

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
 Request Title: Medicaid Fee-for-Service Reform
 Priority Number: R-5

Dept. Approval by: John Bartholomew *JB* 10/25/11
 Date

OSPB Approval by: Gregory A. Kelly 10/24/11
 Date

- Decision Item FY 2012-13
 Base Reduction Item FY 2012-13
 Supplemental FY 2011-12
 Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	\$3,576,353,663	\$0	\$3,592,616,694	(\$1,845,030)	(\$4,101,831)
	FTE	313.0	0.0	313.5	1.8	2.0
	GF	\$909,607,782	\$0	\$992,363,869	(\$865,469)	(\$1,932,879)
	GFE	\$284,175,417	\$0	\$284,175,417	\$0	\$0
	CF	\$611,468,003	\$0	\$537,464,114	(\$57,047)	(\$118,037)
	RF	\$6,849,809	\$0	\$3,563,458	\$0	\$0
	FF	\$1,764,252,652	\$0	\$1,775,049,836	(\$922,514)	(\$2,050,915)
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	\$21,290,686	\$0	\$21,847,209	\$116,204	\$133,108
	FTE	313.0	0.0	313.5	1.8	2.0
	GF	\$7,675,241	\$0	\$7,865,443	\$58,102	\$66,554
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$1,974,533	\$0	\$2,030,651	\$0	\$0
	RF	\$448,289	\$0	\$448,289	\$0	\$0
	FF	\$11,192,623	\$0	\$11,502,826	\$58,102	\$66,554
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	Total	\$2,024,577	\$0	\$2,024,577	\$8,106	\$8,842
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$627,749	\$0	\$627,749	\$4,053	\$4,421
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$255,164	\$0	\$255,164	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$1,141,664	\$0	\$1,141,664	\$4,053	\$4,421
(1) Executive Director's Office; (A) General Administration, Short-term Disability	Total	\$32,188	\$0	\$32,188	\$184	\$212
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$12,334	\$0	\$12,334	\$92	\$106
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$2,503	\$0	\$2,503	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$17,351	\$0	\$17,351	\$92	\$106

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
Fund		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	Total	\$532,854	\$0	\$532,854	\$3,718	\$4,792
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$190,728	\$0	\$190,728	\$1,859	\$2,396
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$53,148	\$0	\$53,148	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$288,978	\$0	\$288,978	\$1,859	\$2,396
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	Total	\$427,325	\$0	\$427,325	\$3,196	\$4,326
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$151,785	\$0	\$151,785	\$1,598	\$2,163
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$42,482	\$0	\$42,482	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$233,058	\$0	\$233,058	\$1,598	\$2,163
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	\$1,586,232	\$0	\$1,546,560	\$11,306	\$1,900
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$679,994	\$0	\$708,357	\$5,653	\$950
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$101,248	\$0	\$53,049	\$0	\$0
	RF	\$13,461	\$0	\$13,461	\$0	\$0
	FF	\$791,529	\$0	\$771,693	\$5,653	\$950
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	\$6,596,052	\$0	\$6,410,052	(\$52,000)	(\$52,000)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,430,918	\$0	\$1,487,168	(\$26,000)	(\$26,000)
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$721,750	\$0	\$497,500	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$4,443,384	\$0	\$4,425,384	(\$26,000)	(\$26,000)
(2) Medical Services Premiums	Total	\$3,543,863,749	\$0	\$3,559,795,929	(\$1,935,744)	(\$4,203,011)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$898,839,033	\$0	\$981,320,305	(\$910,826)	(\$1,983,469)
	GFE	\$284,175,417	\$0	\$284,175,417	\$0	\$0
	CF	\$608,317,175	\$0	\$534,529,617	(\$57,047)	(\$118,037)
	RF	\$6,388,059	\$0	\$3,101,708	\$0	\$0
	FF	\$1,746,144,065	\$0	\$1,756,668,882	(\$967,871)	(\$2,101,505)

Letternote Text Revision Required? Yes: No: If yes, describe the Letternote Text Revision:
 Cash or Federal Fund Name and COFRS Fund Number: CF: 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: None.
 Approval by OIT? Yes: No: Not Required:
 Schedule 13s from Affected Departments: None.
 Other Information:



DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

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

Susan E. Birch
Executive Director

Department Priority: R-5
Request Title: Medicaid Fee-for-Service Reform

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Medicaid Fee-for-Service Reform	(\$1,845,030)	(\$865,469)	1.8

Request Summary:

The Department requests a reduction of \$1,845,030 total funds, \$865,469 General Fund in FY 2012-13 and a reduction of \$4,101,831 total funds, \$1,932,879 General Fund in FY 2013-14 to implement payment reforms that will better align provider incentives with delivering quality, efficient care. This request expands on the studies funded by FY 2010-11 BRI-2/BA-13, "Coordinated Payment and Payment Reform" (COPPR), in key service areas and in conjunction with opportunities provided by the federal government. It proposes several initiatives that carry out the Department's mission and vision, as stated in the strategic plan, by improving the delivery and cost-effectiveness of health care services.

Medicaid services are largely reimbursed on a fee-for-service basis in Colorado, a system that encourages high volumes of services rather than cost-effective care. Providers have little financial incentive to manage and coordinate care for their clients, resulting in an increased likelihood of preventable episodes that need to be treated in the emergency room or inpatient hospital setting. This reimbursement system leads to greater costs for the State.

Most of the payment reforms included in this request involve an element of gainsharing, which is a payment methodology whereby providers receive a percentage of savings that result in other

service categories from greater care management of their clients. Gainsharing puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the gainsharing reforms are guaranteed to be budget neutral or negative.

Physical and Behavioral Health Payment Reforms

The Department requests to implement a gainsharing payment system whereby Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are paid a percentage of any savings in expenditure incurred by clients attributable to their centers. This will result in savings to the State and better health outcomes for clients.

The Department requests to create a gainsharing incentive plan in which Behavioral Health Organizations (BHOs) are held accountable for managing expenditure on psychotropic drugs for seriously and persistently mentally ill clients.

The Department requests funding to hire a consultant to research and plan a pilot program in which participating primary care providers are paid prospectively for services provided in their offices and episodes of care for their clients.

The Department requests to establish an incentive pool to make gainsharing payments to physicians in order to provide cost savings to other Medicaid service categories. These payments would be funded solely from enhanced federal funds for physician rates provided through the Affordable Care Act (ACA). The ACA requires that, for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The Department anticipates that a gainsharing program will meet this requirement.

The Department requests the authority to pay gainsharing incentive payments to providers participating in the Accountable Care Collaborative (ACC) starting in FY 2012-13. Implementing gainsharing in this program will allow the ACC providers to share in any demonstrable aggregate savings of over 7.0% per client, which will provide a concrete incentive for them to manage care in a way that will produce savings beyond the amount already appropriated.

Long-Term Care Payment Reforms

The Department requests funding to redesign the assessment tool and care-planning system for long-term care services in order to create robust, person-centered budgets.

The Department requests funding to study the feasibility and potential impact of changing the long-term care delivery system to include palliative care as a Medicaid benefit and to consolidate services for clients living in naturally occurring retirement communities.

FTE and Operating Expenses

The Department requests 1.0 FTE at the General Professional IV level and 1.0 FTE at the Rates/Financial Analyst II level to coordinate and implement each of the initiatives listed above.

Anticipated Outcomes:

The Department anticipates that creating financial incentives for providers to reduce unnecessary emergency or specialty care will not only

generate short term savings, but also slow long-term Medicaid cost growth.

Please see Appendix A for detailed explanations of anticipated outcomes for each initiative.

Assumptions for Calculations:

Please see Appendix C for detailed calculations.

Consequences if not Funded:

If this request is not funded, the Department will not be able to change its payment systems in a way that will incentivize providers to deliver quality and efficient care. The current payment system provides little incentive for fee-for-service providers to effectively manage and coordinate care for their clients. Providers should be rewarded for delivering cost-effective care by sharing in any accrued savings that result from clients attributable to their practices. Implementing these reforms will foster better client outcomes and short- and long-term efficiencies to the State.

Cash Fund Projections:

Please see Appendix B for a summary table of the cash fund projections.

Relation to Performance Measures:

The requested initiatives would allow the Department to meet its performance measures, as specified in its strategic plan, to improve health outcomes, contain health care costs, and improve the long-term care delivery system. The proposed payment reforms create incentives for providers to manage client health care more effectively and to prevent avoidable complications that result in more costly care. The Department is also focusing on its long-term care delivery system for future improvements.

Current Statutory Authority or Needed Statutory Change:

The Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per section 25.5-4-401(1)(a), C.R.S. (2011).

Appendix A: Medicaid Fee-for-Service Reform Detailed Narrative

In this request, the Department is proposing to reform payment systems to better align provider incentives with delivering quality, efficient care. The Department requested funding to investigate a series of initiatives to reform payment methodologies in FY 2010-11 BRI-2/BA-13, “Coordinated Payment and Payment Reform” (COPPR). This request expands on the results of those studies by requesting to implement payment reforms in key service areas, many in conjunction with financing opportunities provided by the federal government. It proposes several initiatives that carry out the Department’s mission and vision, as stated in the strategic plan, by improving the delivery and cost-effectiveness of health care services. As these reforms tie directly to the Department’s work done thus far through COPPR, the annualization of the appropriated funds from COPPR equaling \$532,000 total funds, \$266,000 General Fund will be incorporated into this request and used to take the next steps in understanding and implementing payment reform.

Most of the payment reforms included in this request involve an element of gainsharing, which is a payment methodology whereby providers receive a percentage of savings that result from greater care management of their clients. Gainsharing puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the gainsharing reforms are guaranteed to be budget neutral or negative. If providers do not produce savings, they will receive no incentive payments and the Department will incur no additional costs. In the more likely case that providers respond to the incentives by concentrating efforts on reducing their clients’ expenditure, the Department will pay a percentage of the savings and retain the rest, resulting in an overall cost savings to the State. Each of the gainsharing initiatives will be implemented through a state plan amendment and, when necessary, a change to the Medical Services Board rules to ensure that they meet compliance with federal and state regulations.

Implementing several payment reforms simultaneously requires a tangible system for determining which providers produced savings in the target service categories. The Department will use a standardized method of attributing clients to the providers with whom they receive the majority of their care. Many clients in the fee-for-service program have access to see any provider of their choice and are not locked in to one organization or physician – the Department is not requesting to change that system in this request. To determine savings and incentive payments for providers, however, the Department would attribute those clients to whichever provider they consistently see for their care, based on the clients’ claims data. For example, a client may have received treatment at several places of service during a year but most consistently received services at a particular FQHC. If the FQHC was able to reduce expenditure for that client in that year, those savings would be attributable to the FQHC and not the other providers that the client saw infrequently. This way, the Department can allocate savings to the providers that were most invested in each client’s health. Further, this gives providers an additional incentive to function as medical homes for clients. Attributing clients to a particular provider encourages the provider to be responsible for the clients and are thus more likely to coordinate and oversee their care.

The first section of this request includes payment reforms to physical and behavioral health. Two of the initiatives in that section are ready to be implemented in FY 2012-13 and are expected to generate savings in that fiscal year. The second section of this request includes payment reforms to long-term care. The Department is requesting to use a portion of the existing COPPR funding to continue studying how to best

implement reforms in that area; as a result, the studies requested are essentially funded through continuation funding. Each reform in this request is different based on the type of program and how federal health care initiatives may affect it. The overarching goal of each is the same, however – to reform reimbursement systems to reward providers for improved performance, measured by both cost-savings and client clinical outcomes, and to do so in a way that is sustainable in the long run for the State.

Physical and Behavioral Health Payment Reforms

FQHC and RHC Rate Reform and Gainsharing

The Department requests a reduction of \$1,594,121 total funds, \$750,082 General Fund in FY 2012-13 and a reduction of \$3,320,426 total funds, \$1,568,186 General Fund in FY 2013-14 to implement a gainsharing payment system whereby Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are paid a percentage of any savings in expenditure incurred by clients attributable to their center. This would result in savings to the State and better health outcomes for clients.

A recent article written by Department staff and published in *Health Affairs*¹ reported results from a study on the impact of FQHCs in Colorado. The authors found that Medicaid clients whose usual source of care was an FQHC during that fiscal year were about one-third less likely to have emergency department visits, inpatient hospitalizations, or preventable hospital admissions than Medicaid clients whose usual source of care was a private, fee-for-service provider. The decreased probability of avoidable treatment among FQHC clients was statistically significant for all of the outcome variables. Currently, several FQHCs and RHCs are working with the Department in conjunction with JSI Research and Training Institute, Inc. in a data collection initiative that will focus on measuring outcomes for more intentional care management. This project will greatly aid the FQHCs and RHCs in understanding where they can continue to decrease expenditure in those service categories and how it can be accomplished.

FQHCs and RHCs are already managing care in a way that produces less cost to the State in other service categories and better health outcomes for their clients. The Department would like to further incentivize this behavior by implementing a gainsharing program, allowing the centers to share a portion of any demonstrable savings. Savings would be measured as the difference between expenditure for hospital services and prescription drugs from the current year to the prior year for clients attributable to each FQHC and RHC. A percentage of savings achieved by each FQHC and RHC would then be paid as a supplemental payment. This program would be budget neutral or negative because it pays providers only if they achieve savings. The supplemental payments would be a percentage of the total savings while the State retains the remainder. The program will begin January 1, 2013. Payments would be lagged by six months due to the required runout of claims – the first payments would be made in FY 2013-14 for savings accrued in the latter six months of FY 2012-13. After that, the payments would be made on an annual basis for the savings accrued over the previous year.

The specific outcomes that the Department would measure include the following: generic drug utilization, hospital readmissions, outpatient hospital visits, and emergency department visits. The Department assumes that the FQHCs and RHCs will be able to reduce utilization and expenditure in each of these areas by 5%, and that they would receive 50% of those savings as supplemental payments. This reduction estimate is feasible given that many of the FQHCs and RHCs are already actively engaged in conversations with the Department and other organizations, such as JSI Research and Training Institute, Inc., regarding

¹ Jennifer Rothkopf, Katie Brookler, Sandeep Wadhwa and Michael Sajovetz. “Medicaid Patients Seen At Federally Qualified Health Centers Use Hospital Services Less Than Those Seen By Private Providers.” *Health Affairs*, 30, no.7 (2011): 1335-1342.

how to measure outcomes and reduce expenditure in those areas. There is evidence that the FQHCs and RHCs are able to manage care in a way that will produce savings elsewhere, and the Department is confident that they will continue to improve. In addition, the FQHCs and RHCs are likely to respond to incentive programs as the majority of their funding comes from Medicaid or Medicare. In contrast, the Department is not requesting savings for a similar gainsharing program for physicians, described below; the Department anticipates that there will be a longer lag in time for physicians to make significant reductions in expenditure in these areas, and the magnitude of savings that physicians can achieve is unclear at this time.

To estimate the savings generated from reducing expenditure in these areas, the Department attributed Medicaid clients in the FY 2009-10 claims data to FQHCs and RHCs and calculated utilization and expenditure for the outcome variables during that year. A client was attributed to a center if they had two or more visits to the center during the fiscal year, at least one full year of enrollment in Medicaid, and at least one evaluation and management procedure code billed during the fiscal year. Please see tables A.1, A.2, A.3, and A.4 for detailed calculations of the savings estimates.

The Department has been working with the FQHCs and RHCs on the possibility of reforming their reimbursement methodology to incentivize certain outcome measures. If this request is approved, the Department will continue to involve them and other stakeholders in each step of implementing the gainsharing program.

Primary Care Provider Subcapitation Pilot Program

The Department requests \$112,500 total funds, \$56,250 General Fund in FY 2012-13 and \$112,500 total funds, \$56,250 General Fund in FY 2013-14 for a consultant to research and plan a pilot program in which participating primary care providers are paid prospectively for services provided in their offices and episodes of care for their clients. The Department assumes that the consultant would need 500 hours to research the program at an estimated rate of \$225 per hour, and that the Department can use a currently contracted vendor to do the research and analysis. The vendor would then be able to begin working on this program in July 2012.

PROMETHEUS Payment² is a model designed by the Health Care Incentives Improvement Institute (HCI3) to set rates for providers that both compensates them fairly and incentivizes them to deliver quality, efficient episodes of care. An episode refers to the entire treatment period, from diagnosis until the end of treatment. The Department would use this model to develop a rate schedule and incentive plan for primary care providers to participate in the pilot program in a future fiscal year. Through the support from the non-profit organization Colorado Health Foundation, HCI3 is conducting an implementation of the PROMETHEUS Payment Model in at least three different pilot sites across Colorado. The results of those pilots will help guide the Department in planning its pilot program. The Colorado Business Group on Health (CBGH) performed preliminary analysis on the potential for the PROMETHEUS Payment Model to impact expenditure for the Department using two years of claims data. In the resulting report provided to the Department³, CBGH found that implementing this sort of payment methodology would produce significantly more savings to the State than the costs to run the program.

² www.prometheuspayment.org

³ "A Report to HCPF on the Feasibility and Benefits of Implementing Bundled Payments." Colorado Business Group on Health, June 2011.

Currently, primary care providers are not at risk for the costs of referring clients to specialists within their office or for any laboratory work for their clients. This can result in inappropriate referrals for and utilization of these services. Once implemented, this pilot program would pay providers prospectively for the work delivered in physicians' offices, including specialty care, as well as for all laboratory work done inside and outside of the physicians' offices. If the physician provides care that shows measurable savings, the provider would receive an incentive payment, calculated in the same way as the gainsharing methodology for FQHCs and RHCs, as discussed above. The incentive would only be paid out if the provider maintains quality standards predetermined by the Department and stakeholders, ensuring that quality of care does not suffer in providers' efforts to decrease costs.

The Department does not expect to implement this program in FY 2012-13, but to begin planning in conjunction with HCI3 and to assess how the program will impact costs and outcomes. This would be accomplished through a shadow model in which the Department will analyze how providers would have been paid during that year if the program was implemented. This program is also intended to work in conjunction with the primary care changes under section 1202 of the Health Care and Education Reconciliation Act (HCER), an amendment to the Affordable Care Act (ACA), as discussed below. Specifically, the Department would use the increase in payments to primary care providers through section 1202 of the HCER as a baseline to then establish how the episodic payments would be made in the primary care subcapitation pilot program once it is implemented.

Grant funding was awarded by the Colorado Health Foundation to HCI3, and there is a possibility that the Department will be able to use some of this funding for administration costs once the program begins; there is no grant funding, however, for the technical costs of designing the program prior to implementation. The Department's funding request is to plan and design the pilot program. If the shadow model is successful, the Department would request to implement the program through the standard budget process upon completion of the shadow model and assessment period.

Psychotropic Utilization Reduction Gainsharing

To align Behavioral Health Organization (BHO) objectives with more efficient outcomes, the Department is requesting a reduction of \$319,123 total funds, \$149,494 General Fund in FY 2012-13 and a reduction of \$860,085 total funds, \$404,033 General Fund in FY 2013-14 to create an incentive plan in which BHOs are held accountable for managing expenditure on psychotropic drugs for their seriously and persistently mentally ill clients.

BHOs manage the mental health benefits for Medicaid clients, but they are not contractually responsible to cover any pharmacy expenditures. The Department pays for all pharmaceuticals through fee-for-service. The Department can incentivize better management of mental health psychotropic drugs by implementing a gainsharing program, which would reward BHOs for having cost-effective prescription practices.

The Department is requesting to implement this by calculating a projected baseline of expenditure on psychotropic drugs for each BHO and a target savings amount below that baseline that the BHOs have to reach. After a set period of time, actual fee-for-service expenditure on psychotropic drugs by BHO would be compared to the projected baseline amount and the target savings amount. The BHOs that meet quality performance measures established by the Department, with input from the BHOs and stakeholders, would then be eligible to receive a percentage of any additional savings they achieved in the form of supplemental payments. The program will focus on the pharmacy expenditure for seriously and persistently mentally ill

clients as those clients have the most contact with the BHOs and are prescribed mainly within the BHO networks.

By implementing this rate reform, BHOs would have a vested interest to prescribe less expensive drugs when possible and to ensure that prescription drugs are the most appropriate treatment method. The Department would also retain some of the savings in pharmacy expenditure, ensuring that this program is budget neutral or negative. If it is determined with stakeholder input that the BHOs can expand the scope of this program to include all of their members, the Department may request for that change through the standard budget process.

The Department would amend BHO contracts to allow the BHOs to manage pharmaceuticals for their clients over the initial period of January 1, 2013 through June 30, 2013. In order to determine if savings have been achieved, the Department assumes that it will require 6 months after the period is closed before any gainsharing payment can be made. This lag is required in order to: allow for all claims to be processed; allow for the collection of drug rebates; and, allow for the gainsharing payment to be calculated and reviewed. As a result, the Department estimates that the first gainsharing payment, if achieved, would not be made until January or February of 2014 (in FY 2013-14). The Department will continue to calculate the savings and make the payments every six months. In order to properly calculate the earned incentive payments, the Department requests \$22,500 total funds, \$11,250 General Fund to increase the contract funding for actuarial certification of the BHO rates each calendar year.

Based on preliminary discussions with the BHOs, the Department will set the target savings percentage at 3%. All savings up to the 3% target would accrue to the Department. Savings beyond the 3% target would be split between the BHOs and the Department, with the BHOs retaining 60% of the savings and the state retaining 40%. The Department assumes that the BHOs would receive over 50% of the additional savings to account for the fact that they already had to achieve a significant amount of savings to reach the 3% target. They can then use the payments to reinvest in outreach efforts to reduce pharmacy expenditure, which would continue to bend the cost curve and produce higher incentive payments for the BHOs.

To be conservative, the Department is only requesting a decrease of funds in Medical Services Premiums equal to achieving the 3% target. Because utilization of these drugs is not currently managed, the Department believes this savings percentage is attainable in FY 2012-13. The Department estimates that the reduction to Medical Services Premiums related to hitting the 3% savings target will be \$341,623 total funds, \$160,744 General Fund in FY 2012-13 and \$882,585 total funds, \$415,283 General Fund in FY 2013-14. See table B.1 for calculations.

In order to properly account for the potential payment of incentives, the Department requests that a footnote be added to the Long Bill beginning in FY 2013-14 that allows for a transfer of up to \$478,273 total funds from the Medical Services Premiums Long Bill group to the Medicaid Mental Health Community Programs Long Bill group. The amount of the transfer is calculated based on a total savings assumption of 10% for the first six months of the program; the Department believes this is a sufficient upper limit for the savings potential for the first year of the program. If 10% savings is achieved, the Department estimates that it would achieve an additional \$797,121 total funds savings in FY 2012-13 and an additional \$1,581,091 total funds savings in FY 2013-14. See table B.3 for calculations.

The Department is requesting transfer authority as opposed to spending authority because it is not clear that the BHOs can achieve savings above the 3% target. If the Department was appropriated additional spending authority in the Medicaid Mental Health Community Programs Long Bill group, there would need

to be a corresponding decrease to the Medical Services Premiums Long Bill group. If, however, the BHOs did not achieve the additional savings, the Department would be at risk of an overexpenditure. In the future, the Department would use the normal budget process to account for any savings achieved; once the program is well established, the Department may seek to convert the transfer authority to spending authority.

Physician Rate Reform and Gainsharing (Sec. 1202 of the Health Care and Education Reconciliation Act)

The Department is requesting to use enhanced federal funds for physician rates provided through section 1202 of the Health Care and Education Reconciliation Act (HCER), an amendment to the Affordable Care Act (ACA), to establish an incentive pool for physicians in order to provide cost savings to other Medicaid service categories. For this reform, along with the ACC gainsharing incentive payment reform described below, the Department is requesting for authority to change reimbursement methodologies without corresponding changes to the Department's appropriation.

Section 1202 of the HCER states that for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate will apply to certain primary care services, including evaluation and management and immunizations, performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

Subject to approval by the Centers for Medicare and Medicaid Services (CMS), rather than increasing rates for those specific codes and practitioners specified in the HCER, the Department will make supplemental payments to qualifying physicians based on predetermined quality measures calculated periodically. In aggregate, the total amount of the supplemental payments will be based on the amount the Department would have paid for those services at the higher Medicaid rates; in this way, the Department will ensure that the program is both budget neutral and in compliance with the federal law requiring payment at not less than 100% of the Medicare rate.

The specific quality measures will be developed in conjunction with stakeholders, but will focus on reducing hospital utilization and expenditure. Physicians who are able to perform better on these quality measures relative to other physicians will receive higher incentive payments. The Department believes that there is the potential for significant savings from implementing this reform – higher incentives will be paid out to physicians who demonstrate that they reduced their clients' utilization of hospital services. It will also give physicians more responsibility for managing care for their clients, which will produce better health outcomes for clients.

The Department is not requesting a decrease in its appropriation to reflect the potential savings of this reform. It is unknown whether physicians can make meaningful impacts on expenditure for their clients in the first year of the program; physicians may need time to gather information on the quality measures to affect client behavior, creating a lag in savings. The Department also does not know by how much the physicians have been able to decrease expenditure in these areas in the past, in contrast to the evidence showing the impact that FQHCs and RHCs have had in the past, as described above. If approved, the Department would track and analyze the impact of this reimbursement change throughout the timeframe of the program to reach a more informed decision on whether it can produce savings and the magnitude of those savings.

The Department is designing this program to be sustainable after the enhanced FMAP expires at the end of 2014. In order to do so, the Department must show that the incentive payments are directly tied to reductions in other areas. As part of calculating supplemental payments, the Department will assess whether the gainsharing methodology has saved the State money beyond the cost of maintaining the funding available in the incentive pool. If the incentive program is shown to demonstratively reduce costs in other areas, the Department would use the standard budget process to request the continuation of the program; this would only occur if the Department can show that the program is at least budget neutral.

Since the increase in physician rates is federally mandated, the Department is not requesting for a change in appropriation in this request but for the authority to use the increase as an incentive pool. The anticipated increase to physician payments will be accounted for in the Department's November 2011 Request for Medical Services Premiums (R1). Based on preliminary calculations, the Department estimates that the incentive pool will equal \$4,950,838 in FY 2012-13 and \$12,872,971 in FY 2013-14.

Instituting this program would decrease the growth in expenditure on other service categories through the same gainsharing mechanism as the FQHC/RHC rate reform. It would foster improved client health through more intentional care management at the physician level, much as the FQHC/RHC payment reform focuses these efforts at the center level. Implementing these two programs together would capture a large portion of the physical health delivery system.

Accountable Care Collaborative Gainsharing Incentive Payments

The Department is requesting the authority to pay gainsharing incentive payments to providers participating in the Accountable Care Collaborative (ACC)⁴ starting in FY 2012-13.

The ACC is expected to decrease aggregate expenditure per enrolled client by 7%, and the Department's appropriation includes that reduction. Currently there is no incentive for the providers in the ACC to reduce expenditure per client beyond that percentage. Implementing gainsharing into this program would allow the Regional Care Collaboration Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs) to share in any demonstrable aggregate savings of over 7% per client. This creates a concrete incentive for providers to manage their clients' care in the most cost-effective way.

The Department is not including any expected savings into this request but the authority to pay a percentage of the savings to the ACC providers. If aggregate per enrollee expenditure is not reduced by more than 7%, than no payments will be made and the Department would only achieve those savings that it was already appropriated. If aggregate per enrollee expenditure is reduced by more than 7%, the Department would retain a portion of those savings and pay the rest as supplemental payments. Implementing gainsharing in the ACC is budget neutral or negative. The Statewide Data and Analytics Contractor (SDAC) currently working with the Department to track and analyze ACC client data is already tasked with calculating the cost savings per client by RCCO and can send that data to the Department quarterly. This information can then be used to determine any supplemental payments owed to the RCCOs.

The specific components of the gainsharing program would be designed in conjunction with stakeholders for an estimated implementation date of January 1, 2013. In particular, the Department would work with the RCCOs and PCMPs to develop a method for determining how the payments will be split between those

⁴ The Accountable Care Collaborative was originally requested in FY 2010-11 S-6/BA-5, "Accountable Care Collaborative."

two entities. The Department would involve the ACC providers and other interested stakeholders in each step to ensure that the program is successful.

Long-Term Care Payment Reforms

Person-Centered Payments in Long-Term Care

The Department requests \$220,000 total funds, \$110,000 General Fund in FY 2012-13 and \$220,000 total funds, \$110,000 General Fund in FY 2013-14 to redesign the assessment tool and care-planning system for long-term care services in order to create robust person-centered budgets for clients in long-term care programs. A person-centered budget is a set amount allocated for a client that is determined by the assessment of the client's needs, which will ultimately lead to significant cost savings for the State and improved health outcomes for clients in long-term care programs.

The Department contracts with single entry point (SEP) agencies to provide information about long-term care services and to assess individuals' needs for services. The SEP agencies perform level-of-care determinations for eligibility for Medicaid waiver and nursing facility services, develop care plans based on those assessments, and provide case management services for individuals receiving Medicaid waiver services. Data from the clients' assessments and their assignments into programs are compiled and stored in the Benefits Utilization System (BUS), which also maintains records of case management services provided to clients receiving long-term care.

The SEPs and the BUS are crucial components of the long-term care delivery system. Jointly, they ensure that clients receive timely information on services, proper assessments of their needs, and case management over time. The current system is not effective or efficient in meeting clients' needs, largely due to its fragmentation. The SEP agencies do not coordinate with other providers managing long-term care services for their clients. The current assessment instrument (known as the ULTC 100.2) requires time-consuming, costly manual data entry and does not yield consistent care plans for clients as it relies on subjective and inconsistent decision making by the case managers. Information from the BUS is difficult to access and is not linked to the MMIS, inhibiting case managers and Department staff from gaining a cohesive understanding of a client's needs and utilization pattern and preventing the Department from making data-informed quality incentive payments based on this information. Without robust data on clients, there is no way to reform the payment structure of long-term care services to be more centered on clients and to reduce cost inefficiencies.

The Department proposes to redesign the current client assessment instrument, the plan of care process, case management, and payment system through a multi-year initiative. In FY 2012-13 and FY 2013-14, the Department would work with stakeholders to develop a new assessment instrument that would identify an individual's functional abilities, assess an individual's need for services, translate those needs into a written plan of care for the individual using standardized care-planning algorithms, and upload the data into a client case file. The Department would also begin building a new information system that can upload authorized service levels into the MMIS to tie the assessments and care plans to the payments made for the clients and to allow for greater data analysis of their utilization and expenditure trends.

Once the Department has adequate tools to assess clients for long-term care services, the Department can develop budgets for clients based on their individual needs. This will allow case managers and clients to manage expenditure under a set amount, ensuring that the services provided and amounts paid are chosen appropriately and are comparable to the amounts paid for clients with similar severities of conditions. It

will also encourage greater cooperation between the client, his/her case manager, and the client's providers. The Department anticipates that this reform will result in increased care coordination and decreased costs in the long run.

The Department requests funding for approximately 1,100 consulting hours to research the Department's needs and determine a concrete plan for replacing the BUS and the current assessment instrument. It is anticipated that the Department will use this funding to contract with different vendors for specific issues throughout the year. As a result, the exact start dates and task orders for the studies are uncertain. Table C details the Department's estimate on how many hours each will be needed to study the BUS and the assessment instrument. The Department does not expect to have solved all problems associated with implementation in FY 2012-13 but to continue working with its vendors in FY 2013-14, which will ensure that the components are implemented successfully and are as effective as possible.

In future budget cycles, the Department may request to change the reimbursement structure for long-term care services once the new assessment tool and BUS are in place. The Department expects that this payment reform would ensure that payments are allocated to the most appropriate services for clients, decreasing the incentive to provide services that are not effective or beneficial to clients and reducing overall Department spending on long-term care services.

Study Future Long-Term Care Goals

The Department is requesting \$125,000 total funds, \$62,500 General Fund in FY 2012-13 and \$125,000 total funds, \$62,500 General Fund in FY 2013-14 to study the feasibility and potential impact of changing the long-term care delivery system in the following areas:

- **Include Palliative Care as a Medicaid Benefit:** There are many Medicaid enrollees whose health and well-being would be improved with enhanced palliative care services instead of other unneeded, unwanted, and costly medical procedures. Although palliative care is often associated with "end of life" care, it is more broadly associated with pain relief and other health and emotional support for individuals with a wide range of serious chronic illnesses, including cancer, congestive heart failure, kidney failure, chronic obstructive pulmonary disease, AIDS, and Alzheimer's disease.

The Department proposes to convene a group of medical professionals, consumers, and their families to evaluate the costs and benefits of an enhanced focus on palliative care services. The Department will evaluate data on Medicaid enrollees with specific chronic illnesses and do both quantitative and qualitative research on specific service interventions, using evidence-based research from other states on the impact of targeted services on specific chronic illnesses. The advisory group will work with the Department to analyze the data and make recommendations for demonstration programs of enhanced palliative care.

- **Consolidate Services for Clients Living in Naturally Occurring Retirement Communities:** The Department proposes to explore the development of both naturally occurring retirement communities (NORCs) and naturally occurring regions (NORs) as a method to maximize efficiency and effectiveness of long-term care services delivery. NORCs were developed to address the desires of older adults who needed long-term care and wanted to continue to live at home. Health and social service planners discovered that many people needing services were living independently in housing that was in close proximity to one another and developed programs where services could be consolidated and delivered by specific providers with lower overall cost. Today NORCs in many locations throughout the U.S.

deliver cost-effective case management, health care management, education, recreation and socialization services to community members. NORCs have demonstrated significant savings by reducing the risk and incidence of heart disease and Alzheimer's disease in older adults, encouraging older adults to utilize and participate in community resources, preventing hospital readmissions, and reducing the risk of falls in older adults⁵.

The Department proposes to convene an advisory group comprised of a broad group of health and social services providers, consumers and family members, as well as other state and local government and community organizations to evaluate the feasibility of developing these types of programs in Colorado. NORCs began in urban areas where individuals needing services were living close together, but there is no reason why this concept could not be applied to a suburban or rural area, resulting in a NOR. The Department will analyze the location where Medicaid enrollees receiving long-term care or other chronic care services are residing, identify common services they are receiving from state and local governments, and analyze the costs and benefits of consolidating services for those individuals. The Department will work with the advisory to develop a demonstration program, if determined feasible, that would measure both health and social outcomes.

The Department requests funding for approximately 625 consulting hours to research the Department's needs and determine a concrete plan for implementing these two initiatives. It is anticipated that the Department will use this funding to contract with different vendors for specific issues throughout the year. As a result, the exact start dates and task orders for the studies are uncertain. Table D details the Department's estimate on how many hours each will be needed to study palliative care and naturally occurring retirement communities. The Department does not expect to have solved all problems associated with implementation in FY 2012-13 but to continue working with its vendors in FY 2013-14, which will ensure that the components are implemented successfully and are as effective as possible.

FTE and Operating Expenses

The Department requests 1.0 FTE at the Rate/Financial Analyst II level to design the program and rates for these initiatives, as described in detail above. The FTE would need to establish the gainsharing methodology for each of the gainsharing reforms, attribute clients to providers, and calculate savings and incentive payments for each program. The FTE would also be responsible for procuring and maintaining contracts with the vendors for each of the requested studies. In addition, the FTE would clear all payment changes with the Centers for Medicare and Medicaid Services (CMS) through state plan amendments and ensure those changes are reflected in rule.

The Department also requests 1.0 FTE at the General Professional IV level to implement these initiatives. The FTE would be responsible for drafting and managing the required provider contracts for each of the reforms and fielding questions and concerns from providers and other stakeholders. The FTE would collaborate with Department staff and provider groups to make sure that each initiative is implemented on time and with input from all applicable parties.

As soon as the Long Bill is signed, the Department would begin the process of hiring the FTE, allowing them to begin as soon after July 1, 2012 as possible. This will give them time to be trained and ready to implement and manage the initiatives, most of which begin January 1, 2013.

⁵ Bedney, Barbara Joyce and Robert Goldberg. "Health Care Cost Containment and NORC Supportive Service Programs: An Overview and Literature Review." *NORCs: An Aging in Place Initiative*. The Jewish Federations of North America, Inc., 22 April 2009. Web. 26 July 2011.

Other Long-Term Care Initiatives

The Department is also pursuing other long-term care initiatives using existing resources.

Community First Choice Option in the State Plan

In addition to the studies requested above, the Department is currently investigating the feasibility of offering the Community First Choice program as a state plan service for disabled individuals and eliminating the Consumer Directed Attendant Support Services (CDASS) program as a home and community based waiver benefit. This will continue to be a priority for research using the Department's existing resources.

Section 2401 of the Affordable Care Act (ACA) specifies that states will receive an increase to its federal financial participation rate of 6 percentage points on services provided under the Community First Choice program, effective October 1, 2011. This program is very similar in scope to the current CDASS program offered under the Elderly, Blind, and Disabled (EBD) and the Mental Illness (MI) waivers and to a small client population covered under the state plan. It is designed to allow clients to stay in their communities instead of being moved to nursing facilities and to give them independence in determining how services are delivered to them. The Department will study how the program can be added as state plan benefit available to clients who need assistance with daily living. Since it will be offered in the state plan, it will no longer need to be offered as a waiver service. Eventually, clients in the Community First Choice program will be given person-centered budgets, as described above.

If the Department determines that this program can be implemented in its state plan, the Department would submit a request through the standard budget process.

Health Homes to Better Integrate Physical and Mental Health for Clients with Chronic Conditions

The Department is also researching how it can design and implement a health home program for clients with chronic conditions. These provider teams will likely include physical health providers, such as the RCCOs; mental health providers, such as Community Mental Health Centers (CMHCs); and long-term care organizations and single entry points.

Section 2703 of the Affordable Care Act (ACA) allocates an enhanced federal match of 90% for payments made to health homes for providing the following activities to their clients: comprehensive care management, care coordination/health promotion, comprehensive transitional care, patient and family support, referrals to community and social support services, and use of Health Information Technology (HIT) to link services. The Department is already paying for some of these activities and could receive a 90% match on those payments, as well as for any enhanced payments for the health home teams to provide more of these services.

The enhanced match from this provision will only apply for eight quarters, effective on the date articulated in the state plan amendment to implement chronic health homes. However, evidence regarding health homes indicates that providing coordinated care to clients will produce better and more efficient outcomes. The Department is studying how to target these objectives by implementing a gainsharing methodology whereby health home providers are paid a percentage of savings from decreasing utilization of other services by clients attributable to those providers. Because of the temporary nature of the enhanced federal

funding, the Department is still investigating how to implement the program in a manner which is sustainable when the enhanced federal funding expires. The Department will request to implement this program once it has established an implementation plan detailing the required program and administrative costs needed and how savings will be achieved.

Timeline

The following table shows the implementation timeline for each of the components of the request:

Item Requested	Administrative Funding for FY 2012-13	Procurement Method if Consultant Costs	Estimated Date Accomplished
FTE and Operating Expenses			
Hire Rates/Financial Analyst II FTE	\$71,357	-	7/1/2012
Hire General Professional IV FTE	\$71,357	-	7/1/2012
<i>Subtotal FTE and Operating Expenses</i>	\$142,714	-	-
FQHC and RHC Rate Reform and Gainsharing			
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Primary Care Provider Subcapitation Pilot Program			
Hire Consultant for Shadow Program	\$112,500	Amend contract	7/1/2012
<i>Subtotal Primary Care Provider Subcapitation Pilot Program</i>	\$112,500	-	-
BHO Psychotropic Utilization Reduction Gainsharing			
Actuary Costs	\$22,500	Amend contract	7/1/2012
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
<i>Subtotal BHO Psychotropic Utilization Reduction Gainsharing</i>	\$22,500	-	-
Physician Rate Reform and Gainsharing Program			
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Accountable Care Collaborative Gainsharing Incentive Payments			
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Person-Centered Payments in Long-Term Care			
Hire Consultant for BUS Redesign	\$120,000	Documented quote	9/1/2012
Hire Consultant for Assessment Tool Redesign	\$100,000	Documented quote	9/1/2012
<i>Subtotal Person-Centered Payments in Long-Term Care</i>	\$220,000	-	-
Study Future Long-Term Care Goals			
Hire Consultant for Naturally Occurring Retirement Communities	\$75,000	Documented quote	9/1/2012
Hire Consultant for Palliative Care	\$50,000	Documented quote	9/1/2012
<i>Subtotal Study Future Long-Term Care Goals</i>	\$125,000	-	-

Appendix B

<p align="center">Table 1.1 Summary of Request FY 2012-13</p>						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	(\$1,845,030)	(\$865,469)	(\$57,047)	\$0	(\$922,514)	1.8
(1) Executive Director's Office; (A) General Administration, Personal Services	\$116,204	\$58,102	\$0	\$0	\$58,102	1.8
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	\$8,106	\$4,053	\$0	\$0	\$4,053	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	\$184	\$92	\$0	\$0	\$92	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	\$3,718	\$1,859	\$0	\$0	\$1,859	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	\$3,196	\$1,598	\$0	\$0	\$1,598	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	\$11,306	\$5,653	\$0	\$0	\$5,653	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	(\$52,000)	(\$26,000)	\$0	\$0	(\$26,000)	0.0
(2) Medical Services Premiums	(\$1,935,744)	(\$910,826)	(\$57,047)	\$0	(\$967,871)	0.0

Appendix B

Table 1.2 Summary of Request FY 2013-14						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	(\$4,101,831)	(\$1,932,879)	(\$118,037)	\$0	(\$2,050,915)	2.0
(1) Executive Director's Office; (A) General Administration, Personal Services	\$133,108	\$66,554	\$0	\$0	\$66,554	2.0
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	\$8,842	\$4,421	\$0	\$0	\$4,421	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	\$212	\$106	\$0	\$0	\$106	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	\$4,792	\$2,396	\$0	\$0	\$2,396	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	\$4,326	\$2,163	\$0	\$0	\$2,163	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	\$1,900	\$950	\$0	\$0	\$950	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	(\$52,000)	(\$26,000)	\$0	\$0	(\$26,000)	0.0
(2) Medical Services Premiums	(\$4,203,011)	(\$1,983,469)	(\$118,037)	\$0	(\$2,101,505)	0.0

Appendix B

Table 2.1 Cash Fund Summary		
Cash Fund Name	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund
Cash Fund Number	24A	15D
FY 2010-11 Expenditures	\$426,069,052	\$2,903,163
FY 2010-11 End of Year Cash Balance	\$22,198,436	\$6,553,278
FY 2011-12 End of Year Cash Balance Estimate	\$22,198,436	\$4,135,739
FY 2012-13 End of Year Cash Balance Estimate	\$22,198,436	\$3,040,811
FY 2013-14 End of Year Cash Balance Estimate	\$22,198,436	\$660,592

Table 3.1
Impact by Component: Base Fund Split
FY 2012-13

	Table	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request		(\$1,845,030)	(\$865,469)	(\$57,047)	\$0	(\$922,514)	1.8
FTE and Operating Expenses							
(1) Executive Director's Office; (A) General Administration, Personal Services	FTE and Operating Expenses	\$116,204	\$58,102	\$0	\$0	\$58,102	1.8
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	FTE and Operating Expenses	\$8,106	\$4,053	\$0	\$0	\$4,053	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	FTE and Operating Expenses	\$184	\$92	\$0	\$0	\$92	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	FTE and Operating Expenses	\$3,718	\$1,859	\$0	\$0	\$1,859	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	FTE and Operating Expenses	\$3,196	\$1,598	\$0	\$0	\$1,598	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	FTE and Operating Expenses	\$11,306	\$5,653	\$0	\$0	\$5,653	0.0
<i>Subtotal FTE and Operating Expenses</i>		<i>\$142,714</i>	<i>\$71,357</i>	<i>\$0</i>	<i>\$0</i>	<i>\$71,357</i>	<i>1.8</i>
FQHC and RHC Rate Reform and Gainsharing							
(2) Medical Services Premiums	A	(\$1,594,121)	(\$750,082)	(\$46,979)	\$0	(\$797,060)	0.0
<i>Subtotal FQHC and RHC Rate Reform and Gainsharing</i>		<i>(\$1,594,121)</i>	<i>(\$750,082)</i>	<i>(\$46,979)</i>	<i>\$0</i>	<i>(\$797,060)</i>	<i>0.0</i>
Primary Care Provider Subcapitation Pilot Program							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	\$112,500	\$56,250	\$0	\$0	\$56,250	0.0
<i>Subtotal Primary Care Provider Subcapitation Pilot Program</i>		<i>\$112,500</i>	<i>\$56,250</i>	<i>\$0</i>	<i>\$0</i>	<i>\$56,250</i>	<i>0.0</i>
Psychotropic Utilization Reduction Gainsharing							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	B.2	\$22,500	\$11,250	\$0	\$0	\$11,250	0.0
(2) Medical Services Premiums	B.1	(\$341,623)	(\$160,744)	(\$10,068)	\$0	(\$170,811)	0.0
<i>Subtotal Psychotropic Utilization Reduction Gainsharing</i>		<i>(\$319,123)</i>	<i>(\$149,494)</i>	<i>(\$10,068)</i>	<i>\$0</i>	<i>(\$159,561)</i>	<i>0.0</i>
Person-Centered Payments in Long-Term Care							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	C	\$220,000	\$110,000	\$0	\$0	\$110,000	0.0
<i>Subtotal Person-Centered Payments in Long-Term Care</i>		<i>\$220,000</i>	<i>\$110,000</i>	<i>\$0</i>	<i>\$0</i>	<i>\$110,000</i>	<i>0.0</i>
Study Future Long-Term Care Goals							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	D	\$125,000	\$62,500	\$0	\$0	\$62,500	0.0
<i>Subtotal Future Long-Term Care Goals</i>		<i>\$125,000</i>	<i>\$62,500</i>	<i>\$0</i>	<i>\$0</i>	<i>\$62,500</i>	<i>0.0</i>
COPPR Annualization							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	(\$532,000)	(\$266,000)	\$0	\$0	(\$266,000)	0.0
<i>Subtotal COPPR Annualization</i>		<i>(\$532,000)</i>	<i>(\$266,000)</i>	<i>\$0</i>	<i>\$0</i>	<i>(\$266,000)</i>	<i>0.0</i>

Table 3.2 Impact by Component: Base Fund Split FY 2013-14							
Summary of Request FY 2013-14	Table	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request		(\$4,101,831)	(\$1,932,879)	(\$118,037)	\$0	(\$2,050,915)	2.0
FTE and Operating Expenses							
(1) Executive Director's Office; (A) General Administration, Personal Services	FTE and Operating Expenses	\$133,108	\$66,554	\$0	\$0	\$66,554	2.0
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	FTE and Operating Expenses	\$8,842	\$4,421	\$0	\$0	\$4,421	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	FTE and Operating Expenses	\$212	\$106	\$0	\$0	\$106	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	FTE and Operating Expenses	\$4,792	\$2,396	\$0	\$0	\$2,396	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	FTE and Operating Expenses	\$4,326	\$2,163	\$0	\$0	\$2,163	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	FTE and Operating Expenses	\$1,900	\$950	\$0	\$0	\$950	0.0
<i>Subtotal FTE and Operating Expenses</i>		\$153,180	\$76,590	\$0	\$0	\$76,590	2.0
FQHC and RHC Rate Reform and Gainsharing							
(2) Medical Services Premiums	A	(\$3,320,426)	(\$1,568,186)	(\$92,027)	\$0	(\$1,660,213)	0.0
<i>Subtotal FQHC and RHC Rate Reform and Gainsharing</i>		(\$3,320,426)	(\$1,568,186)	(\$92,027)	\$0	(\$1,660,213)	0.0
Primary Care Provider Subcapitation Pilot Program							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	\$112,500	\$56,250	\$0	\$0	\$56,250	0.0
<i>Subtotal Primary Care Provider Subcapitation Pilot Program</i>		\$112,500	\$56,250	\$0	\$0	\$56,250	0.0
Psychotropic Utilization Reduction Gainsharing							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	B.2	\$22,500	\$11,250	\$0	\$0	\$11,250	0.0
(2) Medical Services Premiums	B.1	(\$882,585)	(\$415,283)	(\$26,010)	\$0	(\$441,292)	0.0
<i>Subtotal Psychotropic Utilization Reduction Gainsharing</i>		(\$860,085)	(\$404,033)	(\$26,010)	\$0	(\$430,042)	0.0
Person-Centered Payments in Long-Term Care							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	C	\$220,000	\$110,000	\$0	\$0	\$110,000	0.0
<i>Subtotal Person-Centered Payments in Long-Term Care</i>		\$220,000	\$110,000	\$0	\$0	\$110,000	0.0
Study Future Long-Term Care Goals							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	D	\$125,000	\$62,500	\$0	\$0	\$62,500	0.0
<i>Subtotal Future Long-Term Care Goals</i>		\$125,000	\$62,500	\$0	\$0	\$62,500	0.0
COPPR Annualization							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	(\$532,000)	(\$266,000)	\$0	\$0	(\$266,000)	0.0
<i>Subtotal COPPR Annualization</i>		(\$532,000)	(\$266,000)	\$0	\$0	(\$266,000)	0.0

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Table A.1				
FQHC and RHC Rate Reform and Gainsharing				
Generic Drug Substitution				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Prescription Drugs in FY 2009-10	\$17,127,253	\$17,127,253	Actual expenditure on prescription drugs for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Prescription Drugs from Replacing Brand Names with Generics	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	(\$856,363)	(\$856,363)	Row A * Row B
D	Estimated Trend for Prescription Drugs	6.25%	6.25%	Average expenditure growth in prescription drug expenditure before rebate from FY 2007-08 and FY 2009-10
E	Estimated Total Full Year Savings	(\$1,027,223)	(\$1,091,441)	FY 2012-13: Row C * (1 + Row D) ³ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	(\$428,010)	(\$1,091,441)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	\$0	\$214,005	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	Total Estimated Savings Retained by Medicaid	(\$428,010)	(\$877,436)	Row G + Row H

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Table A.2				
FQHC and RHC Rate Reform and Gainsharing				
Emergency Department Utilization Reduction				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Emergency Department Visits in FY 2009-10	\$11,833,692	\$11,833,692	Actual expenditure on emergency department visits for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Emergency Department Visits	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	(\$591,685)	(\$591,685)	Row A * Row B
D	Estimated Trend for Outpatient Hospitals	8.92%	8.92%	Average expenditure growth in outpatient hospital expenditure from FY 2006-07 and FY 2009-10
E	Estimated Total Full Year Savings	(\$764,526)	(\$832,708)	FY 2012-13: Row C * (1 + Row D) ³ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	(\$318,553)	(\$832,708)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	\$0	\$159,277	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	Total Estimated Savings Retained by Medicaid	(\$318,553)	(\$673,431)	Row G + Row H

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Table A.3				
FQHC and RHC Rate Reform and Gainsharing				
Hospital Readmissions Reduction				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Hospital Readmissions in FY 2009-10	\$7,414,388	\$7,414,388	Actual expenditure on hospital readmissions for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Hospital Readmissions	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	(\$370,719)	(\$370,719)	Row A * Row B
D	Estimated Trend for Inpatient Hospitals	3.52%	3.52%	Average expenditure growth in inpatient hospital expenditure from FY 2006-07 and FY 2009-10
E	Estimated Total Full Year Savings	(\$411,235)	(\$425,701)	FY 2012-13: Row C * (1 + Row D) ³ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	(\$171,348)	(\$425,701)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	\$0	\$85,674	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	Total Estimated Savings Retained by Medicaid	(\$171,348)	(\$340,027)	Row G + Row H

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Table A.4				
FQHC and RHC Rate Reform and Gainsharing				
Outpatient Visit Utilization Reduction				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Outpatient Hospital Visits in FY 2009-10	\$25,120,080	\$25,120,080	Actual expenditure on outpatient hospital visits for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Outpatient Visits	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	(\$1,256,004)	(\$1,256,004)	Row A * Row B
D	Estimated Trend for Outpatient Hospitals	8.92%	8.92%	Average expenditure growth in outpatient hospital expenditure from FY 2006-07 and FY 2009-10
E	Estimated Total Full Year Savings	(\$1,622,903)	(\$1,767,637)	FY 2012-13: Row C * (1 + Row D) ³ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	(\$676,210)	(\$1,767,637)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	\$0	\$338,105	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	Total Estimated Savings Retained by Medicaid	(\$676,210)	(\$1,429,532)	Row G + Row H

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Table B.1				
Psychotropic Utilization Reduction Gainsharing Cost Savings				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Psychotropic Drugs in CY 2010, Net of Drug Rebate	\$21,910,088	\$21,910,088	Actual expenditure on psychotropic drugs for SMI clients between January and December 2010
B	Estimated Reduction	-3.00%	-3.00%	Target Reduction for BHOs
C	Total Estimated Medical Services Premiums Fee-for-Service Savings (in CY 2010 Dollars)	(\$657,303)	(\$657,303)	Row A * Row B
D	Estimated Trend for Psychotropic Drugs	7.65%	7.65%	Average expenditure growth in antipsychotic drug expenditure before rebate from FY 2007-08 and FY 2009-10
E	Total Estimated Medical Services Fee-for-Service Savings	(\$819,896)	(\$882,585)	FY 2012-13: Row C * (1 + Row D) ³ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings	(\$341,623)	(\$882,585)	Row E* Row F

Table B.2				
Psychotropic Utilization Reduction Gainsharing Administrative Costs				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Estimated Hours for Actuarial Assessment of Changes to Rate-Setting Methodology	100	100	Assumed based on scope of work
B	Estimated Cost per Hour for Actuary	\$225.00	\$225.00	Hourly rate of actuary currently contracted by the Department
C	Total Actuary Costs for Psychotropic Gainsharing Initiative	\$22,500	\$22,500	Row A * Row B

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Table B.3				
Psychotropic Utilization Reduction Gainsharing Incentive Payments for July to December 2012 Savings				
FOR INFORMATIONAL PURPOSES ONLY				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Psychotropic Drugs in CY 2010, Net of Drug Rebate	\$21,910,088	\$21,910,088	Actual expenditure on psychotropic drugs for SMI clients between January and December 2010
B	Estimated Reduction Beyond Target Reduction	-7.00%	-7.00%	Example showing savings beyond the estimated target reduction
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in CY 2010 Dollars)	(\$1,533,706)	(\$1,533,706)	Row A * Row B
D	Estimated Trend for Psychotropic Drugs	7.65%	7.65%	Average expenditure growth in antipsychotic drug expenditure before rebate from FY 2007-08 and FY 2009-10
E	Estimated Total Medical Services Fee-for-Service Savings	(\$1,913,090)	(\$2,059,364)	FY 2012-13: Row C * (1 + Row D) ³ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Medical Services Fee-for-Service Savings	(\$797,121)	(\$2,059,364)	Row E * Row F
H	Estimated Net Savings Retained by Medicaid	\$0	\$478,273	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 60% * -1
I	Total Estimated Savings Retained by Medicaid	(\$797,121)	(\$1,581,091)	Row G + Row H

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Table C				
Person-Centered Budget Administrative Costs				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Estimated Hours to Research BUS Redesign and Implementation	600	600	Assumed based on scope of work
B	Estimated Cost per Hour for Consultant	\$200.00	\$200.00	Hourly rate of consulting firm currently contracted by the Department
C	Total Consulting Costs to Research BUS Redesign and Implementation	\$120,000	\$120,000	Row A * Row B
D	Estimated Hours to Research Assessment Tool and SEP Redesign	500	500	Assumed based on scope of work
E	Estimated Cost per Hour for Consultant	\$200.00	\$200.00	Hourly rate of consulting firm currently contracted by the Department
F	Total Consulting Costs to Research Assessment Tool and SEP Redesign	\$100,000	\$100,000	Row D * Row E
G	Total Administrative Costs for Person-Centered Budgets	\$220,000	\$220,000	Row C + Row F

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Table D				
Study Future Long-Term Care Goals				
Row	Item	FY 2012-13	FY 2013-14	Description
A	Estimated Hours to Research Palliative Care Benefit	250	250	Assumed based on scope of work
B	Estimated Cost per Hour for Consultant	\$200.00	\$200.00	Hourly rate of consulting firm currently contracted by the Department
C	Total Consulting Costs to Research Palliative Care Benefit	\$50,000	\$50,000	Row A * Row B
D	Estimated Hours to Research Naturally Occurring Retirement Communities	375	375	Assumed based on scope of work
E	Estimated Cost per Hour for Consultant	\$200.00	\$200.00	Hourly rate of consulting firm currently contracted by the Department
F	Total Consulting Costs to Research Naturally Occurring Retirement Communities	\$75,000	\$75,000	Row D * Row E
G	Total Administrative Costs for Studying Future Long-Term Care Goals	\$125,000	\$125,000	Row C + Row F

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Grand Total of FTE and Operating Expenses				
	General Professional IV		Rate/Financial Analyst II	
	FY 2012-13	FY 2013-14	FY 2012-13	FY 2013-14
FTE				
Personal Services	\$58,102	\$66,554	\$58,102	\$66,554
Health, Life and Dental	\$4,053	\$4,421	\$4,053	\$4,421
Short Term Disability	\$92	\$106	\$92	\$106
Amortization Equalization Disbursement	\$1,859	\$2,396	\$1,859	\$2,396
Supplemental Amortization Equalization Disbursement	\$1,598	\$2,163	\$1,598	\$2,163
Operating Expenses	\$5,653	\$950	\$5,653	\$950
TOTAL	\$71,357	\$76,590	\$71,357	\$76,590

FTE and Operating Expenses									
								GRAND TOTAL	
Fiscal Year(s) of Request		FY 2012-13	FY 2013-14	FY 2012-13	FY 2013-14	FY 2012-13	FY 2013-14	FY 2012-13	FY 2013-14
PERSONAL SERVICES	Title:	General Professional IV		Rate/Financial Analyst II					
Number of PERSONS / class title		1	1	1	1				
Number of months working in FY 2012-13 and FY 2013-14		12	12	12	12				
Number of months paid in FY 2012-13 and FY 2013-14		11	12	11	12				
Calculated FTE per classification		0.9	1.0	0.9	1.0	0.0	0.0	1.8	2.0
Annual base salary		\$56,796	\$59,636	\$56,796	\$59,636	\$0	\$0		
Salary		\$52,063	\$59,636	\$52,063	\$59,636	\$0	\$0	\$104,126	\$119,272
PERA FY 2012-13	10.15%	\$5,284	\$6,053	\$5,284	\$6,053	\$0	\$0	\$10,568	\$12,106
Health, Life, and Dental	\$368.42	\$4,053	\$4,421	\$4,053	\$4,421	\$0	\$0		
Short Term Disability	0.177%	\$92	\$106	\$92	\$106	\$0	\$0		
Medicare	1.45%	\$755	\$865	\$755	\$865	\$0	\$0	\$1,510	\$1,730
Subtotal Personal Services		\$62,247	\$71,081	\$62,247	\$71,081	\$0	\$0	\$116,204	\$133,108
OPERATING EXPENSES									
Supplies @ \$500/\$500*	\$500	\$500	\$500	\$500	\$500	\$0	\$0	\$1,000	\$1,000
Computer @ \$900/\$0	\$900	\$900	\$0	\$900	\$0	\$0	\$0	\$1,800	\$0
Office Suite Software @ \$330/\$0	\$330	\$330	\$0	\$330	\$0	\$0	\$0	\$660	\$0
Office Equipment @ \$3,440/\$0	\$3,473	\$3,473	\$0	\$3,473	\$0	\$0	\$0	\$6,946	\$0
Telephone Base @ \$450/\$450*	\$450	\$450	\$450	\$450	\$450	\$0	\$0	\$900	\$900
Subtotal Operating Expenses		\$5,653	\$950	\$5,653	\$950	\$0	\$0	\$11,306	\$1,900
GRAND TOTAL ALL COSTS		\$67,900	\$72,031	\$67,900	\$72,031	\$0	\$0	\$127,510	\$135,008

*The \$450 for Telephone Base and \$500 for Supplies will carry over each year as an acceptable expense.

As detailed above, the Department would begin the hiring process for both FTE as soon as the Long Bill is signed in order for them to start immediately after the start of FY 2012-13. They would then be able to work on implementing the programs that are set to begin in January 2013, which includes the FQHC and RHC rate reform and gainsharing, BHO psychotropic utilization reduction gainsharing, and the physician rate reform and gainsharing program. The Department hopes to also implement ACC gainsharing incentive payments in January 2013, but may delay implementation depending on input from stakeholders. The study of the primary care subcapitation pilot program would be completed by an existing vendor and could begin as soon as funding is available in July 2012. The Department would also amend the contract for the actuary currently working with the Department to set the rates for the psychotropic utilization reduction gainsharing program as soon as funding is available in July 2012. The implementation dates for person-centered payments in long-term care and studies of future long-term care goals are estimates; as described in each of their sections, the Department would contract with vendors throughout the current and request years to complete these studies. These would be managed by requested and existing FTE.