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 JB	**Date:** November 2, 2009 10/20/09
Priority Number:	BRI-2	**OSPB Approval:**		**Date:** 10-30-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,644,862,260	2,685,778,769	0	2,596,970,183	3,154,785,608	(2,532,684)	3,152,252,924	0	3,152,252,924	(5,184,041)
	FTE	266.1	287.6	0.0	287.6	317.0	0.9	317.9	0.0	317.9	1.0
	GF	1,008,070,364	877,283,555	0	1,053,465,012	1,245,142,192	(454,577)	1,244,687,615	0	1,244,687,615	(1,317,938)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,791,140	171,911,010	0	229,811,201	357,612,743	(219,260)	357,393,483	0	357,393,483	(456,703)
	CFE/RF	4,245,540	4,432,897	0	4,432,897	4,679,994	0	4,679,994	0	4,679,994	0
	FF	1,482,503,424	1,632,151,307	0	1,309,261,073	1,547,350,679	(1,858,847)	1,545,491,832	0	1,545,491,832	(3,409,400)
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	19,502,741	20,887,436	0	20,887,436	22,608,612	48,699	22,657,311	0	22,657,311	53,126
	FTE	266.1	287.6	0.0	287.6	317.0	0.9	317.9	0.0	317.9	1.0
	GF	8,010,994	8,057,854	0	8,057,854	7,505,041	24,350	7,529,391	0	7,529,391	26,563
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	604,469	1,196,011	0	1,196,011	1,884,880	0	1,884,880	0	1,884,880	0
	CFE/RF	1,501,807	1,579,589	0	1,579,589	1,830,045	0	1,830,045	0	1,830,045	0
	FF	9,385,471	10,053,982	0	10,053,982	11,388,646	24,349	11,412,995	0	11,412,995	26,563
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	1,148,096	1,976,111	0	1,976,111	1,661,541	5,620	1,667,161	0	1,667,161	950
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	557,186	709,406	0	709,406	691,404	2,810	694,214	0	694,214	475
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	13,014	266,182	0	266,182	126,899	0	126,899	0	126,899	0
	CFE/RF	12,337	13,461	0	13,461	13,461	0	13,461	0	13,461	0
	FF	565,559	987,062	0	987,062	829,777	2,810	832,587	0	832,587	475
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	1,298,595	3,731,605	0	3,731,605	3,910,800	157,000	4,067,800	0	4,067,800	157,000
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	771,478	1,328,043	0	1,328,043	1,320,400	78,500	1,398,900	0	1,398,900	78,500
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	463,750	0	463,750	562,500	0	562,500	0	562,500	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	527,117	1,939,812	0	1,939,812	2,027,900	78,500	2,106,400	0	2,106,400	78,500

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

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

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

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐		**Base Reduction Item FY 2010-11**	☑		**Supplemental FY 2009-10**	☐		**Budget Amendment FY 2010-11**	☐	
Request Title:	Coordinated Payment and Payment Reform										
Department:	Health Care Policy and Financing				**Dept. Approval by:**		John Bartholomew		**Date:**	November 2, 2009	
Priority Number:	BRI-2				**OSPB Approval:**				**Date:**		
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	**Total**	73,720,837	88,808,586	0	88,808,586	88,808,586	792,720	89,601,306	0	89,601,306	1,634,760
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	73,720,837	88,808,586	0	88,808,586	88,808,586	792,720	89,601,306	0	89,601,306	1,634,760
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0

Non-Line Item Request: None.

Letternote Revised Text: [a]Medical Services Premiums: Of this amount, $85,184,021 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.; $21,498,147 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program; $784,875 shall be from the Autism Treatment Fund created in Section 25.5-6-805, C.R.S.; $1,725,479 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a), C.R.S.; $27,040,854 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S.; $250,000 shall be from the Coordinated Care for People with Disabilities Fund; $3,026,893 shall be from the Comprehensive Primary and Preventive Care Fund; and, $212,806,547 shall be from Hospital Provider Fee Cash Fund.

Cash or Federal Fund Name and COFRS Fund Number: CF: Health Care Expansion Fund 18K; FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: None.

Approval by OIT? **Yes:** ☐ **No:** ☐ **N/A:** ☑

Schedule 13s from Affected Departments: None.

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

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

SELECT ONE (click on box):

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

SELECT ONE (click on box):

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

Short Summary of Request:

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

Background and Appropriation History:

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

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

Consistent with Governor Ritter's vision and the Commission's recommendations for a system based on shared responsibility, where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents, the Department is continuing to purposefully and systematically advance its health care reform efforts; this request is the next in that series of steps.

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

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

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

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

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

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

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

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

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

General Description of Request:

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

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

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

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

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

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

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

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

Payment Coordination

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

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

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

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

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

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

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

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

Additional Auditor for the Nursing Facilities Section

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

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

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

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

Pilot Audit of a Community Mental Health Center

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

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

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

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

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

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

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

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

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

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

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

Increased enrollment of Medicare-eligible Clients into Medicare

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

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

Payment Reform

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

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

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

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

HCBS Waiver Rate Reform

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

Physician Payment Rate Reform

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

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

Reform Methodology of Payments to Federally Qualified Health Centers

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

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

Consequences if Not Funded:

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

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

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

Calculations for Request:

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

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

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

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

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

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

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

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

Impact on Other Government Agencies: None

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

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

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

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

Implementation Schedule:

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

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

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

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

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

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

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

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

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

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

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

Performance Measures:

This Change Request affects the following Performance Measures:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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