

STATE OF COLORADO FY 2011-12 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13											
Change Request for FY 2011-12 Budget Request Cycle											
Decision Item FY 2011-12		Base Reduction Item FY 2011-12			Supplemental FY 2010-11			Budget Amendment FY 2011-12			
Request Title: Medicaid Reductions											
Department: Health Care Policy and Financing					Dept. Approval by: John Bartholomew			Date: November 1, 2010 ^{10/25}			
Priority Number: BRI-5					OSPB Approval: <i>[Signature]</i>			Date: 10-27-10			
	Fund	1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual FY 2009-10	Appropriation FY 2010-11	Supplemental Request FY 2010-11	Total Revised Request FY 2010-11	Base Request FY 2011-12	Decision/Base Reduction FY 2011-12	November 1 Request FY 2011-12	Budget Amendment FY 2011-12	Total Revised Request FY 2011-12	Change from Base (Column 5) FY 2012-13
Total of All Line Items	Total	3,105,716,162	3,395,491,225	0	3,395,491,225	3,390,817,709	(30,361,244)	3,360,456,465	0	3,360,456,465	(43,421,488)
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	843,421,654	794,438,875	0	794,438,875	1,200,518,430	(14,776,147)	1,185,742,283	0	1,185,742,283	(20,963,834)
	GFE	0	161,444,485	0	161,444,485	161,444,485	0	161,444,485	0	161,444,485	0
	CF	350,149,984	351,708,845	0	351,708,845	321,646,545	(540,014)	321,106,531	0	321,106,531	(844,331)
	CFE/RF	3,928,088	7,707,617	0	7,707,617	3,446,761	0	3,446,761	0	3,446,761	0
	FF	1,908,215,436	2,080,191,403	0	2,080,191,403	1,703,761,488	(15,045,083)	1,688,716,405	0	1,688,716,405	(21,623,323)
(1) Executive Director's Office: (C) Information Technology Contracts and Projects. Information Technology Contracts	Total	22,767,387	34,553,769	0	34,553,769	31,825,489	189,000	32,014,489	0	32,014,489	0
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	5,348,546	6,134,303	0	6,134,303	6,147,926	47,250	6,195,176	0	6,195,176	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	642,364	2,433,429	0	2,433,429	1,766,770	0	1,766,770	0	1,766,770	0
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,676,149	25,885,709	0	25,885,709	23,810,465	141,750	23,952,215	0	23,952,215	0
(1) Executive Director's Office: (E) Utilization and Quality Review Contracts, Professional Services Contracts	Total	4,524,546	6,462,871	0	6,462,871	7,270,839	400,000	7,670,839	0	7,670,839	400,000
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	1,125,802	1,766,994	0	1,766,994	1,945,421	100,000	2,045,421	0	2,045,421	100,000
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	60,449	86,596	0	86,596	115,486	0	115,486	0	115,486	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,338,294	4,609,281	0	4,609,281	5,209,932	300,000	5,509,932	0	5,509,932	300,000
(2) Medical Services Premiums	Total	2,877,822,564	3,106,858,127	0	3,106,858,127	3,101,279,542	(25,941,407)	3,075,338,135	0	3,075,338,135	(38,440,995)
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	762,936,068	700,606,422	0	700,606,422	1,079,820,226	(12,671,299)	1,067,148,927	0	1,067,148,927	(18,634,630)
	GFE	0	161,444,485	0	161,444,485	161,444,485	0	161,444,485	0	161,444,485	0
	CF	343,695,933	339,633,220	0	339,633,220	307,745,803	(299,401)	307,446,402	0	307,446,402	(585,865)
	CFE/RF	3,917,255	7,595,243	0	7,595,243	3,334,253	0	3,334,253	0	3,334,253	0
	FF	1,767,273,308	1,897,578,757	0	1,897,578,757	1,548,934,775	(12,970,707)	1,535,964,068	0	1,535,964,068	(19,220,500)

STATE OF COLORADO FY 2011-12 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13											
Change Request for FY 2011-12 Budget Request Cycle											
Decision Item FY 2011-12	<input type="checkbox"/>	Base Reduction Item FY 2011-12	<input checked="" type="checkbox"/>	Supplemental FY 2010-11	<input type="checkbox"/>	Budget Amendment FY 2011-12	<input type="checkbox"/>				
Request Title:	Medicaid Reductions										
Department:	Health Care Policy and Financing			Dept. Approval by:	John Bartholomew		Date:	November 1, 2010			
Priority Number:	BRI-5			OSPB Approval:			Date:				
	1	2	3	4	5	6	7	8	9	10	
	Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base (Column 5)	
Fund	FY 2009-10	FY 2010-11	FY 2010-11	FY 2010-11	FY 2011-12	FY 2011-12	FY 2011-12	FY 2011-12	FY 2011-12	FY 2012-13	
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments for Medicaid Eligible Clients	Total	223,368,053	247,616,458	0	247,616,458	250,441,839	(5,008,837)	245,433,002	0	245,433,002	(5,380,493)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	79,359,784	85,931,156	0	85,931,156	112,604,857	(2,252,098)	110,352,759	0	110,352,759	(2,419,204)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	6,393,602	9,555,600	0	9,555,600	12,018,486	(240,613)	11,777,873	0	11,777,873	(258,466)
	CFE/RF	10,833	12,046	0	12,046	12,180	0	12,180	0	12,180	0
	FF	137,603,834	152,117,656	0	152,117,656	125,806,316	(2,516,126)	123,290,190	0	123,290,190	(2,702,823)
Non-Line Item Request:	None.										
Letternote Revised Text:	<p>(2) Medical Services Premiums: Of this amount, \$171,705,885 \$171,602,713(H) shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., \$88,721,925 \$88,540,127(H) shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S., and \$2,500,923 \$2,486,492 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I), C.R.S.</p> <p>(3) Medicaid Mental Health Community Program; (A) Mental Health Capitation Payments: (a) Of this amount, \$10,261,740 \$10,056,505(H) shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S., \$4,723,204 \$1,688,740(H) shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., and \$33,542 \$32,628 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I), C.R.S.</p>										
Cash or Federal Fund Name and COFRS Fund Number:	CF: Health Care Expansion Fund (18K); Breast and Cervical Cancer Prevention and Treatment Fund (15D); Hospital Provider Fee Cash Fund (24A). FF: Title XIX.										
Reappropriated Funds Source, by Department and Line Item Name:	Department of Public Health and Environment: (9) Prevention Services Division: (3) Chronic Disease and Cancer Prevention Grants Program, Transfer to the Department of Health Care Policy and Financing for Breast and Cervical Cancer Treatment										
Approval by OIT?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	N/A: <input checked="" type="checkbox"/>								
Schedule 13s from Affected Departments:	N/A										

CHANGE REQUEST for FY 2011-12 BUDGET REQUEST CYCLE

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

SELECT ONE (click on box):

- Decision Item FY 2011-12
- Base Reduction Item FY 2011-12
- Supplemental Request FY 2010-11
- Budget Request Amendment FY 2011-12

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:

To meet budget balancing goals, the Department proposes to reduce Medicaid expenditure through a series of initiatives. These initiatives would provide a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies to reduce Medicaid program expenditures by \$30,361,244 total funds and \$14,776,147 General Fund in FY 2011-12. This proposal annualizes to a reduction of \$43,421,488 total funds and \$20,953,834 General Fund in FY 2012-13.

General Description of Request:

To meet budget balancing goals, the Department proposes the following reductions for FY 2011-12:

Pharmacy State Maximum Allowable Cost Expansion

For this reduction, the Department would expand utilization of its state maximum allowable cost (SMAC) pricing for pharmaceuticals. Currently, the Department's base budget includes \$1,568,256 in savings from previous budget requests, including \$1,057,450 from the FY 2010-11 budget request cycle (see HB 10-1376, Footnote 8a). In FY 2011-12, the Department would expand utilization of SMAC pricing to achieve a

total of \$3,568,256 savings over other pricing methodologies. This represents an incremental change of \$2,000,000 total funds.

At this time, the Department is unable to specifically name the drugs which would be included on the SMAC list, for multiple reasons. First, the Department will need to conduct stakeholder research to determine what drugs are appropriate to subject to SMAC pricing. Second, in FY 2010-11, the Department will transition from pricing based on average wholesale price (AWP) to pricing based on wholesale acquisition cost (WAC).¹ The transition is expected to be budget neutral; however, because the Department has not yet finalized the WAC-based pricing methodologies, it does not know the relative prices of drugs as they relate to AWP pricing. Once that information is known, the Department will be able to determine the specific drugs to add to the SMAC pricing list.

Despite not knowing the specific drugs, the Department is confident that it can achieve additional savings. In order to achieve the savings in its FY 2010-11 appropriation, the Department has only needed to place 3 drugs on the SMAC list. Therefore, the Department anticipates that a substantial amount of savings can still be achieved by expanding SMAC pricing.

The Department estimates that the policy would reduce fee-for-service expenditure by \$1,833,333 total funds, \$865,263 General Fund in FY 2011-12, and annualize to a reduction of \$2,000,000 total funds, \$943,924 General Fund in FY 2012-13. This rate reduction would also affect payments to risk-based physical health managed care organizations, and PACE, as most fee-for-service pricing adjustments do.

Restrict Adult Oral Nutrition Benefit

For clients 5 years of age or older, the Department would restrict oral nutritional supplements to clients who: have malnourishment conditions; have inborn errors in metabolism; and, clients who use nutritional supplements through feeding tubes. Under this restriction, the Department would only pay for nutrition products which are

¹ This transition is a result of a federal lawsuit; the company which publishes AWP pricing information has agreed to discontinue its publication.

medically necessary; this policy is similar to policies enacted by other states, including Washington and Utah.² The Department estimates that the policy would reduce fee-for-service expenditure by \$3,039,219 total funds, \$1,519,609 General Fund in FY 2011-12, and annualize to a reduction of \$3,580,421 total funds, \$1,790,210 General Fund in FY 2012-13. This reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table A.

Reduce Rates for Certain Diabetes Supplies

For this reduction, the Department would reduce its payment for blood glucose/reagent strips. Currently, the Department pays \$31.80 per box of 50 strips. However, the current median market price for this product is approximately \$18.00. The Department proposes to reduce its rate for this product to \$18.00. The Department estimates that the policy would reduce fee-for-service expenditure by \$842,727 total funds, \$397,735 General Fund in FY 2011-12, and annualize to a reduction of \$992,794 total funds, \$468,561 General Fund in FY 2012-13. This reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table B.

Reduce Facility Payments for Uncomplicated Cesarean Section Deliveries

For this reduction, the Department would reduce the amount that it pays facilities for an uncomplicated cesarean section (C-section) delivery to the same amount that the Department pays for complicated vaginal deliveries. The Department would achieve this reduction by setting the diagnosis related group (DRG) relative weight for uncomplicated C-sections (DRG 371) at the same weight as complicated vaginal deliveries (DRG 372). The Department estimates that the policy would reduce fee-for-service expenditure by \$6,276,004 total funds, \$3,138,002 General Fund in FY 2011-12, and annualize to a reduction of \$7,087,549 total funds, \$3,543,774 General Fund in FY 2012-13. This reduction would also impact risk-based physical health managed care organizations. The Department's calculation is shown in Appendix B, Table C.

² For example (Washington state), see: <http://maa.dshs.wa.gov/news/DMEChangesFAQ.htm>

Reduce Payments for Inpatient Renal Dialysis

For this reduction, the Department would reduce the amount that it pays for inpatient renal dialysis (DRG 317). Currently, the relative weight for this DRG code is based on an average length of stay (ALOS) of 3.2 days. However, analysis of FY 2009-10 claims indicate that clients being served under this DRG have an ALOS of only 1.2 days. This has resulted in the Department substantially overpaying for renal dialysis claims. Based on FY 2008-09 provider cost information, the Department estimates that, for the majority of expenditure, the Department has reimbursed hospitals at approximately 185% of cost. The Department would reduce the relative weight of the DRG to the point where the Department estimates that it would be paying at or about actual cost for this service.

The Department estimates that the policy would reduce fee-for-service expenditure by \$2,169,701 total funds, \$1,084,850 General Fund in FY 2011-12, and annualize to a reduction of \$2,450,264 total funds, \$1,225,132 General Fund in FY 2012-13. This rate reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table D.

Deny Hospital Readmissions Within 48 Hours

For this reduction, the Department would no longer make a separate payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition. The Department's current policy is that it will not make payments for readmissions for related conditions within 24 hours. If a hospital receives a denial of a readmission, the hospital may follow the normal procedures for requesting reconsideration. The Department estimates that the policy would reduce fee-for-service expenditure by \$2,475,418 total funds, \$1,168,303 General Fund in FY 2011-12, and annualize to a reduction of \$2,795,512 total funds, \$1,319,375 General Fund in FY 2012-13. This reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table E.

Prior Authorize Certain Radiology Services at Outpatient Hospitals

For this reduction, the Department would, effective April 1, 2012, require prior authorization in outpatient hospital departments for certain procedures which currently require prior authorization in free-standing imaging (radiology) facilities. These procedures include the high tech imaging technologies of magnetic resonance imaging (MRI), computerized tomography (CT scans), positron emission tomography (PET scans), and single photon emission computed tomography (SPECT scans). When ordered for emergencies, no prior authorization will be required.

The Department implemented prior authorization requirements for these procedures at stand-alone facilities in July 2009. After the prior authorization was implemented, the Department experienced a reduction in average quarterly expenditure for these services of 25.42%. The Department expects similar results for outpatient radiology services. However, expenditure for outpatient radiology services is roughly 8.75 times the amount of expenditure for independent radiology. Therefore, to provide a conservative savings estimate, the Department has adjusted the savings percent to half of that previously experienced, to 12.71%

The Department estimates that the policy would reduce fee-for-service expenditure by \$672,136 total funds, \$317,223 General Fund in FY 2011-12, and annualize to a reduction of \$4,392,545 total funds, \$2,073,113 General Fund in FY 2012-13. This reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table F.

Reduce Rates for Procedure Codes Paid Above 95% of Medicare Rates

For this reduction, the Department would, effective April 1, 2012, set a maximum rate of 95% of the equivalent Medicare rate for procedure codes. Codes that are currently paid below the 95% level would not be affected. This reduction would primarily affect physician services, injectable drugs, and durable medical equipment, although other service categories may also be affected. The Department estimates that the policy would reduce fee-for-service expenditure by \$958,192 total funds, \$452,230 General Fund in

FY 2011-12, and annualize to a reduction of \$6,546,557 total funds, \$3,089,725 General Fund in FY 2012-13. This reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table G.

Cap Consumer Directed Attendant Support Services Wage Rates

For this reduction, the Department would impose a cap on the wage rate that a client enrolled in the Consumer Directed Attendant Support Services (CDASS) program is allowed to pay attendants. Under the program, clients are responsible for determining the wage within an allocation that is determined by their case manager. Information provided by the Department's fiscal intermediary has shown that wage rates set by clients are highly variable, and can change as often as weekly. In the three major categories of services, between 12% and 21% of wages are set at \$20 per hour or higher. Further, some clients are setting wage rates far beyond what the Department would otherwise pay for these services – in some cases, as much as \$100 per hour.

In calendar year 2009, the Department's cost for an average client enrolled in the traditional home and community based services waiver for elderly, blind, and disabled (HCBS-EBD) was 22.2% of a client enrolled in the HCBS-EBD CDASS option. In order to reduce costs in the CDASS program, the Department will impose wage rate caps based on its current rates for similar services in the HCBS-EBD waiver, including homemaker, personal care, and health maintenance. However, the actual wage caps will be set after the Department solicits stakeholder input. Because the Department can not yet predict the wage rate caps, it has set a target savings rate of 3.5% of total expenditure. The Department believes this savings amount is achievable based on currently available information on wage rates and expenditure.

The Department estimates that the policy would reduce fee-for-service expenditure by \$1,420,692 total funds, \$710,346 General Fund in FY 2011-12, and annualize to a reduction of \$1,677,708 total funds, \$838,854 General Fund in FY 2012-13. This rate reduction would also impact PACE. The Department's calculation is shown in Appendix B, Table H.

Reduce FQHC Rates to Remove Unsupported Pharmacy Costs

In reviewing federally qualified health center (FQHC) cost reports, the Department has learned that there are several FQHCs which include the cost of their pharmacies in the cost report, but do not allow Medicaid clients to utilize their pharmacies. Additionally, for those FQHCs that do allow Medicaid clients to use their pharmacies, there is discrepancy in the costs they include in their cost reports and how they bill Medicaid for drugs. To date, the Department has found four FQHCs that include the costs of their pharmacies in their cost report, but do not fill prescriptions for Medicaid clients. Since the Department gathers this information once FQHCs submit their cost report, and cost reports are filed based on each FQHC's specific fiscal year end, there may be more that fall into this category.

For this reduction, the Department would issue a clarifying policy: for those FQHCs that do not allow Medicaid clients to use their pharmacies, the pharmacy cost center would be considered a non-allowable cost center and removed from their rate calculation. This includes any indirect costs (such as overhead) that were also being attributed to pharmacy.

FQHCs qualify for the federal 340B Drug Pricing Program, therefore, they receive significant discounts on the cost of drugs they purchase. The Department intends to work with FQHCs to determine if additional savings can be captured by increasing FQHC pharmacy participation in that program. If the Department estimates that savings could be achieved by increasing FQHC pharmacy participation, the Department may request further programmatic changes through the regular budget process.

The Department estimates that the policy would reduce fee-for-service expenditure by \$951,019 total funds, \$448,844 General Fund in FY 2011-12, and annualize to a reduction of \$1,095,677 total funds, \$517,117 General Fund in FY 2012-13. This rate reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table I.

Enforce Limitations on Acute Home Health Services

For this reduction, the Department will better enforce an existing cap on acute home health services. Acute home health services are provided for clients with conditions including: infections; new medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes; care related to post-surgical recovery; post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders; exacerbation or severe instability of a chronic condition; new diagnosis of a long term chronic condition, such as, but not limited to, diabetes; complications of pregnancy. Department regulations at 10 CCR 2505-10 8.523(K) define “Acute Home Health” as services that are provided for 60 days or less. After the 60 day period, clients are required to be prior authorized to receive additional services.

Currently, the Department’s Medicaid Management Information System does not contain a system edit that requires prior authorization after 60 days. As a result, in FY 2009-10 the Department paid claims for over 700 clients receiving services classified as acute home health past the 60 day limit. In total, claims for these clients above the 60 day limit during this period totaled \$6.2 million. The Department believes that the majority of care that is being delivered is appropriate. As a result, the Department reduces the potential savings estimate by 85%. Once a client receives a prior authorization from a single entry point, that client may continue to receive home health services. As a result, the Department does not anticipate that any client who has a medical need for home health services will be denied.

The Department will provide adequate notice to clients, providers, and single entry points prior to implementing this proposal. The Department is aware that an overly fast implementation may cause claims to be denied improperly. Therefore, the Department will use its stakeholder outreach process to ensure that clients and providers are properly noticed of the upcoming change.

The Department estimates that the policy would reduce fee-for-service expenditure by \$1,131,555 total funds, \$565,777 General Fund in FY 2011-12, and annualize to a reduction of \$1,418,106 total funds, \$709,053 General Fund in FY 2012-13. This

reduction would also impact risk-based physical health managed care organizations, and PACE. The Department's calculation is shown in Appendix B, Table J.

Reduction to Managed Care Expenditure

As a result of the proposed fee-for-service reductions, expenditure will also be reduced for risk-based managed care organizations. This is because rates for those programs are based on estimated expenditure for actuarially equivalent populations; therefore, as estimates for fee-for-service populations are reduced, rates will be reduced to match. This includes health maintenance organizations and the Program of All-Inclusive Care for the Elderly (PACE). The Department estimates that the policy would reduce managed care expenditure by \$4,171,411 total funds, \$2,003,117 General Fund in FY 2011-12, and annualize to a reduction of \$4,403,862 total funds, \$2,115,792 General Fund in FY 2012-13. The Department's calculation is shown in Appendix B, Table K.

Reduce Mental Health Capitation Program

For this reduction, the Department would make permanent the 2% reduction that is effective January 1, 2011 in the Mental Health Capitation program. The Department's Base Request assumes that the reduction would expire at the end of FY 2010-11; the Department's reconciliation table removes the reduction from the FY 2011-12 base. The Department estimates that the policy would reduce fee-for-service expenditure by \$5,008,837 total funds, \$2,252,098 General Fund in FY 2011-12, and annualize to a reduction of \$5,380,493 total funds, \$2,419,204 General Fund in FY 2012-13. The Department's calculation is shown in Appendix B, Table L.

Increase to Information Technology Contracts

As a result of the proposed initiatives, the Department anticipates that there may be minor changes required to the Medicaid Management Information System (MMIS) to accommodate the policy changes. For each proposal, there will be a requirement for rate changes and system edits, which will require resources at the Department's fiscal agent. Additionally, more complex changes may be needed depending on the final

implementation of the initiatives. For FY 2011-12 only, the Department requests \$189,000 total funds, \$47,250 General Fund to add 1,500 pool hours at a cost of \$126 per hour for required system changes. If funding for system changes is not approved as requested, the Department may not achieve the savings proposed in this request.

Increase to Utilization Review Program

As a result of the proposed initiatives, the Department anticipates that there will be an increase in required prior authorizations and medical reviews. The Department requests \$400,000 total funds, \$100,000 General Fund to increase its current utilization review program. This funding will add the capacity to perform 10,000 additional prior authorizations and reviews at approximately \$40 per prior authorization. The actual cost per review will depend on the specific requirements developed on the Department's utilization review contractor. These reviews will be related to the oral nutrition reduction, inpatient readmissions, radiology services, and acute home health. It is unknown at this time how many new prior authorizations will be performed. However, if funding for utilization reviews is not adequate, the Department may not achieve the savings proposed in this request.

Consequences if Not Funded:

The proposed measures in this request are necessary in order to achieve a balanced budget in FY 2011-12. If these measures are not approved, other reductions would be required to balance the budget.

Calculations for Request:

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	(\$30,361,244)	(\$14,776,147)	(\$540,014)	\$0	(\$15,045,083)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$189,000	\$47,250	\$0	\$0	\$141,750
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$300,000
(2) Medical Services Premiums	(\$25,941,407)	(\$12,671,299)	(\$299,401)	\$0	(\$12,970,707)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,008,837)	(\$2,252,098)	(\$240,613)	\$0	(\$2,516,126)

Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	(\$43,421,488)	(\$20,953,834)	(\$844,331)	\$0	(\$21,623,323)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$0	\$0	\$0	\$0	\$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$300,000
(2) Medical Services Premiums	(\$38,440,995)	(\$18,634,630)	(\$585,865)	\$0	(\$19,220,500)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,380,493)	(\$2,419,204)	(\$258,466)	\$0	(\$2,702,823)

Calculations of fund splits are contained in Appendix A. Calculations for each individual reduction are contained in Appendix B.

Cash Funds Projections:

Cash Fund Name	Cash Fund Number	FY 2009-10 Expenditures	FY 2009-10 End of Year Cash Balance	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate	FY 2012-13 End of Year Cash Balance Estimate
Health Care Expansion Fund	18K	\$111,444,298	\$79,234,953	\$35,822,131	\$753,168	\$10,456,327
Hospital Provider Fee Cash Fund	24A	\$298,055,638	\$5,714,436	\$5,714,436	\$5,714,436	\$5,714,436
Breast and Cervical Cancer Prevention and Treatment Fund	15D	\$2,201,761	\$9,036,534	\$7,981,503	\$6,472,606	\$5,458,052

Assumptions for Calculations:

Summary information, including fund splits, for the Department's request is contained in Appendix A. Where necessary, the calculations for individual proposals are shown in the following tables in Appendix B:

Proposal	Table
Restrict Adult Oral Nutrition Benefit	Table A
Reduce Rates for Certain Diabetes Supplies	Table B
Reduce Payments for Uncomplicated Cesarean Section Deliveries	Table C
Reduce Payments for Inpatient Renal Dialysis	Table D
Deny Hospital Readmissions Within 48 Hours	Table E
Prior Authorize Certain Radiology Services at Outpatient Hospitals	Table F
Reduce Rates for Procedure Codes Paid Above 95% of Medicare Rates	Table G
Cap Consumer Directed Attendant Support Services Wage Rates	Table H
Reduce FQHC Rates to Remove Unsupported Pharmacy Costs	Table I
Enforce Limitations on Acute Home Health Services	Table J
Reduction to Managed Care Expenditure	Table K
Reduce Mental Health Capitation Program	Table L

Impact on Other Government Agencies: None.

Cost Benefit Analysis: This request is estimated to save the State \$14,776,147 General Fund in FY 2011-12 and \$20,953,834 General Fund in FY 2012-13, while aligning some reimbursement levels to more accurately reflect actual costs for services, would require other services (such as those at FQHCs) to have full justification of reimbursable expenditures, and would curb unnecessary utilization of other services (such as radiology).

Implementation Schedule: Implementation dates for each initiative are described in the narrative above, and in Appendix B, in the table for each proposal. In the majority of cases, the Department can implement the reductions administratively, without a State Plan amendment or rule changes. If rule changes are necessary, the Department may submit emergency rules to the Medical Services Board after the Long Bill is signed to ensure that the reduction is implemented on schedule.

Statutory and Federal Authority: Except where noted below, the Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per 25.5-4-401 (1) (a), C.R.S. (2010).

25.5-4-401 (1) (a), C.R.S. (2010)

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.

Under this statute, the proposed reductions can be achieved through a budget action by applying a restriction to the appropriation without an executive order or statutory change.

Performance Measures:

Not applicable.

Appendix A

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

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	(\$30,361,244)	(\$14,776,147)	(\$540,014)	\$0	(\$15,045,083)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$189,000	\$47,250	\$0	\$0	\$141,750
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$300,000
(2) Medical Services Premiums	(\$25,941,407)	(\$12,671,299)	(\$299,401)	\$0	(\$12,970,707)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,008,837)	(\$2,252,098)	(\$240,613)	\$0	(\$2,516,126)

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

Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	(\$43,421,488)	(\$20,953,834)	(\$844,331)	\$0	(\$21,623,323)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$0	\$0	\$0	\$0	\$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$300,000
(2) Medical Services Premiums	(\$38,440,995)	(\$18,634,630)	(\$585,865)	\$0	(\$19,220,500)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,380,493)	(\$2,419,204)	(\$258,466)	\$0	(\$2,702,823)

Appendix A

Table 2.1						
Impact by Component: Base Fund Split						
FY 2011-12						
FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	(\$30,361,244)	(\$14,776,147)	(\$540,014)	\$0	(\$15,045,083)	
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$189,000	\$47,250	\$0	\$0	\$141,750	Narrative
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$300,000	Narrative
(2) Medical Services Premiums	(\$25,941,407)	(\$12,671,299)	(\$299,401)	\$0	(\$12,970,707)	
Pharmacy State Maximum Allowable Cost Expansion	(\$1,833,333)	(\$865,263)	(\$51,403)	\$0	(\$916,667)	Narrative
Restrict Adult Oral Nutrition Benefit	(\$3,039,219)	(\$1,519,609)	\$0	\$0	(\$1,519,610)	Table A
Reduce Rates for Certain Diabetes Supplies	(\$842,727)	(\$397,735)	(\$23,628)	\$0	(\$421,364)	Table B
Reduce Payments for Uncomplicated Cesarean Section Deliveries	(\$6,276,004)	(\$3,138,002)	\$0	\$0	(\$3,138,002)	Table C
Reduce Payments for Inpatient Renal Dialysis	(\$2,169,701)	(\$1,084,850)	\$0	\$0	(\$1,084,851)	Table D
Deny Hospital Readmissions Within 48 Hours	(\$2,475,418)	(\$1,168,303)	(\$69,406)	\$0	(\$1,237,709)	Table E
Prior Authorize Certain Radiology Services at Outpatient Hospitals	(\$672,136)	(\$317,223)	(\$18,845)	\$0	(\$336,068)	Table F
Reduce Rates for Procedure Codes Paid Above 95% of Medicare Rates	(\$958,192)	(\$452,230)	(\$26,866)	\$0	(\$479,096)	Table G
Cap Consumer Directed Attendant Support Services Wage Rates	(\$1,420,692)	(\$710,346)	\$0	\$0	(\$710,346)	Table H
Reduce FQHC Rates to Remove Unsupported Pharmacy Costs	(\$951,019)	(\$448,844)	(\$26,665)	\$0	(\$475,510)	Table I
Enforce Limitations on Acute Home Health Services	(\$1,131,555)	(\$565,777)	\$0	\$0	(\$565,778)	Table J
Reduction to HMO Expenditure	(\$2,945,547)	(\$1,390,185)	(\$82,588)	\$0	(\$1,472,774)	Table K
Reduction to PACE Expenditure	(\$1,225,864)	(\$612,932)	\$0	\$0	(\$612,932)	Table K
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,008,837)	(\$2,252,098)	(\$240,613)	\$0	(\$2,516,126)	
Reduce Mental Health Capitation Program	(\$5,008,837)	(\$2,252,098)	(\$240,613)	\$0	(\$2,516,126)	Table L

Appendix A

Table 2.2						
Impact by Component: Base Fund Split						
FY 2012-13						
FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	(\$43,421,488)	(\$20,953,834)	(\$844,331)	\$0	(\$21,623,323)	
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$0	\$0	\$0	\$0	\$0	Narrative
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$300,000	Narrative
(2) Medical Services Premiums	(\$38,440,995)	(\$18,634,630)	(\$585,865)	\$0	(\$19,220,500)	
Pharmacy State Maximum Allowable Cost Expansion	(\$2,000,000)	(\$943,924)	(\$56,076)	\$0	(\$1,000,000)	Narrative
Restrict Adult Oral Nutrition Benefit	(\$3,580,421)	(\$1,790,210)	\$0	\$0	(\$1,790,211)	Table A
Reduce Rates for Certain Diabetes Supplies	(\$992,794)	(\$468,561)	(\$27,836)	\$0	(\$496,397)	Table B
Reduce Payments for Uncomplicated Cesarean Section Deliveries	(\$7,087,549)	(\$3,543,774)	\$0	\$0	(\$3,543,775)	Table C
Reduce Payments for Inpatient Renal Dialysis	(\$2,450,264)	(\$1,225,132)	\$0	\$0	(\$1,225,132)	Table D
Deny Hospital Readmissions Within 48 Hours	(\$2,795,512)	(\$1,319,375)	(\$78,381)	\$0	(\$1,397,756)	Table E
Prior Authorize Certain Radiology Services at Outpatient Hospitals	(\$4,392,545)	(\$2,073,113)	(\$123,159)	\$0	(\$2,196,273)	Table F
Reduce Rates for Procedure Codes Paid Above 95% of Medicare Rates	(\$6,546,557)	(\$3,089,725)	(\$183,553)	\$0	(\$3,273,279)	Table G
Cap Consumer Directed Attendant Support Services Wage Rates	(\$1,677,708)	(\$838,854)	\$0	\$0	(\$838,854)	Table H
Reduce FQHC Rates to Remove Unsupported Pharmacy Costs	(\$1,095,677)	(\$517,117)	(\$30,721)	\$0	(\$547,839)	Table I
Enforce Limitations on Acute Home Health Services	(\$1,418,106)	(\$709,053)	\$0	\$0	(\$709,053)	Table J
Reduction to HMO Expenditure	(\$3,072,206)	(\$1,449,964)	(\$86,139)	\$0	(\$1,536,103)	Table K
Reduction to PACE Expenditure	(\$1,331,656)	(\$665,828)	\$0	\$0	(\$665,828)	Table K
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,380,493)	(\$2,419,204)	(\$258,466)	\$0	(\$2,702,823)	
Reduce Mental Health Capitation Program	(\$5,380,493)	(\$2,419,204)	(\$258,466)	\$0	(\$2,702,823)	Table L

Appendix A

Table 3.1 Cash Fund Splits FY 2011-12							
FY 2011-12	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Health Care Expansion Fund	Reappropriated Funds	Federal Funds
Total Request	(\$30,361,244)	(\$14,776,147)	(\$137,636)	(\$15,345)	(\$387,033)	\$0	(\$15,045,083)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$189,000	\$47,250	\$0	\$0	\$0	\$0	\$141,750
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$0	\$0	\$300,000
(2) Medical Services Premiums	(\$25,941,407)	(\$12,671,299)	(\$103,172)	(\$14,431)	(\$181,798)	\$0	(\$12,970,707)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,008,837)	(\$2,252,098)	(\$34,464)	(\$914)	(\$205,235)	\$0	(\$2,516,126)

Table 3.2 Cash Fund Splits FY 2012-13							
FY 2012-13	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Health Care Expansion Fund	Reappropriated Funds	Federal Funds
Total Request	(\$43,421,488)	(\$20,953,834)	(\$238,908)	(\$29,221)	(\$576,202)	\$0	(\$21,623,323)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$0	\$0	\$0	\$0	\$0	\$0	\$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	\$400,000	\$100,000	\$0	\$0	\$0	\$0	\$300,000
(2) Medical Services Premiums	(\$38,440,995)	(\$18,634,630)	(\$201,887)	(\$28,239)	(\$355,739)	\$0	(\$19,220,500)
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	(\$5,380,493)	(\$2,419,204)	(\$37,021)	(\$982)	(\$220,463)	\$0	(\$2,702,823)

Appendix A

Table 4.1: New Letternote Totals for FY 2011-12

Long Bill Group	Line Item	Fund	Appropriation Type	COFRS Number	Base Request	Requested Total	Incremental Change
(2) Medical Services Premiums	Medical Services Premiums	Hospital Provider Fee Cash Fund	Cash Fund	24A	\$171,705,885	\$171,602,713	(\$103,172)
(2) Medical Services Premiums	Medical Services Premiums	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	\$2,500,923	\$2,486,492	(\$14,431)
(2) Medical Services Premiums	Medical Services Premiums	Health Care Expansion Fund	Cash Fund	18K	\$88,721,925	\$88,540,127	(\$181,798)
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Hospital Provider Fee Cash Fund	Cash Fund	24A	\$1,723,204	\$1,688,740	(\$34,464)
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	\$33,542	\$32,628	(\$914)
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Health Care Expansion Fund	Cash Fund	18K	\$10,261,740	\$10,056,505	(\$205,235)

Table 4.2: New Letternote Totals for FY 2012-13

Long Bill Group	Line Item	Fund	Appropriation Type	COFRS Number	FY 2011-12 Base Request	Requested Total	Incremental Change
(2) Medical Services Premiums	Medical Services Premiums	Hospital Provider Fee Cash Fund	Cash Fund	24A	\$171,705,885	\$171,503,998	(\$201,887)
(2) Medical Services Premiums	Medical Services Premiums	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	\$2,500,923	\$2,472,684	(\$28,239)
(2) Medical Services Premiums	Medical Services Premiums	Health Care Expansion Fund	Cash Fund	18K	\$88,721,925	\$88,366,186	(\$355,739)
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Hospital Provider Fee Cash Fund	Cash Fund	24A	\$1,723,204	\$1,686,183	(\$37,021)
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	\$33,542	\$32,560	(\$982)
(3) Medicaid Mental Health Community Programs	Mental Health Capitation Payments	Health Care Expansion Fund	Cash Fund	18K	\$10,261,740	\$10,041,277	(\$220,463)

Appendix B

Table A.1				
Restrict Adult Oral Nutrition Benefit				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for Oral Nutrition for Clients Age 5 and Older	\$3,553,824	-	Based on FY 2009-10 MMIS claims data
B	FY 2009-10 Average Monthly Clients Age 5 and Older using Oral Nutrition	1,120	-	Based on FY 2009-10 MMIS claims data
C	Average Monthly Expenditure Per Adult Client Per Month	\$264.42	-	(Row A / Row B) / 12
D	Estimated Number of Clients Meeting Exemption Requirements	224	-	Exemptions for clients with metabolic conditions and malnourishment, estimated at 20% of the total number of clients receiving services, based on a review of client diagnoses.
E	Estimated Number of Affected Clients	896	-	Row B - Row D
F	Estimated Savings (in FY 2009-10 Dollars)	(\$2,843,044)	-	(Row C * Row E * 12) * -1
G	Estimated Trend for Durable Medical Equipment	7.99%	-	Average expenditure growth in durable medical equipment between FY 2006-07 and FY 2009-10
H	Estimated Full Year Savings	(\$3,315,512)	(\$3,580,421)	FY 2010-11: Row F * (1 + Row G) ² FY 2011-12: Row H * (1 + Row G)
I	Savings Adjustment for Implementation Date	91.67%	100%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
J	Total Estimated Savings	(\$3,039,219)	(\$3,580,421)	Row H * Row I

Appendix B

Table B.1				
Reduce Rates for Certain Diabetes Supplies				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure on Blood Glucose/Reagent Strips	\$1,840,999	-	Based on FY 2009-10 MMIS claims data
B	Current Rate	\$31.48		Current fee schedule, per box of 50 strips
C	Proposed Rate	\$18.00		Proposed
D	Percent Reduction	-42.82%		Row C - Row B
E	Estimated Reduction (in FY 2009-10 Dollars)	(\$788,331)		Row A * Row D
F	Estimated Trend	7.99%	7.99%	Average increase in durable medical equipment payments from FY 2006-07 through FY 2009-10
G	Estimated Full Year Savings	(\$919,339)	(\$992,794)	FY 2010-11: Row E * (1 + Row F) ² FY 2011-12: Row G * (1 + Row F)
H	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
I	Total Estimated Savings	(\$842,727)	(\$992,794)	Row G * Row H

Appendix B

Table C.1				
Reduce Payments for Uncomplicated Cesarean Section Deliveries				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for Uncomplicated C-Section Deliveries	\$17,461,898	-	Based on FY 2009-10 MMIS claims data
B	Current DRG Weight for Uncomplicated C-Section Deliveries	1.0684	-	Actual DRG Weight for DRG 371 (uncomplicated cesarean delivery)
C	Proposed DRG Weight for Uncomplicated C-Section Deliveries	0.6775	-	Actual DRG Weight for DRG 372 (complicated vaginal delivery)
D	Estimated Percent Reduction to Expenditure	-36.59%	-	Row C / Row B - 1
E	Estimated Expenditure for Uncomplicated C-Section Deliveries After Reduction (FY 2009-10 Dollars)	(\$6,388,858)	-	Row A * Row D
F	Estimated Trend	3.52%	3.52%	Average increase in inpatient hospital payments from FY 2006-07 through FY 2009-10
G	Estimated Full Year Savings	(\$6,846,550)	(\$7,087,549)	FY 2010-11: Row E * (1 + Row F) ² FY 2011-12: Row G * (1 + Row F)
H	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
I	Total Estimated Savings	(\$6,276,004)	(\$7,087,549)	Row G * Row H

Appendix B

Table D.1 Reduce Payments for Inpatient Renal Dialysis				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for Inpatient Renal Dialysis	\$4,807,206	-	Based on FY 2009-10 MMIS claims data
B	Estimated Reimbursement as a Percent of Cost	185.00%	-	Based on analysis of FY 2008-09 cost reports for dialysis expenditure.
C	Proposed Reimbursement as a Percent of Cost	100.00%	-	Assumed, see narrative.
D	Estimated Percent Reduction to Expenditure	-45.95%	-	(Row C / Row B) - 1
E	Estimated Expenditure for Inpatient Renal Dialysis After Reduction (FY 2009-10 Dollars)	(\$2,208,716)	-	Row A * Row D
F	Estimated Trend	3.52%	3.52%	Average increase in inpatient hospital payments from FY 2006-07 through FY 2009-10
G	Estimated Full Year Savings	(\$2,366,947)	(\$2,450,264)	FY 2010-11: Row E * (1 + Row F) ² FY 2011-12: Row G * (1 + Row F)
H	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
I	Total Estimated Savings	(\$2,169,701)	(\$2,450,264)	Row G * Row H

Appendix B

Table E.1				
Deny Hospital Readmissions Within 48 Hours				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	Estimated FY 2009-10 Expenditure for Readmissions within 48 Hours	\$4,383,044	-	Based on FY 2008-09 MMIS claims data
B	Estimated FY 2009-10 Expenditure for Readmissions within 24 Hours	\$1,948,799	-	Based on FY 2008-09 MMIS claims data
C	Estimated FY 2009-10 Savings for Readmissions between 24 and 48 Hours ⁽¹⁾	(\$2,434,245)	-	(Row A - Row B) * -1
D	Estimated Trend	3.52%	3.52%	Average increase in inpatient hospital payments from FY 2006-07 through FY 2009-10
E	Estimated Full Year Savings	(\$2,700,456)	(\$2,795,512)	FY 2010-11: Row E * (1 + Row F) ³ FY 2011-12: Row G * (1 + Row F)
F	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
G	Total Estimated Savings	(\$2,475,418)	(\$2,795,512)	Row E * Row F

(1) The Department's current policy is to deny payment for readmissions within 24 hours. Therefore, only the claims paid for readmissions between 24 and 48 hours can be counted as savings. The Department's claim data still shows readmissions within 24 hours because the Department's MMIS does not currently automatically reject those claims; manual review is required. The Department anticipates that system changes to implement an automatic process will be complete prior to the implementation of the 48-hour policy.

Appendix B

Table F.1				
Prior Authorize Certain Radiology Services at Outpatient Hospitals				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for Selected Radiology Services at Outpatient Hospitals	\$26,745,318	-	Based on FY 2009-10 MMIS claims data
B	Reduction to Practitioner Radiology Services due to Enhanced Prior Authorization Requirements	-25.42%	-	Based on FY 2008-09 and FY 2009-10 MMIS claims data.
C	Estimated Reduction to Selected Radiology Services at Outpatient Hospitals	-12.71%	-	Assumed, see narrative Row B / 2
D	Estimated Reduction (in FY 2009-10 Dollars)	(\$3,399,330)	-	Row A * Row C
E	Estimated Trend	8.92%	8.92%	Average increase in outpatient hospital expenditure from FY 2005-06 through FY 2009-10
F	Estimated Full Year Savings	(\$4,032,818)	(\$4,392,545)	FY 2010-11: Row D * (1 + Row E) ² FY 2011-12: Row F * (1 + Row E)
G	Savings Adjustment for Implementation Date	16.67%	100.00%	Estimated implementation date: April 1, 2012. Only 2 months of savings are assumed in FY 2011-12 to account for cash accounting.
H	Total Estimated Savings	(\$672,136)	(\$4,392,545)	Row F * Row G

Appendix B

Table G.1				
Reduce Rates for Procedure Codes Paid Above 95% of Medicare Rates				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	Procedure Codes Above 95% of the Medicare Rate	423	-	Based on FY 2009-10 MMIS claims data
B	FY 2009-10 Expenditure for Procedure Codes Priced Above 95% of the Medicare Rate	\$25,271,340	-	Based on FY 2009-10 MMIS claims data
C	Estimated FY 2009-10 Expenditure for Repriced Codes	\$20,837,449	-	Based on repricing all FY 2009-10 claims for procedure codes above 95% of the Medicare rate to 95% of the Medicare rate. Because the calculation is done on a procedure code basis, the derivation of this figure is not shown.
D	Estimated Reduction to Expenditure	(\$4,433,891)	-	Row C - Row B
E	Estimated Trend	13.87%	13.87%	Average increase in physician payments from FY 2006-07 through FY 2009-10
F	Estimated Full Year Savings	(\$5,749,150)	(\$6,546,557)	FY 2010-11: Row D * (1 + Row E) ² FY 2011-12: Row F * (1 + Row E)
G	Savings Adjustment for Implementation Date	16.67%	100.00%	Estimated implementation date: April 1, 2012. Only 2 months of savings are assumed in FY 2011-12 to account for cash accounting.
H	Total Estimated Savings	(\$958,192)	(\$6,546,557)	Row F * Row G

Appendix B

Table H.1				
Cap Consumer Directed Attendant Support Services Wage Rates				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for HCBS-EBD CDASS Program	\$37,788,935	-	Based on FY 2009-10 MMIS claims data
B	Estimated Reduction to Expenditure	-3.50%	-	Assumed, see narrative.
C	Estimated Reduction (in FY 2009-10 Dollars)	(\$1,322,613)	-	Row A * Row B
D	Estimated Trend	8.25%	8.25%	Half of the average increase in expenditure for the Department's Elderly, Blind, and Disabled HCBS waiver from FY 2006-07 through FY 2009-10
E	Estimated Full Year Savings	(\$1,549,846)	(\$1,677,708)	FY 2011-12: Row C * (1 + Row D) ² FY 2012-13: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
G	Total Estimated Savings	(\$1,420,692)	(\$1,677,708)	Row E * Row F

Appendix B

Table I.1				
Reduce FQHC Rates to Remove Unsupported Pharmacy Costs				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for Federally Qualified Health Centers (FQHC)	\$76,244,360	-	Based on FY 2009-10 MMIS claims data
B	Number of FQHCs with Unsupported Pharmacy Costs	4	-	Based on current cost report information
C	Proportion of Total FQHC Expenditure from Providers with Unsupported Pharmacy Costs	24.30%	-	Based on current expenditure and cost report information.
D	Estimated Reduction to FQHC Expenditure	-1.22%	-	Calculated based on provider-specific information, including the percent of pharmacy costs reported, the percent of total expenditure for each affected provider, and the rate effective date. Because of the complexity of the calculation, the derivation is not shown.
E	Estimated Reduction to FQHC Expenditure (FY 2009-10 Dollars)	(\$930,181)	-	Row A * Row D
F	Estimated Trend	5.61%	5.61%	Average increase in FQHC payments from FY 2006-07 through FY 2009-10
G	Estimated Full Year Savings	(\$1,037,475)	(\$1,095,677)	FY 2011-12: Row E * (1 + Row F) ² FY 2012-13: Row G * (1 + Row F)
H	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
I	Total Estimated Savings	(\$951,019)	(\$1,095,677)	Row G * Row H

Appendix B

Table J.1				
Enforce Limitations on Acute Home Health Services				
Row	Item	FY 2011-12	FY 2012-13	Comment
A	FY 2009-10 Expenditure for Acute Home Health Above 60 Day Limit	\$6,235,685	-	Based on FY 2009-10 MMIS claims data
B	Estimated Reduction to Expenditure	-15.00%	-	Assumed, see narrative.
C	Estimated Reduction (in FY 2009-10 Dollars)	(\$935,353)	-	Row A * Row B
D	Estimated Trend	14.88%	14.88%	Average increase in outpatient hospital expenditure from FY 2005-06 through FY 2009-10
E	Estimated Full Year Savings	(\$1,234,424)	(\$1,418,106)	FY 2011-12: Row C * (1 + Row D) ² FY 2012-13: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	91.67%	100.00%	Estimated implementation date: July 1, 2011. Only 11 months of savings are assumed in FY 2011-12 to account for cash accounting.
G	Total Estimated Savings	(\$1,131,555)	(\$1,418,106)	Row E * Row F

Appendix B

Table K.1 Reduction to Managed Care Expenditure								
Row	Item	Estimated Reduction (FY 2009-10 Dollars)	FY 2009-10 Expenditure in Service Category	Percentage Reduction As a Percent of Service Category	Estimated HMO Expenditure	Estimated Reduction to HMO Expenditure	Estimated PACE Expenditure	Estimated Reduction to PACE Expenditure
A	Pharmacy State Maximum Allowable Cost Expansion	(\$2,000,000)	\$135,083,015	-1.48%	\$14,385,000	(\$212,980)	\$7,462,785	(\$110,492)
B	Restrict Adult Oral Nutrition Benefit	(\$2,843,044)	\$81,224,073	-3.50%	\$8,649,557	(\$302,756)	\$2,580,072	(\$90,309)
C	Reduce Rates for Certain Diabetes Supplies	(\$788,331)	\$81,224,073	-0.97%	\$8,649,557	(\$83,949)	\$2,580,072	(\$25,041)
D	Reduce Payments for Uncomplicated Cesarean Section Deliveries	(\$6,388,858)	\$351,813,970	-1.82%	\$37,464,695	(\$680,350)	\$11,175,324	(\$202,941)
E	Reduce Payments for Inpatient Renal Dialysis	(\$2,208,716)	\$351,813,970	-0.63%	\$37,464,695	(\$235,206)	\$11,175,324	(\$70,160)
F	Deny Hospital Readmissions Within 48 Hours	(\$2,434,245)	\$351,813,970	-0.69%	\$37,464,695	(\$259,223)	\$11,175,324	(\$77,323)
G	Prior Authorize Certain Radiology Services at Outpatient Hospitals	(\$3,399,330)	\$152,670,208	-2.23%	\$16,257,862	(\$361,995)	\$4,849,549	(\$107,979)
H	Reduce Rates for Procedure Codes Paid Above 95% of Medicare Rates	(\$4,433,891)	\$252,146,269	-1.76%	\$26,851,074	(\$472,165)	\$8,009,393	(\$140,842)
I	Cap Consumer Directed Attendant Support Services Wage Rates	(\$1,322,613)	\$193,612,819	-0.68%	\$0	\$0	\$22,613,816	(\$154,480)
J	Reduce FQHC Rates to Remove Unsupported Pharmacy Costs	(\$930,181)	\$79,021,110	-1.18%	\$8,414,964	(\$99,055)	\$2,510,095	(\$29,547)
K	Enforce Limitations on Acute Home Health Services	(\$935,353)	\$160,400,069	-0.58%	\$0	\$0	\$5,095,087	(\$29,711)
L	Totals	(\$27,684,563)				(\$2,707,680)		(\$1,038,826)
M	Estimated Trend					4.30%		8.63%
N	Estimated FY 2011-12 Reduction⁽¹⁾					(\$2,945,547)		(\$1,225,864)
O	Estimated FY 2012-13 Reduction⁽²⁾					(\$3,072,206)		(\$1,331,656)

Notes: This calculation uses the inputs from each of the individual reductions. To prevent double counting, the total calculated amount from each fee-for-service reduction is not used; rather, the total reduction in FY 2009-10 dollars is used. FY 2009-10 actual expenditure is used to determine an approximate percent reduction by service category. The weighted average percentage reduction is applied to the total FY 2009-10 HMO and PACE expenditure to calculate an approximate reduction to managed care rates. Because of its complexity, the calculation of the weighted average percent reduction is not shown.

(1) Formula: Row L * (1 + Row M)²

(2) Formula: Row N * (1 + Row M)

Appendix B

Table L.1			
Reduce Mental Health Capitation Program			
Row	Item	Total	Comment
A	Estimated FY 2011-12 Mental Health Capitation Program Base	\$250,441,839	Department Reconciliation Table
B	Proposed Reduction	-2.00%	Assumed
C	Estimated FY 2011-12 Reduction	(\$5,008,837)	Row A * Row B
D	Estimated Trend	7.42%	Average increase in appropriation from FY 2008-09 through FY 2010-11
E	Estimated FY 2012-13 Reduction	(\$5,380,493)	Row C * (1 + Row D)