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
Priority Number: BA-13

Dept. Approval by: John Bartholomew JB **Date:** January 25, 2010 1/22/10
OSPB Approval: **Date:** 1-22-10

	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	2,644,862,260	2,715,308,963	0	2,715,308,963	3,154,785,608	(2,532,684)	3,152,252,924	375,000	3,152,627,924	(4,809,041)
	FTE	266.1	287.8	0.0	287.8	317.0	0.9	317.9	0.0	317.9	1.0
	GF	1,008,070,364	1,219,254,957	0	1,219,254,957	1,245,142,192	(454,577)	1,244,687,615	187,500	1,244,875,115	(1,130,438)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,791,140	168,597,924	0	168,597,924	357,612,743	(219,260)	357,393,483	0	357,393,483	(456,703)
	CFE/RF	4,245,540	4,439,707	0	4,439,707	4,679,994	0	4,679,994	0	4,679,994	0
	FF	1,482,503,424	1,323,016,375	0	1,323,016,375	1,547,350,679	(1,858,847)	1,545,491,832	187,500	1,545,679,332	(3,221,900)
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	19,502,741	20,901,734	0	20,901,734	22,608,612	48,699	22,657,311	0	22,657,311	53,126
	FTE	266.1	287.8	0.0	287.8	317.0	0.9	317.9	0.0	317.9	1.0
	GF	8,010,994	8,645,285	0	8,645,285	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	618,917	0	618,917	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	10,057,943	0	10,057,943	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	2,010,111	0	2,010,111	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	975,474	0	975,474	691,404	2,810	694,214	0	694,214	475
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	13,014	17,114	0	17,114	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	1,004,062	0	1,004,062	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	1,298,595	3,711,605	0	3,711,605	3,910,800	157,000	4,067,800	375,000	4,442,800	532,000
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	771,478	1,455,543	0	1,455,543	1,320,400	78,500	1,398,900	187,500	1,586,400	266,000
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	326,250	0	326,250	562,500	0	562,500	0	562,500	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	527,117	1,929,812	0	1,929,812	2,027,900	78,500	2,106,400	187,500	2,293,900	266,000

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:** January 25, 2010
Priority Number:	BA-13	**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
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	22,200,548	27,834,289	0	27,834,289	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	6,708,927	0	6,708,927	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	538,643	0	538,643	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	20,486,391	0	20,486,391	28,087,875	34,398	28,122,273	0	28,122,273	0
(2) Medical Services Premiums	**Total**	2,526,991,443	2,572,042,638	0	2,572,042,638	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	1,112,661,142	0	1,112,661,142	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	167,097,000	0	167,097,000	352,549,563	(232,747)	352,316,816	0	352,316,816	(456,703)
	CFE/RF	2,631,068	2,746,329	0	2,746,329	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,289,538,167	0	1,289,538,167	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	0	0	0	0	194,124	194,124	0	194,124	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	13,487	13,487	0	13,487	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	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:** January 25, 2010
Priority Number:	BA-13	**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; 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:	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:	BA-13
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 $375,000 in total funds for FY 2010-11, including $187,500 from the General Fund, and $375,000 in total funds for FY 2011-12, including $187,500 from the General Fund, for the implementation of proposed steps toward payment coordination and payment reform. This request amends the Department's Base Reduction Item 2, "Coordinated Payment and Payment Reform," submitted November 6, 2009. See tables B.1, B.2, and B.3 for the total impact of these requests in FY 2010-11 and 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 in federal requirements with regard to pharmacy claims submitted by physicians and hospitals.

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

In alignment with these reform efforts, the Department's November 6, 2009 FY 2010-11, Budget Request included four initiatives as part of the proposed Budget Reduction Item, Coordinated Payment and Payment Reform (COPPR): consolidation of payment and billing processes for 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, and increase enrollment of Medicare-eligible clients into Medicare.

To further these efforts, the Department now requests authority for three additional 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 three 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.

General Description of Request:

This request is for $375,000 in total funds for FY 2010-11, including $187,500 from the General Fund, and $375,000 in total funds for FY 2011-12, including $187,500 from the General Fund, for the implementation of proposed steps toward payment coordination and payment reform. This request amends the Department's Base Reduction Item 2, "Coordinated Payment and Payment Reform," submitted November 6, 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

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

care. The payment reform component supports the goal through performance-based payment structures which incentivize desired outcomes.

This request includes a combination of three proposed changes which complement each other and, if approved, would enable the Department to realize long term efficiency savings. The initiatives in this proposal include requests for the funding of contracted services. The requested funds for contractors are estimated based on the usual cost for rate setting work, and on the expected complexity of the initiative. The annual cost of rate setting for provider types such as Health Management Organizations (HMOs), Program for All-Inclusive Care for the Elderly (PACE) and Behavioral Health Organizations (BHOs) typically are between $150,000 and $200,000. The requested annual contractor cost for each of the initiatives in this request falls at or below the low end of this scale.

Payment Coordination

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 Coordination Initiatives Proposed in the Department's Base Budget Request

The Department's November 6, 2009, Budget Request included four practical and specific initiatives toward payment coordination which were part of the proposed Budget Reduction Item, Coordinated Payment and Payment Reform (COPPR). These initiatives are:

- Consolidation of Payment and Billing Processes (Federally Qualified Health Centers and Behavioral Health Organizations): Eliminate a manual work-around utilized to reimburse claims for mental health services provided by Federally Qualified Health Centers.
- 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.

This request proposes a fifth payment coordination initiative to develop an integrated care model for dual-eligible clients.

Integrated Care of Dual Eligible Clients

As part of this initiative, the Department requests $150,000 in total funds including $75,000 General Fund for FY 2010-11, and an additional $150,000 in total funds including $75,000 General Fund for FY 2011-12, to hire a contractor to seek cost efficiencies through an integrated approach to the care management of clients who are eligible for both Medicare and Medicaid ("dual eligibles"). In addition, the contractor would develop a rate structure to pay for the care of these clients which would enable both Medicare and the Department to realize a share of the savings. The Department expects the workload to be similar to rate setting work for other provider types, which typically have annual costs between $150,000 and $200,000.

According to a 2008 study by The Lewin Group, "Dual eligibles currently account for 10% of all national health expenditures and 1.6% of the nation's Gross Domestic Product (GDP). This population is predominantly served through the traditional fee-for-service (FFS) coverage model."[3] The dual eligible population continues to grow, and coupled with typical fee-for-service per capita cost increases, the future costs of serving these clients is expected to significantly increase from already high levels.

In September 2009, 54,273 full-benefit dual eligible clients were enrolled in Medicaid in Colorado. Many of these individuals are high needs and high cost clients. For example, estimated per capita spending in FY 2009-10 for the Department's Adults 65 and Older population, where approximately 85% of the population is dual-eligible, is $20,438 for a

[3] The Lewin Group. November 2008. "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities," p. 3.

total annual fiscal impact of $788,018,426.[4] The Department seeks to control and reduce the cost of providing services to clients in this eligibility group through benefit design and payment coordination. Specifically, the Department proposes an integrated care plan between Medicare and Medicaid. The Lewin study points out that "the dual eligible population experiences extremely high per capita medical costs in the areas that an integrated coverage model can favorably impact, e.g., inpatient hospital, outpatient hospital, specialist physician, pharmacy and nursing homes."[5]

One vehicle for integrating care of the dual eligible population is the current infrastructure of Special Needs Plans (SNPs). An SNP is a type of Medicare Advantage Plan created under the Medicare Modernization Act of 2003 (MMA). Other Medicare Advantage Plans include: Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private Fee-for-Service plans. Medicare clients who are in a defined Special Needs demographic may enroll in one of the SNPs, which more comprehensively serves their needs. The SNP which is part of this request was specifically created under the MMA to serve dual eligible clients.

If this request is funded, the Department would develop a pilot program to more effectively and cost-efficiently coordinate care and to develop a financing mechanism that allows Medicaid to realize cost savings within an existing Special Needs Plan. However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), SNPs which currently service dual eligible clients may not expand to serve additional clients in this category until new requirements for reporting and benefits are met. If SNPs choose not to meet these requirements, the Department would be limited in the ability to serve additional dual eligible clients through SNPs. In order to maximize the potential for future expansion of serving dual eligible clients, the Department would also develop an alternative non-Special Needs Plan methodology. Colorado would be one of the first states to develop a non-SNP methodology and therefore identify state

[4] Per capita and expenditure costs are from the Department's November 6, 2009 Budget Request, Decision Item 1, "Request for Medical Services Premiums," Exhibit E, page EE-1.

[5] Lewin, p. 5.

resources that have not previously been used to serve this population. Most states which are developing an integrated program for dual eligibles do so within the SNP framework; however, a non-SNP alternative may be better capable of meeting MIPPA requirements and may be a way to serve a larger population of dual eligible clients through a managed care plan.

The Department would work with the federal partner, Medicare, to coordinate care and to share cost savings. The integrated care plan would encompass both a model of care and a payment methodology. Instead of clients having to navigate through multiple health care delivery systems, the Department would have a coordinated set of benefits and simplified payment structures. For example, the methodology could increase coordination of care among hospitals, physicians, nursing facilities and providers of home health and home and community-based services. Many of the services dual eligible clients receive from these providers are covered to differing degrees by both Medicare and Medicaid. An integrated care model would not only improve access for the clients, but it is a more efficient model which would enable both the Department and Medicare to realize savings while improving the quality of care received by these clients.

A problem experienced by other states pursuing an integrated care model is that if a new model is implemented without also implementing a new payment system, most of the savings are realized by Medicare with very little, if any, savings to Medicaid. In fact, the Lewin Group projected that Colorado would experience initial Medicaid costs by implementing an integrated care model before realizing long term savings.[6] This request is to develop a new integrated model of care which would be implemented simultaneously with a new payment methodology so that both Medicaid and Medicare realize a share of the savings from the implementation of the new model.

Colorado is one of seven states to participate in The Center for Health Care Strategies state initiative, "Transforming Care for Dual Eligibles," which makes the Department eligible to receive technical assistance, training and advising while developing an

[6] Lewin, p.28.

integrated strategy for this client population if this request is approved. This assistance would enable the Department to more efficiently implement this request.

In FY 2010-11, under the Department's direction, the contractor would research and develop the integrated care model and payment methodology. In FY 2011-12, MMIS systems impacts would be identified, and data would be collected and analyzed to determine the estimated cost savings which may be realized upon full implementation of an integrated care model.

Using FY 2004-05 expenditure data, The Lewin Group projected that, if an integrated care model for dual eligible clients were to be implemented in Colorado in January 2010, the state could save approximately 3% in total expenditure across both Medicaid and Medicare, $51,066,425 in the initial year, with savings increasing to 6%, $119,113,378 per year, by the fifth year of implementation.[7] However, the Department is not assuming cost savings as part of this Request, as it is unknown what reforms the Department and its contractor would propose after the initial planning stages. As such, it is not fully known what savings might be achieved, or if the savings estimated by the Lewin Group (which are based on national data and extrapolated to the state-level) will be accurate or achievable. Once a plan for implementation is determined, the Department would submit additional budget requests in the future with savings estimates based on the actual implementation details.

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, this request is to fund the development of methodologies to restructure payments which would enable full facilitation of an outcomes-based program.

[7] Lewin, p. 26, Table 6.

In support of this goal, this request includes two specific and tangible payment reform initiatives: Physician Payment Reform and Waiver Rate Reform. This request is to conduct a comprehensive one-year study to determine national best practices in rate reform and to develop payment methodologies which would be utilized in "shadow pricing" modeling during the second fiscal year. The modeling would utilize actual claims data to analyze the expenditure of the proposed methodologies. Shadow pricing works in this way: claims would be paid utilizing existing methodology, while the "shadow" model would process claims in tandem using the proposed methodologies, but without actually paying them, to evaluate the proposed methodology and inform the recommendation for future reform implementation. This two-step process to be conducted over two years would enable the Department to gain valuable insight from other state efforts while at the same time creating a means by which the Department could evaluate proposed changes in payment methodologies for practicality in reducing the expenditure for services provided to Colorado's Medicaid clients.

Physician Payment Reform

This request is for $100,000 in total funds, including $50,000 General Fund for FY 2010-11 and an additional $100,000 in total funds, including $50,000 General Fund for FY 2011-12 to hire a contractor to create a new outcomes-based rate structure for payments to physicians. In FY 2010-11, the contractor would be tasked with developing the new rate structure while maintaining an ongoing dialogue with the physician community, as directed by the Department. In FY 2011-12, the contractor would use actual claims data to analyze the impact of restructuring the rates. The Department is requesting an annual amount for contract services which is lower than rate setting work for other providers since fully-developed rates will not be required within one year.

This proposal is not a request to change the rate methodology. However, the requested research would inform future rate reform decisions. The research would use a methodical approach with actual claims data to examine how an outcomes-based method 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.

The first step is to conduct a review of current research, other states' practices and also seek federal guidance. This is to ensure that efforts are not duplicated and also enables the Department to learn from the experience of other state Medicaid departments. This is important since funding is limited, and it is imperative that the Department perform reform efforts in the most efficient manner. Once the contractor is up to speed with national reform efforts, the conclusions and findings would be analyzed for applicability toward meeting the Department's needs. By the end of FY 2010-11, the contractor would have an alternative rate structure ready for analysis using actual claims data.

In FY 2011-12, actual data from claims paid for physician services using the existing fee-for-service rate structure would also be "shadow priced" using the alternative, outcomes-based structure. By the end of FY 2011-12, the contractor would report on the estimated impact of the new structure, and this report will inform the Department of future steps toward physician rate reform. This timeline would allow the Department to submit a budget action in FY 2012-13, for broad-scale implementation of physician payment reform to begin in FY 2013-14.

Waiver Rate Reform

The waiver rate reform proposal is similar to the physician payment reform. This request is for $125,000 in total funds, including $62,500 General Fund for FY 2010-11 and an additional $125,000 in total funds, including $62,500 General Fund for FY 2011-12 to hire a contractor to research the potential of applying an outcomes-based approach to the payment of claims for waiver services. The requested funds, which are higher than those requested for physician payment reform, reflect the higher complexity of waiver service pricing as compared to payments to physicians. As with physician payment reform, the Department is requesting an annual amount for contract services which is lower than typical rate setting work for other providers since fully-developed rates will not be required within one year.

Waiver 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; individuals with AIDS; and, clients who have suffered a traumatic brain injury. In FY 2010-11, the

contractor would develop an alternative outcomes-based rate structure for two of the largest Home and Community Based Services waivers. In FY 2011-12, actual claims data would be used to analyze the impact of restructuring the rates.

As with the initiative to reform physician payments, the first step in exploring waiver rate reform is to conduct a review of current research and of other states' practices, and the findings would be analyzed for applicability toward meeting the Department's needs. In FY 2011-12, actual data from claims paid for waiver services using the existing fee-for-service rate structure would also be "shadow priced" using the alternative, outcomes-based structure. As with physician payment reform, this initiative is not a request to change the rate methodology. However, the requested research would inform future rate reform decisions.

A primary difference in this initiative as compared with the initiative to reform physician payments is that the results of this initiative may not just recommend a restructuring of the rate structure of waiver services, but may recommend restructuring the waivers. Colorado differs from many states in having many waiver programs. Having a large number of waivers is not always the most efficient way to deliver services, and some of Colorado's waivers have issues with client access and long wait lists. This request differs from previous attempts to provide economic incentives for better care in that this is a methodical, comprehensive project which would include extensive data analysis to quantify impacts.

The efforts requested in this initiative may result in reduced wait lists and increased access for Colorado's disabled community. In fact, a measure of increased access would likely be a specific performance metric utilized in the outcomes-based rate structure.

The timeline for this initiative mirrors that of the physician payment reform. In FY 2010-11, the contractor would research national best practices and develop an alternative rate structure for two of the Department's largest waiver programs. In FY 2011-12, actual data from claims paid for waiver services would be "shadow priced" using the alternative, outcomes-based structure. By the end of FY 2011-12, the contractor would report on the estimated impact of the new structure. This timeline would allow the

Department to submit a budget action in FY 2012-13, for broad-scale implementation of waiver rate reform to begin in FY 2013-14.

Future Payment Coordination and Payment Reform Efforts

If the request is approved, at the conclusion of the exploratory period, the Department may request contractor funding as well as funding for IT system and other implementation costs as appropriate to implement alternative rate methodologies as determined by the recommendations made as part of the scope of this request.

Consequences if Not Funded:

If this request is not funded, 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. In order for the Department to achieve efficiencies and savings in the longer term, it is imperative that the Department lays the groundwork for future reform efforts.

If the Integrated Care of Dual Eligible Clients initiative is not approved, the Department would not be able to take advantage of technical assistance, training and advising from The Center for Health Care Strategies. In addition, due to the impact of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), changes to Special Needs Plans will be made to meet this legislation. Developing a pilot non-SNP alternative for dual eligibles who have a disability is part of state statute and delaying implementation of this program may jeopardize the Department's ability to meet its statutory requirements.

Calculations for Request:

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**$375,000**	**$187,500**	**$0**	**$0**	**$187,500**	**0.0**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$375,000	$187,500	$0	$0	$187,500	0.0

Note: This table matches the schedule 13, column 8; this table presents the incremental difference this request, BA-13, has upon the previously submitted request, BRI-2 (presented in column 6).

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**$375,000**	**$187,500**	**$0**	**$0**	**$187,500**	**0.0**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$375,000	$187,500	$0	$0	$187,500	0.0

Note: This table presents the incremental difference this request, BA-13, has upon the previously submitted request, BRI-2 for the out-year. It does not match the schedule 13. The Department intends this request to amend the original COPPR request, BRI-2. The Schedule 13 presents the combined impact of the two requests in column 10. See tables B.1, B.2, and B.3 in the appendix for the derivation of the out year impact.

Assumptions for Calculations: Assumptions are noted in the narrative above and summarized in the table below.

	FY 2010-11			FY 2011-12		
Component	**Total Funds**	**General Fund**	**Federal Funds**	**Total Funds**	**General Fund**	**Federal Funds**
Payment Coordination						
Integrated Care of Dual Eligibles	$150,000	$75,000	$75,000	$150,000	$75,000	$75,000
Payment Reform						
Physician Payment Reform	$100,000	$50,000	$50,000	$100,000	$50,000	$50,000
Waiver Rate Reform	$125,000	$62,500	$62,500	$125,000	$62,500	$62,500
Total Request	**$375,000**	**$187,500**	**$187,500**	**$375,000**	**$187,500**	**$187,500**

The Department assumes that there is no impact from enhanced federal matching funds due to the American Recovery and Reinvestment Act (ARRA), since the total request represents administrative costs.

The requested funds for contractors are estimated based on the usual cost for rate setting work, and on the expected complexity of the initiative. The annual cost of rate setting for provider types such as Health Management Organizations (HMOs), Program for All-Inclusive Care for the Elderly (PACE) and Behavioral Health Organizations (BHOs) typically are between $150,000 and $200,000. The requested annual contractor cost for each of the initiatives in this request falls at or below the low end of this scale.

Impact on Other Government Agencies: None

Cost Benefit Analysis:

While a quantitative cost-benefit analysis is not applicable to this request, the Department believes that there are significant benefits to this proposal, including:

- 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

The Department believes that the benefits of these initiatives outweigh the costs.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	March 2010 – June 2011
RFP Issued	March 2010
Contract or MOU Awarded/Signed	June 2010
Start-Up Date	July 2010
Initial Phase of Rate Reform Initiatives Completed (i.e., review of best practices)	June 2011
Second Phase of Rate Reform Initiatives Completed (i.e., shadow pricing)	June 2012

Statutory and Federal Authority:

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.

Performance Measures:

This Change Request affects the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs.
- 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.
- Increase number of clients enrolled in community based settings.

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.

Table A.1
Medical Services Premiums Cash Funds Report: Combined COPPR Impact (BRI-2 and BA-13)

Cash Fund	FY 2009-10			FY 2010-11		
	Spending Authority	Request	Change	Spending Authority	Request	Change
Certified Funds	$22,707,094	$22,707,094	$0	$21,498,147	$21,498,147	$0
Hospital Provider Fee Cash Fund	$41,415,100	$41,415,100	$0	$212,806,547	$212,806,547	$0
Health Care Expansion Fund	$82,475,369	$82,475,369	$0	$85,416,768	$85,197,508	($219,260)
Breast and Cervical Cancer Prevention and Treatment Fund	$1,733,316	$1,733,316	$0	$1,725,479	$1,725,479	$0
Colorado Autism Treatment Fund	$784,875	$784,875	$0	$784,875	$784,875	$0
Coordinated Care for People with Disabilities Fund	$250,000	$250,000	$0	$250,000	$250,000	$0
Nursing Facility Cash Fund	$26,294,630	$26,294,630	$0	$27,040,854	$27,040,854	$0
Comprehensive Primary and Preventive Care Fund	$2,638,017	$2,638,017	$0	$3,026,893	$3,026,893	$0
Pediatric Specialty Hospital Fund	$10,013	$10,013	$0	$0	$0	$0
Tobacco Education Program Fund	$15,000,000	$15,000,000	$0	$0	$0	$0
Health Disparities Grant Program Fund	$1,000,000	$1,000,000	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$6,000,000	$6,000,000	$0	$0	$0	$0
Prevention, Early Detection, and Treatment Fund	$19,000,000	$19,000,000	$0	$0	$0	$0
Primary Care Fund	$7,400,000	$7,400,000	$0	$0	$0	$0
Total	**$226,708,414**	**$226,708,414**	**$0**	**$352,549,563**	**$352,330,303**	**($219,260)**

Table B.1
Summary of Complete COPPR Request

Combined COPPR: Summary of Request FY 2010-11						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**($2,157,684)**	**($267,077)**	**($219,260)**	**$0**	**($1,671,347)**	**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	$532,000	$266,000	$0	$0	$266,000	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
Combined COPPR: Summary of Request FY 2011-12						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**($4,809,041)**	**($1,130,438)**	**($456,703)**	**$0**	**($3,221,900)**	**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	$532,000	$266,000	$0	$0	$266,000	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

Table B.2
Summary of Individual COPPR Requests - FY 2010-11

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
BRI-2: Summary of Request FY 2010-11						
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
BA-13: Summary of Request FY 2010-11						
Total Request	**$375,000**	**$187,500**	**$0**	**$0**	**$187,500**	**0.0**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$375,000	$187,500	$0	$0	$187,500	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	$0	$0	$0	$0	$0	0.0
(2) Medical Services Premiums; Long Bill Group Total	$0	$0	$0	$0	$0	0.0

Table B.3
Summary of Individual COPPR Requests - FY 2011-12

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
BRI-2: Summary of Request FY 2011-12						
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
BA-13: Summary of Request FY 2011-12						
Total Request	**$375,000**	**$187,500**	**$0**	**$0**	**$187,500**	**0.0**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$375,000	$187,500	$0	$0	$187,500	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	$0	$0	$0	$0	$0	0.0
Total of Both Requests	**($4,809,041)**	**($1,130,438)**	**($456,703)**	**$0**	**($3,221,900)**	**1.0**