer. Consequently, the Department assumes that utilization of AACDs, when tablet computers are easily accessible to clients with qualifying disabilities, will increase by 200%. Despite this increase in utilization, the large price difference between the traditional AACD and tablet computers still results in net savings.

The Department estimates savings of \$184,500 total funds, \$90,146 General Fund in FY 2011-12. This amount annualizes to \$492,000 total funds, \$240,391 General Fund in FY 2012-13 and a like amount in FY 2013-14.

See Table K.1 in Appendix C for detailed calculations.

### **Durable Medical Equipment Preferred Provider**

As a large purchaser of diabetic testing supplies, the Department is able to leverage purchasing power to obtain discount pricing. The Department has been approached by vendors offering provision of diabetic test strips at a rate (net of rebate) lower than current costs. Further, some vendors offer free glucose meters, client education and outreach. The Department anticipates that it will be able to achieve better pricing through a competitive bid process.

Preliminary research indicates that net payment could be reduced by as much as \$4.50 per box. This savings is in addition to savings the Department achieved from previously reducing reimbursement for diabetic test strips as part of FY 2011-12 BRI-5 "Medicaid Program Reductions". While reimbursement to providers would necessarily increase as their direct acquisition cost would increase, the Department can ensure, through the competitive bid process, that the manufacturer rebate will be sufficient to reduce net expenditure below current levels. As additional criteria for a sole source provider for these supplies, the Department will require a prospective rebate agreement which will be reconciled retroactively. This reduces the gap between expenditure and collection of rebates and any cash flow issues that could potentially arise as a result. Providers that have approached the Department have indicated willingness to adhere to such a policy. If the criteria described cannot be met by any provider that bids through the competitive bid process, the initiative will not be implemented.

Current annual utilization of glucose meters is estimated at 16,782 units and approximately \$45 per unit. With the manufacturer supplying these units for free, the Department can achieve significant savings.

Lastly, the Department would require the preferred provider to offer free client education and outreach. Helping clients understand how to properly manage their condition results in long run savings. When clients are able to manage their diabetes well, conditions such as diabetic ketoacidosis, high blood pressure, tissue degeneration, and a litany of secondary conditions can be avoided. The Department would account for any savings achieved from the additional client education through the normal budget process.

Implementation is scheduled for July 1, 2012. The net effect of leveraging the Department's purchasing power to obtain steep rebates, changing reimbursement on testing strips, and free glucose meters is estimated to result in \$1,150,732 total funds, \$562,246 General Fund savings in FY 2012-13. This annualizes to \$1,422,312 total funds, \$694,940 General Fund in FY 2013-14.

See Table L.1 in Appendix C for detailed calculations.

### **Continuation of Class I Nursing Facility Rate Reduction**

Nursing facility reimbursement has two components. The first component, funded by a combination of General Fund and federal funds, covers expenditure for direct and indirect health care, raw food, administrative and general services, and fair rental value. The second component is funded by the Nursing Facility Provider Fee and federal funds and consists of supplemental payments to facilities for performance, acuity adjustments, and growth beyond the General Fund cap<sup>3</sup>.

As part of the FY 2011-12 budget balancing package, across the board reductions to nearly all provider types were implemented. As part of this measure, SB 11-215 "2011 Nursing Facility Rate Reduction" was passed which reduced the General Fund portion of FY 2011-12 nursing facility per diem rates by 1.5%. This reduction did not represent an additional cut to nursing facility reimbursement relative to FY 2010-11 rates, but rather a continuation of the 1.5% reduction effective March 1, 2010 as imposed by HB 10-1324 "Nursing Facility Per Diem Rates". Unlike the reductions to other provider types, the reduction to nursing facility reimbursement as outlined in SB 11-215 was limited to FY 2011-12. Under the Department's proposal, the reduction will continue indefinitely. As the reimbursement methodology for this provider type is outlined in statute, legislation will be required to implement this proposal.

The Department proposes a continuation of the 1.5% rate reduction to the General Fund portion of Class I nursing facility reimbursement. This proposal will generate an estimated \$9,024,677 total funds, \$4,512,338 General Fund savings in FY 2012-13 and \$9,320,345 total funds, \$4,660,172 General Fund in FY 2013-14.

See Table M.1 in Appendix C for detailed calculations.

### **Increased Utilization of Ambulatory Surgical Centers**

Clients in need of outpatient surgery are able to access services in a variety of settings. Depending on the invasiveness of the procedure, a client can have a surgery performed in an outpatient hospital setting, in an ambulatory surgical center (ASC), or even in a physician's office. Medicaid reimbursement methodologies are different from setting to setting. For example, outpatient hospital services are reimbursed using a cost based methodology while ASCs are reimbursed on a fixed fee schedule. The differences in reimbursement methodologies result in disparity in reimbursement for identical procedures performed in different settings. A procedure performed in an ASC is typically less expensive than the same procedure performed in the outpatient hospital setting. Because equivalent clinical outcomes can be achieved in either setting, there is

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<sup>3</sup> SB 09-263 established a three percent annual growth cap on the General Fund portion of the statewide average nursing facility per diem rate net of patient payment.

an opportunity for efficiency gains when utilization of outpatient surgery services is shifted from the outpatient hospital setting to the ASC setting.

Over the last year, the Department has engaged the ambulatory surgical center provider community to determine if opportunities for greater efficiencies, such as those described above, can be achieved. As a result of this collaboration, the Department is currently running a limited scope trial to determine if utilization can be shifted from the outpatient setting to the ASC setting when ASCs are actively engaged in offering and promoting access of their facilities to surgeons that participate in Medicaid. Following completion of the trial (mid FY 2011-12), the Department will have the data necessary to structure incentives within the ASC reimbursement methodology to incentivize this migration between settings while capturing the efficiency of acquiring services from the least costly setting.

As the trial is not yet complete, the Department cannot yet estimate the exact fiscal impact from of this proposal, comparison of costs between settings and examination of a broad grouping of procedure codes indicates that savings of \$500,000 total funds, \$244,299 General Fund is attainable in FY 2011-12. This annualizes to \$1,000,000 total funds, \$488,599 General Fund in FY 2012-13 and a like amount in FY 2013-14.

### **Pharmacy Rate Methodology Transition**

Until recently, many states have utilized average wholesale price (AWP), a pricing statistic provided primarily by First Data Bank, as the primary component of their pharmaceutical reimbursement methodology. Following a lawsuit wherein the flaws of average wholesale price setting were exposed, First Data Bank ceased to publish average wholesale pricing data. This occurred September 26, 2011. States that utilized this information in their pricing methodology, including Colorado, were forced to establish new pricing methodologies.

The Department has implemented a new pricing methodology that relies on a combination of state maximum allowable cost (SMAC) and wholesale acquisition cost (WAC). Although the Department is currently in transition and using a temporary SMAC list, implementation is expected to be complete by spring of 2012. The reimbursement for each drug will be changing (in some cases drastically) under the implementation of the final reimbursement methodology. To ensure drug pricing is fair and directly connected to actual provider costs, a rate rebalance is required.

The rate rebalance presents an opportunity as the Department will be able to realign reimbursement to reflect actual provider costs. The Department believes this is most effectively accomplished by reducing reimbursement to pharmacies for the material component of the pharmaceuticals and simultaneously increasing dispensing fees. This ensures that both the time and material components are reimbursed at a level that most accurately reflects costs to pharmacies. Further, the Department is able to complete the rebalance in a manner that generates savings. Under the proposed methodology, the Department is committed to reducing aggregate pharmaceutical expenditure by \$4,000,000 total funds, \$1,954,394 General Fund in FY 2012-13 through the rates rebalance process.

As many states have been forced to find an alternative to AWP pricing, several have completed dispensing fee studies. Alabama's rate rebalance resulted in significant reductions to drug costs and an increase of their dispensing fee to \$10.18. Oregon also saw significant reductions to drug costs, but opted to stratify their dispensing fee. Until the final SMAC data set is available, the Department cannot explicitly state how much reimbursement for the raw material cost of pharmaceuticals will be reduced, or the exact level of the dispensing fee. The Department is engaging a private contractor to perform an analysis about the adequacy

**Appendix B**

**Table 1.1  
Summary of Estimate  
FY 2011-12**

<b>Summary of FY 2011-12 Impact</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Estimated Impact</b>	<b>(\$7,859,799)</b>	<b>(\$19,618,256)</b>	<b>\$15,625,858</b>	<b>\$0</b>	<b>(\$3,867,401)</b>
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$250,000	\$62,500	\$0	\$0	\$187,500
(2) Medical Services Premiums	(\$8,109,799)	(\$19,680,756)	\$15,625,858	\$0	(\$4,054,901)

**Table 1.2  
Summary of Request  
FY 2012-13**

<b>Summary of Request FY 2012-13</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Request</b>	<b>(\$29,699,322)</b>	<b>(\$30,471,105)</b>	<b>\$15,496,446</b>	<b>\$0</b>	<b>(\$14,724,663)</b>
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$500,000	\$125,000	\$0	\$0	\$375,000
(2) Medical Services Premiums	(\$30,199,322)	(\$30,596,105)	\$15,496,446	\$0	(\$15,099,663)

**Table 1.3  
Summary of Request  
FY 2013-14**

<b>Summary of Request FY 2013-14</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Request</b>	<b>(\$31,976,323)</b>	<b>(\$31,592,518)</b>	<b>\$15,479,358</b>	<b>\$0</b>	<b>(\$15,863,163)</b>
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$500,000	\$125,000	\$0	\$0	\$375,000
(2) Medical Services Premiums	(\$32,476,323)	(\$31,717,518)	\$15,479,358	\$0	(\$16,238,163)

**Appendix B**

**Table 2.1  
Impact by Component: Base Fund Split  
FY 2011-12**

<b>FY 2011-12</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Source</b>
<b>Total Impact</b>	<b>(\$7,859,799)</b>	<b>(\$19,618,256)</b>	<b>\$15,625,858</b>	<b>\$0</b>	<b>(\$3,867,401)</b>	
<b>(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts</b>	<b>\$250,000</b>	<b>\$62,500</b>	<b>\$0</b>	<b>\$0</b>	<b>\$187,500</b>	<b>Narrative</b>
<b>(2) Medical Services Premiums</b>	<b>(\$8,109,799)</b>	<b>(\$19,680,756)</b>	<b>\$15,625,858</b>	<b>\$0</b>	<b>(\$4,054,901)</b>	
Preterm Labor Prevention	\$131,615	\$65,807	\$0	\$0	\$65,808	Table A
Synagis Prior Authorization Review	(\$211,253)	(\$103,217)	(\$2,409)	\$0	(\$105,627)	Table B
Expansion of Physician Administered Drug Rebate Program	(\$1,738,620)	(\$869,310)	\$0	\$0	(\$869,310)	Table C
Reimbursement Rate Alignment for Developmental Screenings	(\$1,620,574)	(\$791,810)	(\$18,477)	\$0	(\$810,287)	Table D
Physician Administered Drug Pricing and Unit Limits	(\$359,305)	(\$175,555)	(\$4,097)	\$0	(\$179,653)	Table E
Public Transportation Utilization	(\$615,598)	(\$300,780)	(\$7,019)	\$0	(\$307,799)	Table F
Home Health Therapies Cap	(\$60,601)	(\$29,609)	(\$691)	\$0	(\$30,301)	Table G
Home Health Care Cap	(\$652,941)	(\$319,026)	(\$7,444)	\$0	(\$326,471)	Table H
Seroquel Restrictions	(\$694,210)	(\$339,190)	(\$7,915)	\$0	(\$347,105)	Table I
Dental Efficiency	(\$603,812)	(\$295,022)	(\$6,884)	\$0	(\$301,906)	Table J
Augmentative Communication Devices	(\$184,500)	(\$90,146)	(\$2,104)	\$0	(\$92,250)	Table K
DME Preferred Provider	\$0	\$0	\$0	\$0	\$0	Table L
Continuation of Nursing Facility Reduction	\$0	\$0	\$0	\$0	\$0	Table M
Ambulatory Surgical Centers	(\$500,000)	(\$244,299)	(\$5,701)	\$0	(\$250,000)	Narrative
Pharmacy Rate Methodology Transition	(\$1,000,000)	(\$488,599)	(\$11,401)	\$0	(\$500,000)	Narrative
Hospital Provider Fee Financing	\$0	(\$15,700,000)	\$15,700,000	\$0	\$0	Narrative

**Appendix B**

**Table 2.2  
Impact by Component: Base Fund Split  
FY 2012-13**

<b>FY 2012-13</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Source</b>
<b>Total Request</b>	<b>(\$29,699,322)</b>	<b>(\$30,471,105)</b>	<b>\$15,496,446</b>	<b>\$0</b>	<b>(\$14,724,663)</b>	
<b>(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts</b>	<b>\$500,000</b>	<b>\$125,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$375,000</b>	<b>Narrative</b>
<b>(2) Medical Services Premiums</b>	<b>(\$30,199,322)</b>	<b>(\$30,596,105)</b>	<b>\$15,496,446</b>	<b>\$0</b>	<b>(\$15,099,663)</b>	
Preterm Labor Prevention	(\$902,736)	(\$451,368)	\$0	\$0	(\$451,368)	Table A
Synagis Prior Authorization Review	(\$419,772)	(\$205,100)	(\$4,786)	\$0	(\$209,886)	Table B
Expansion of Physician Administered Drug Rebate Program	(\$2,418,276)	(\$1,209,138)	\$0	\$0	(\$1,209,138)	Table C
Reimbursement Rate Alignment for Developmental Screenings	(\$2,092,701)	(\$1,022,490)	(\$23,860)	\$0	(\$1,046,351)	Table D
Physician Administered Drug Pricing and Unit Limits	(\$416,472)	(\$203,488)	(\$4,748)	\$0	(\$208,236)	Table E
Public Transportation Utilization	(\$209,574)	(\$102,398)	(\$2,389)	\$0	(\$104,787)	Table F
Home Health Therapies Cap	(\$382,453)	(\$186,866)	(\$4,360)	\$0	(\$191,227)	Table G
Home Health Care Cap	(\$4,117,163)	(\$2,011,640)	(\$46,941)	\$0	(\$2,058,582)	Table H
Seroquel Restrictions	(\$1,931,172)	(\$943,568)	(\$22,018)	\$0	(\$965,586)	Table I
Dental Efficiency	(\$1,641,594)	(\$802,081)	(\$18,716)	\$0	(\$820,797)	Table J
Augmentative Communication Devices	(\$492,000)	(\$240,391)	(\$5,609)	\$0	(\$246,000)	Table K
DME Preferred Provider	(\$1,150,732)	(\$562,246)	(\$13,120)	\$0	(\$575,366)	Table L
Continuation of Nursing Facility Reduction	(\$9,024,677)	(\$4,512,338)	\$0	\$0	(\$4,512,339)	Table M
Ambulatory Surgical Centers	(\$1,000,000)	(\$488,599)	(\$11,401)	\$0	(\$500,000)	Narrative
Pharmacy Rate Methodology Transition	(\$4,000,000)	(\$1,954,394)	(\$45,606)		(\$2,000,000)	Narrative
Hospital Provider Fee Financing	\$0	(\$15,700,000)	\$15,700,000	\$0	\$0	Narrative

**Appendix B**

**Table 2.3  
Impact by Component: Base Fund Split  
FY 2013-14**

<b>FY 2013-14</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>	<b>Source</b>
<b>Total Request</b>	<b>(\$31,976,323)</b>	<b>(\$31,592,518)</b>	<b>\$15,479,358</b>	<b>\$0</b>	<b>(\$15,863,163)</b>	
<b>(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts</b>	<b>\$500,000</b>	<b>\$125,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$375,000</b>	<b>Narrative</b>
<b>(2) Medical Services Premiums</b>	<b>(\$32,476,323)</b>	<b>(\$31,717,518)</b>	<b>\$15,479,358</b>	<b>\$0</b>	<b>(\$16,238,163)</b>	
(2) Medical Services Premiums						
Preterm Labor Prevention	(\$1,000,608)	(\$500,304)	\$0	\$0	(\$500,304)	Table A
Synagis Prior Authorization Review	(\$486,552)	(\$237,729)	(\$5,547)	\$0	(\$243,276)	Table B
Expansion of Physician Administered Drug Rebate Program	(\$2,803,032)	(\$1,401,516)	\$0	\$0	(\$1,401,516)	Table C
Reimbursement Rate Alignment for Developmental Screenings	(\$2,431,758)	(\$1,188,154)	(\$27,725)	\$0	(\$1,215,879)	Table D
Physician Administered Drug Pricing and Unit Limits	(\$482,738)	(\$235,865)	(\$5,504)	\$0	(\$241,369)	Table E
Public Transportation Utilization	(\$209,574)	(\$102,398)	(\$2,389)	\$0	(\$104,787)	Table F
Home Health Therapies Cap	(\$402,407)	(\$196,615)	(\$4,588)	\$0	(\$201,204)	Table G
Home Health Care Cap	(\$4,326,979)	(\$2,114,155)	(\$49,334)	\$0	(\$2,163,490)	Table H
Seroquel Restrictions	(\$2,238,420)	(\$1,093,689)	(\$25,521)	\$0	(\$1,119,210)	Table I
Dental Efficiency	(\$1,859,598)	(\$908,597)	(\$21,202)	\$0	(\$929,799)	Table J
Augmentative Communication Devices	(\$492,000)	(\$240,391)	(\$5,609)	\$0	(\$246,000)	Table K
DME Preferred Provider	(\$1,422,312)	(\$694,940)	(\$16,216)	\$0	(\$711,156)	Table L
Continuation of Nursing Facility Reduction	(\$9,320,345)	(\$4,660,172)	\$0	\$0	(\$4,660,173)	Table M
Ambulatory Surgical Centers	(\$1,000,000)	(\$488,599)	(\$11,401)	\$0	(\$500,000)	Narrative
Pharmacy Rate Methodology Transition	(\$4,000,000)	(\$1,954,394)	(\$45,606)	\$0	(\$2,000,000)	Narrative
Hospital Provider Fee Financing	\$0	(\$15,700,000)	\$15,700,000	\$0	\$0	Narrative

**Appendix B**

**Table 3.1  
Cash Fund Splits  
FY 2011-12**

<b>FY 2011-12</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Hospital Provider Fee Cash Fund</b>	<b>Breast and Cervical Cancer Prevention and Treatment Fund</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Impact</b>	<b>(\$7,859,799)</b>	<b>(\$19,618,256)</b>	<b>\$15,634,956</b>	<b>(\$9,098)</b>	<b>\$0</b>	<b>(\$3,867,401)</b>
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$250,000	\$62,500	\$0	\$0	\$0	\$187,500
(2) Medical Services Premiums	(\$8,109,799)	(\$19,680,756)	\$15,634,956	(\$9,098)	\$0	(\$4,054,901)

**Table 3.2  
Cash Fund Splits  
FY 2012-13**

<b>FY 2012-13</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Hospital Provider Fee Cash Fund</b>	<b>Breast and Cervical Cancer Prevention and Treatment Fund</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Request</b>	<b>(\$29,699,322)</b>	<b>(\$30,471,105)</b>	<b>\$15,521,424</b>	<b>(\$24,978)</b>	<b>\$0</b>	<b>(\$14,724,663)</b>
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$500,000	\$125,000	\$0	\$0	\$0	\$375,000
(2) Medical Services Premiums	(\$30,199,322)	(\$30,596,105)	\$15,521,424	(\$24,978)	\$0	(\$15,099,663)

**Table 3.3  
Cash Fund Splits  
FY 2013-14**

<b>FY 2013-14</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Hospital Provider Fee Cash Fund</b>	<b>Breast and Cervical Cancer Prevention and Treatment Fund</b>	<b>Reappropriated Funds</b>	<b>Federal Funds</b>
<b>Total Request</b>	<b>(\$31,976,323)</b>	<b>(\$31,592,518)</b>	<b>\$15,506,433</b>	<b>(\$27,075)</b>	<b>\$0</b>	<b>(\$15,863,163)</b>
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$500,000	\$125,000	\$0	\$0	\$0	\$375,000
(2) Medical Services Premiums	(\$31,976,323)	(\$31,592,518)	\$15,506,433	(\$27,075)	\$0	(\$15,863,163)

Appendix B

Table 4.2: New Letternote Totals for FY 2012-13

Long Bill Group	Line Item	Fund	Appropriation Type	COFRS Number	FY 2011-12 Base Request	Requested Total	Incremental Change
(2) Medical Services Premiums	Medical Services Premiums	Hospital Provider Fee Cash Fund	Cash Fund	24A	\$354,420,151	\$369,941,575	\$15,521,424
(2) Medical Services Premiums	Medical Services Premiums	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	\$2,731,400	\$2,706,422	(\$24,978)

**Appendix B**

**Table 5.1 Cash Fund Projections**

<b>Cash Fund Name</b>	<b>Hospital Provider Fee Cash Fund</b>	<b>Breast and Cervical Cancer Prevention and Treatment Fund</b>
<b>Cash Fund Number</b>	24A	15D
<b>FY 2010-11 Expenditures</b>	\$426,069,052	\$2,903,163
<b>FY 2010-11 End of Year Cash Balance</b>	\$22,198,436	\$6,553,278
<b>FY 2011-12 End of Year Cash Balance Estimate</b>	\$22,198,436	\$4,135,739
<b>FY 2012-13 End of Year Cash Balance Estimate</b>	\$22,198,436	\$3,040,811
<b>FY 2013-14 End of Year Cash Balance Estimate</b>	\$22,198,436	\$660,592

**Appendix C**

**Table A.1  
Savings Summary from Preterm Birth Prevention Initiative**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Clients at Risk of Low Birth Weight or Preterm Birth	\$54,846	(\$778,236)	(\$828,576)	Table A.2
B	Clients at Risk of Preterm Birth Only	\$76,769	(\$124,500)	(\$172,032)	Table A.3
<b>C</b>	<b>Total Savings</b>	<b>\$131,615</b>	<b>(\$902,736)</b>	<b>(\$1,000,608)</b>	<b>Row A + Row B</b>

**Table A.2  
Savings for Clients at Risk of Both Preterm Birth and Low Birth Weight**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Average Monthly Potentially Eligible Clients at Risk of Preterm Birth and Low Birth Weight	58	64	71	Estimate based on survey of FY 2009-10 MMIS data by diagnostic code inflated annually by the percentage increase in Medicaid births from FY 2008-09 to FY 2009-10 (10.73%)
B	Cost of 17P treatment per Client	\$725.55	\$725.55	\$725.55	21 doses at \$14.55 administration fee per dose and \$20.00 per dose for the medication
C	Estimated Monthly Cost	\$42,082	\$46,435	\$51,514	Row A * Row B
D	Applicable Months	11	12	12	Assumes August 1, 2011 implementation date
E	Estimated Total Costs	\$462,902	\$557,220	\$618,168	Row C * Row D
F	Average Monthly Avoided Preterm Births	11	12	13	Row A / 5.5 (See Narrative)
G	Applicable Months	4	12	12	Assumes August 1, 2011 implementation date and six months of utilization before clinical results are seen. Also adjusted for cash based accounting.
H	Savings Per Preterm Birth	(\$9,274)	(\$9,274)	(\$9,274)	Based on FY 2009-10 MMIS data
I	Gross Savings	(\$408,056)	(\$1,335,456)	(\$1,446,744)	Row F * Row G
<b>J</b>	<b>Estimated Savings</b>	<b>\$54,846</b>	<b>(\$778,236)</b>	<b>(\$828,576)</b>	<b>Row G + Row K</b>

Appendix C

Table A.3  
Savings for Clients at Risk of Preterm Labor

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Monthly Potentially Eligible Clients at Risk of Preterm Labor	25	28	31	Estimate based on survey of FY 2009-10 MMIS data by diagnostic code inflated annually by the percentage increase in Medicaid births from FY 2009-10 to FY 2010-11 (10.73%)
B	Cost of 17P treatment per Client	\$725.55	\$725.55	\$725.55	21 doses at \$14.55 administration fee per dose and \$20.00 per dose for the medication
C	Estimated Monthly Cost	\$18,139	\$20,315	\$22,492	Row A * Row B
D	Applicable Months	11	12	12	Assumes August 1, 2011 implementation date
E	Estimated Total Costs	\$199,529	\$243,780	\$269,904	Row C * Row D
F	Average Monthly Avoided Preterm Labor	5	5	6	Row A / 5.5 (See Narrative)
G	Applicable Months	4	12	12	Assumes August 1, 2011 implementation date and six months of utilization before clinical results are seen. Also adjusted for cash based accounting.
H	Savings Per Preterm Labor	(\$6,138)	(\$6,138)	(\$6,138)	Based on FY 2009-10 MMIS data
I	Gross Savings	(\$122,760)	(\$368,280)	(\$441,936)	Row F * Row G
J	<b>Estimated Savings</b>	<b>\$76,769</b>	<b>(\$124,500)</b>	<b>(\$172,032)</b>	<b>Row G + Row K</b>

**Appendix C**

**Table B.1  
Synagis PAR Review**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Synagis Expenditure	\$6,833,049	\$7,920,187	\$9,180,289	FY 2010-11 MMIS data inflated annually by the percentage growth in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
B	Estimated Percentage Where Lower Dose Would Have Been Equally Effective	5.30%	5.30%	5.30%	See Narrative
C	Avoidable Expenditure	\$362,152	\$419,770	\$486,555	Row A * Row B
D	Average Monthly Savings	\$30,179	\$34,981	\$40,546	Row C / 12
E	Applicable Months	7	12	12	Assumes November 2011 implementation and adjustments for cash based accounting
<b>F</b>	<b>Estimated Savings</b>	<b>(\$211,253)</b>	<b>(\$419,772)</b>	<b>(\$486,552)</b>	<b>Row D * Row E * -1</b>

**Appendix C**

**Table C.1  
Enhanced Physician Administered Drug Rebate Program**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	FY 2009-10 Expenditure on J-Codes Not Receiving Rebates	\$10,992,329	\$12,741,209	\$14,768,335	Based on FY 2009-10 MMIS claims data inflated annually by the average percentage of pharmacy expenditure growth from FY 2009-10 to FY 2010-11 (15.91%)
B	Estimated Percentage of Collectable Rebates	18.98%	18.98%	18.98%	50% of the FY 2009-10 rebate percentage for those J-Codes the Department collected rebates. (See Narrative)
C	Estimated Collectable Rebates	\$2,086,344	\$2,418,281	\$2,803,030	Row A * Row B
D	Average Monthly Collectable Rebates	\$173,862	\$201,523	\$233,586	Row C / 12
E	Applicable Months	10	12	12	Assumes September 2011 implementation and adjustments for cash based accounting
<b>G</b>	<b>Estimated Savings</b>	<b>(\$1,738,620)</b>	<b>(\$2,418,276)</b>	<b>(\$2,803,032)</b>	<b>Row D * Row E * -1</b>

**Appendix C**

**Table D.1  
Summary of Savings from Reimbursement Rate Alignment for Developmental Screenings Initiative**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Opening Depression Screening Rate and Setting Age Limits	(\$191,302)	(\$248,679)	(\$290,561)	Table D.2
B	Changing Developmental Screening Rate and Setting Age Limits	(\$1,429,272)	(\$1,844,022)	(\$2,141,197)	Table D.3
<b>C</b>	<b>Total Savings</b>	<b>(\$1,620,574)</b>	<b>(\$2,092,701)</b>	<b>(\$2,431,758)</b>	<b>Row A + Row B</b>

**Table D.2  
Opening Depression Screening Rate (Code 99420) and Setting Age Limits**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12<sup>(1)</sup></b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Forecasted Utilization <sup>(2)</sup>	5,569	7,248	8,476	Forecasted using linear regression of historical monthly utilization of code 99420 for clients over age four.
B	Current Rate	\$35.83	\$35.83	\$35.83	Department rate, effective July 1, 2011
C	Estimated Expenditure Under Current Rate	\$199,537	\$259,696	\$303,695	Row A * Row B
D	Forecasted Utilization Under Proposed Age Limits	817	1,093	1,303	Forecasted using linear regression of historical monthly utilization of code 99420 for clients ages eleven to twenty
E	Proposed Rate	\$10.08	\$10.08	\$10.08	Rate based on 100% of Medicare
F	Estimated Expenditure Under Proposed Rate	\$8,235	\$11,017	\$13,134	Row D * Row E
<b>G</b>	<b>Estimated Savings</b>	<b>(\$191,302)</b>	<b>(\$248,679)</b>	<b>(\$290,561)</b>	<b>Row F - Row C</b>

**Appendix C**

**Table D.3  
Changing Developmental Screening Rate (Code 96110) and Setting Age Limits**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12<sup>(1)</sup></b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Forecasted Utilization <sup>(2)</sup>	75,904	97,930	113,712	Forecasted using linear regression of historical monthly utilization of code 96110 for clients up to four years old
B	Current Rate	\$35.83	\$35.83	\$35.83	MMIS rate after 0.75% cut effective July 1, 2011
C	Estimated Expenditure Under Current Rate	\$2,719,640	\$3,508,832	\$4,074,301	Row A * Row B
D	Proposed Rate	\$17.00	\$17.00	\$17.00	Rate based on commercial insurance rates
E	Estimated Expenditure Under Proposed Rate	\$1,290,368	\$1,664,810	\$1,933,104	Row A * Row D
<b>F</b>	<b>Estimated Savings</b>	<b>(\$1,429,272)</b>	<b>(\$1,844,022)</b>	<b>(\$2,141,197)</b>	<b>Row E - Row C</b>

(1) Proposed rate changes will be effective August 1, 2011.

(2) Currently, providers bill code 96110 for both developmental and depression screenings; to estimate the impact of changing the rates separately for the two screenings, the Department assumes that depression screenings were given to clients over the age of four and developmental screenings were given to clients four years old and under. In addition, this analysis takes into account the proposed age limits of zero to four years old for developmental screenings and eleven to twenty years old for depression screenings.

Appendix C

**Table E.1**  
**Summary of Savings from Physician Administered Drug Pricing Adjustments and Unit Limitations**

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Savings from Pricing and Unit Adjustments to J1631	(\$18,551)	(\$21,503)	(\$24,929)	Table E.2
B	Savings from Pricing and Unit Adjustments to J2680	(\$3,710)	(\$4,302)	(\$4,985)	Table E.3
C	Savings from Pricing Adjustment to J2794	(\$337,044)	(\$390,667)	(\$452,824)	Table E.4
<b>D</b>	<b>Total Savings</b>	<b>(\$359,305)</b>	<b>(\$416,472)</b>	<b>(\$482,738)</b>	<b>Row A + Row B + Row C</b>

**Table E.2**  
**Physician Administered Drug Pricing and Unit Limit Adjustments (J1631)**

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Current Reimbursement Per Unit	\$1.34	\$1.34	\$1.34	CY 2010 MMIS Data
B	Total Billed Units	26,300	30,484	35,334	CY 2010 MMIS Data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
C	Total Reimbursement	\$35,242	\$40,849	\$47,348	Row A * Row B
D	Medicare per Unit Reimbursement	\$15.44	\$15.44	\$15.44	Medicare Fee Schedule
E	Adjusted CY 2010 Reimbursed Units Under Unit Limitations	1,081	1,253	1,452	Unit restriction applied to CY 2010 MMIS data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
F	Estimated Reimbursement at Medicare Rate for Adjusted Units	\$16,691	\$19,346	\$22,419	Row D * Row E
<b>G</b>	<b>Estimated Savings</b>	<b>(\$18,551)</b>	<b>(\$21,503)</b>	<b>(\$24,929)</b>	<b>Row F - Row C</b>

Appendix C

**Table E.3  
Physician Administered Drug Pricing and Unit Limit Adjustments (J2680)**

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Current Reimbursement Per Unit	\$0.85	\$0.85	\$0.85	CY 2010 MMIS Data
B	Total Billed Units	22,963	26,616	30,851	CY 2010 MMIS Data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
C	Total Reimbursement	\$19,519	\$22,624	\$26,223	Row A * Row B
D	Medicare per Unit Reimbursement	\$10.88	\$10.88	\$10.88	Medicare Fee Schedule
E	Adjusted CY 2010 Reimbursed Units Under Unit Limitations	1,453	1,684	1,952	Unit restriction applied to CY 2010 MMIS data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
F	Estimated Reimbursement at Medicare Rate for Adjusted Units	\$15,809	\$18,322	\$21,238	Row D * Row E
G	<b>Estimated Savings</b>	<b>(\$3,710)</b>	<b>(\$4,302)</b>	<b>(\$4,985)</b>	<b>Row F - Row C</b>

**Table E.4  
Physician Administered Drug Pricing and Unit Limit Adjustments (J2794)**

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Current Reimbursement Per Unit	\$6.37	\$6.37	\$6.37	CY 2010 MMIS Data
B	Total Billed Units	278,549	322,866	374,234	CY 2010 MMIS Data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
C	Total Reimbursement	\$1,774,357	\$2,056,656	\$2,383,871	Row A * Row B
D	Medicare per Unit Reimbursement	\$5.16	\$5.16	\$5.16	Medicare Fee Schedule
E	Adjusted CY 2010 Reimbursed Units Under Unit Limitations	278,549	322,866	374,234	Unit restriction applied to CY 2010 MMIS data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
F	Estimated Reimbursement at Medicare Rate for Adjusted Units	\$1,437,313	\$1,665,989	\$1,931,047	Row D * Row E
G	<b>Estimated Savings</b>	<b>(\$337,044)</b>	<b>(\$390,667)</b>	<b>(\$452,824)</b>	<b>Row F - Row C</b>

**Appendix C**

**Table F.1  
Increased Utilization of Public Transportation**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14<sup>(2)</sup></b>	<b>Description</b>
A	Estimated Monthly Expenditure Under Current Policy on Base Contract	\$535,740	\$535,740	\$535,740	Based on current contracted service costs and forecasted expenditure for Weld County
B	Estimated Monthly Expenditure Under Incentive Program on Base Contract <sup>(1)</sup>	\$508,276	\$508,276	\$508,276	Based on maximum allowable contractor bids as stated in the current request for NEMT proposals
C	Difference	(\$27,465)	(\$27,465)	(\$27,465)	Row A - Row B
D	Applicable Months	5	12	12	Assumes January 1, 2012 implementation date and adjustments for cash based accounting
E	Maximum Contractor Incentive Payment	\$30,000	\$120,000	\$120,000	Maximum of \$10,000 monthly contingent up the contractor successfully hitting public transportation utilization targets (paid quarterly).
F	One-time Cash Savings from Transition to Retrospective Payment System	(\$508,276)	\$0	\$0	See Narrative
<b>G</b>	<b>Estimated Savings</b>	<b>(\$615,598)</b>	<b>(\$209,574)</b>	<b>(\$209,574)</b>	<b>(Row C * Row D) + Row E + Row F</b>

(1) While the Department has estimated the monthly contract amount, contractors have yet to bid. This amount may vary.

(2) Under the fixed price contract, savings will be the same in FY 2013-14 as in FY 2012-13

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Table G.1  
Unit Cap of 48 Units on Home Health Therapies

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Monthly Reimbursed Units Over the Proposed Cap of 48	328	345	363	CY 2010 MMIS data inflated annually by the percentage growth in home health expenditure from FY 2009-10 to FY 2010-11 (5.09%)
B	Estimated Percentage of Units That Will Qualify for Exemption	10%	10%	10%	See Narrative
C	Average Monthly Avoidable Units	295	311	327	Row A * (1- Row B)
D	Applicable Months	2	12	12	Assumes Implementation April 1, 2012 and adjustments for cash based accounting
E	Estimated Total Units Over the 48 Unit Cap	656	4,140	4,356	Row A * Row C
F	Average Cost per Unit of Home Health Therapy	\$92.38	\$92.38	\$92.38	CY 2010 MMIS Data
G	<b>Estimated Savings</b>	<b>(\$60,601)</b>	<b>(\$382,453)</b>	<b>(\$402,407)</b>	<b>Row B * Row D * -1</b>

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**Table H.1**  
**Limit Home Health Care to 8 Hours per Day**

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Estimated Monthly Units Reimbursed for Clients Exceeding the 8 Hour Limit	73,192	76,917	80,832	CY 2010 MMIS data inflated annually by the percentage growth in home health expenditure from FY 2009-10 to FY 2010-11 (5.09%)
B	Percentage of Units Over the 8 Hour Cap	21.94%	21.94%	21.94%	Based on CY 2010 MMIS data
C	Estimated Monthly Units Over the 8 Hour Cap	16,058	16,876	17,735	Row A * Row B
D	Estimated Percentage of Units Over the 8 Hour Cap That Would Qualify for an Exemption	10%	10%	10%	See Narrative
E	Estimated Average Monthly Avoidable Units	14,452	15,188	15,962	Row C * (1 - Row D)
F	Applicable Months	2	12	12	Assumes April 1, 2012 implementation and adjustments for cash-based accounting
G	Total Avoidable Units over 8 Hour Cap	28,904	182,256	191,544	Row E * Row F
H	Average Cost per Unit	\$22.59	\$22.59	\$22.59	Based on CY 2010 MMIS data
<b>I</b>	<b>Estimated Savings</b>	<b>(\$652,941)</b>	<b>(\$4,117,163)</b>	<b>(\$4,326,979)</b>	<b>Row G * Row H * -1</b>

**Appendix C**

**Table I.1  
Seroquel Restrictions**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Expenditure on Low Dose Units of Seroquel	\$4,760,281	\$5,517,642	\$6,395,499	FY 2010-11 MMIS Data inflated annually by the percentage growth in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
B	Percentage of Low Dose Units Likely to be Off Label Use	70%	70%	70%	See Narrative
C	Estimated Off Label Use Seroquel Expenditure	\$3,332,197	\$3,862,349	\$4,476,849	Row A * Row B
D	Estimated Increase in Expenditure for Substitutes of Off Label Use Seroquel	\$1,666,099	\$1,931,175	\$2,238,425	Row C * (50%) - Based on the ratio of the average cost of Seroquel substitutes to Seroquel
E	Estimated Net Savings	(\$1,666,099)	(\$1,931,175)	(\$2,238,425)	Row D - Row C
F	Average Monthly Savings	(\$138,842)	(\$160,931)	(\$186,535)	Row E / 12
G	Applicable Months	5	12	12	Assumes January 2012 implementation and adjustments for cash based accounting
<b>H</b>	<b>Estimated Savings</b>	<b>(\$694,210)</b>	<b>(\$1,931,172)</b>	<b>(\$2,238,420)</b>	<b>Row F * Row G</b>

**Appendix C**

**Table J.1  
Dental Efficiencies**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Estimated Average Monthly Expenditure on Orthodontics	\$1,207,623	\$1,367,995	\$1,549,665	FY 2010-11 MMIS Data inflated annually by the percentage growth in dental expenditure from FY 2009-10 to FY 2010-11 (13.28%)
B	Estimated Percentage of Reduced Expenditure Under New Definition	10%	10%	10%	See Narrative
C	Monthly Savings	(\$120,762)	(\$136,800)	(\$154,967)	Row A * Row B * -1
D	Number of Applicable Months in Fiscal Year	5	12	12	Assumes implementation of January 2012 and cash based accounting adjustments
<b>E</b>	<b>Estimated Savings</b>	<b>(\$603,812)</b>	<b>(\$1,641,594)</b>	<b>(\$1,859,598)</b>	<b>Row C * Row D</b>

**Appendix C**

**Table K.1  
Augmentative Communication Device (ACD) Options**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Average Monthly ACD Units Purchased	11	12	13	Based on FY 2010-11 data with an annual trend equal to the percentage change in durable medical equipment expenditure from FY 2009-10 to FY 2010-11 (8.02%)
B	Cost per Unit	\$6,500.00	\$6,500.00	\$6,500.00	Based on average invoice pricing
C	Current Average Monthly Expenditure	\$71,500	\$78,000	\$84,500	Row A * Row B
D	Monthly Number of Clients that Would Opt for the ACD Step-down Options Instead of an ACD	9	10	10	Assumes only an 80% conversion as not all clients would be able to use the ACD step-down unit due to dexterity deficiencies (See Narrative)
E	Monthly Number of Clients that elect to obtain ACD Step-down Option That Would NOT have Otherwise Obtained an ACD Despite Qualifying	18	20	20	Assumes 200% more utilization by those that are eligible for a ACD but elect not to obtain one than those that are eligible and would have chosen an ACD
F	Total Monthly ACD Step-down Option Purchases	27	30	30	Row D + Row E
G	Average Cost of the ACD Step-down Option with Required Communication Applications	\$800.00	\$800.00	\$800.00	Estimate based on average retail value of ACD step-down device
H	Monthly Expenditure on ACD Step-down Option	\$21,600	\$24,000	\$24,000	Row F * Row G
I	Monthly Expenditure on ACDs when ACD Step-down Option is Available	\$13,000	\$13,000	\$19,500	(Row A - Row D) * Row B
J	Total Monthly Expenditure when ACD Step-down Option is Available	\$34,600	\$37,000	\$43,500	Row H + Row I
K	Difference Between Monthly Expenditure	(\$36,900)	(\$41,000)	(\$41,000)	Row J - Row C
L	Applicable Months	5	12	12	Assumes January 2012 implementation and adjustments for cash based accounting
<b>M</b>	<b>Estimated Savings</b>	<b>(\$184,500)</b>	<b>(\$492,000)</b>	<b>(\$492,000)</b>	<b>Row K * Row L</b>

**Appendix C**

**Table L.1  
Sole Source DME Provider**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Description</b>
A	Average Units of Test Strips Purchased per Month	6,459	7,317	8,289	FY 2009-10 MMIS data inflated annually by the percentage growth in DME expenditure from FY 2009-10 to FY 2010-11 (13.28%)
B	Price Per Unit Under Current Policy	\$18.00	\$18.00	\$18.00	Fee Schedule
C	Price Per Unit Under Sole Source	\$13.50	\$13.50	\$13.50	Based on estimates provided by DME suppliers
D	Difference in Price Per Unit	(\$4.50)	(\$4.50)	(\$4.50)	Row C - Row B
E	Monthly Savings on Test Strips	(\$29,066)	(\$32,927)	(\$37,301)	Row A * Row D
F	Average Monthly Units of Meters	1,406	1,593	1,805	FY 2009-10 MMIS data inflated annually by the percentage growth in DME expenditure from FY 2009-10 to FY 2010-11 (13.28%)
G	Average Cost per Unit	\$45.00	\$45.00	\$45.00	Average based on FY 2009-10 MMIS data
H	Average Monthly Saving from Meters	(\$63,270)	(\$71,685)	(\$81,225)	Row F * Row G * -1 (all meters provided free of charge)
J	Applicable Months	-	11	12	Assumes July 2012 implementation and adjustments for cash based accounting
<b>K</b>	<b>Estimated Savings</b>	<b>\$0</b>	<b>(\$1,150,732)</b>	<b>(\$1,422,312)</b>	<b>(Row E + Row H) * Row J</b>

**Appendix C**

**Table M.1  
Continuation of FY 2011-12 1.5% Nursing Facility Reduction**

<b>Row</b>	<b>Item</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>	<b>Notes</b>
A	Estimated FY 2012-13 Per Diem for Core Components <sup>(1)</sup>	\$185.69	\$191.26	\$197.00	FY 2011-12 estimate inflated by the maximum allowable growth under current legislation (3%)
B	Rate Under Continuation of 1.5% Reduction		\$188.39	\$194.05	Row A * (1 - 0.015)
C	Difference		(\$2.87)	(\$2.95)	Row B - Row A
D	Estimated Covered Days of Service <sup>(1)</sup>	3,238,178	3,400,087	3,417,087	FY 2011-12 estimate inflated by 0.5%
E	Estimated Percentage of Covered Days Reported in the Same Fiscal Year In		92.46%	92.46%	See Narrative
F	Current Year's Dates of Service Reported in Current Fiscal Year		3,143,720	3,159,439	Row D * Row E
G	Savings For Current Year's Dates of Service		(\$9,024,677)	(\$9,320,345)	Row C * Row G
H	Savings for Prior Year's Dates of Service		\$0	(\$735,951)	Row C * (Row D - Row F) using prior year's figures
<b>G</b>	<b>Estimated Savings</b>		<b>(\$9,024,677)</b>	<b>(\$9,320,345)</b>	<b>Row G + Row H</b>

(1) As reported in the Department's February 15, 2011 Medical Services Premiums Supplemental Request.

of the current dispensing fee; however, preliminary analysis by the Department based on the results from other states suggests a dispensing fee of \$8.00 to \$10.00 may be recommended. For reference, with approximately 3,783,212 prescriptions filled in FY 2010-11, an increase of the dispensing fee to \$9.00 would generate an increase of \$18,916,060 reimbursement in dispensing fees; to achieve a net reduction of \$4,000,000 total funds, the Department would implement a \$22,916,060 reduction in material component reimbursement.

It is important to recognize that, while these figures are large, reimbursement under AWP pricing blurred the distinction between material acquisition costs and service provision costs. While providers were reimbursed at a level that approximated their acquisition costs plus costs of providing service at the aggregate level, these two components could not be cleanly separated from one another. The significant increase to the dispensing fee and decrease to material reimbursement under SMAC/WAC pricing signifies the magnitude of distortion between relative costs for the two components under the AWP pricing methodology, not a change in aggregate level of reimbursement to pharmacies.

### **Utilization Management Vendor Funding**

As a result of the proposed initiatives, the Department anticipates that there will be an increase in required prior authorizations and medical reviews. The Department requests \$250,000 total funds, \$62,500 General Fund in FY 2011-12 annualizing to \$500,000 total funds, \$125,000 General Fund in FY 2012-13 to increase its current utilization review program. This funding will add the capacity to perform 12,500 additional prior authorizations and reviews at approximately \$40 per prior authorization. The actual cost per review will depend on the specific requirements developed on the Department's utilization review contractor. These reviews will be related to the Seroquel reviews, Synagis reviews, dental efficiencies, and home health limitations. It is unknown at this time how many new prior authorizations will be performed. However, if funding for utilization reviews is not adequate, the Department may not achieve the savings proposed in this request.

### **Hospital Provider Fee Financing**

Through Upper Payment Limit (UPL) financing, the Department is able to increase Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund. This is accomplished by certifying the uncompensated costs from these entities as public expenditure. The matching federal funds are then accounted for as General Fund offset in the current year. With the implementation of the Health Care Affordability Act of 2009 (HB 09-1293), the Department is no longer able to certify public expenditure for outpatient hospitals as the hospital provider fee program brings Medicaid payment to hospitals up to the UPL.

Section 25.5-4-402.3(4)(b)(VII), C.R.S. (2011) states that the Hospital Provider Fee Cash Fund may be utilized to offset the loss of any federal matching funds due to a decrease in certification of public expenditure for outpatient hospital services. Therefore, for this request the Department would utilize funding from the Hospital Provider Fee cash fund to offset the increase to General Fund in the Medical Services Premiums line incurred due to a loss of certification of public expenditure. Each year, a total of \$15,700,000 would be reserved from the Hospital Provider Fee cash fund for this purpose. To account for this transfer, the Department's appropriation for FY 2012-13, and each subsequent fiscal year, should be adjusted to increase cash funds expenditure by \$15,700,000 from the Hospital Provider Fee cash fund, and General Fund should be decreased by a corresponding \$15,700,000.