in drug expenditures. The federal formula uses the state's 2003 drug benefit per member per month for people dually eligible for Medicaid and Medicare, inflated by either the average growth rate from the National Health Expenditure per-capita drug expenditures or actual growth in drug expenditures. The inflated rate per member per month is multiplied by the number of dual-eligible clients, and then multiplied by a declining percentage contained in the Medicare Modernization Act to determine the state obligation (80 percent in calendar year 2012).

Both dual-eligible enrollment and the National Health Expenditures per-capita drug expenditures have come in higher than expected. Since the Department already has the National Health Expenditures per-capita drug expenditures, the only variable that may change in the February update is the enrollment projection.

Supplemental Request, Department Priority #5
Medicaid Budget Reduction

	Request	Recommendation	Staff Rec. Higher/(Lower)
Total	($7,859,799)	($6,948,163)	$911,636
General Fund	(19,618,256)	(19,172,833)	445,423
Cash Funds	15,625,858	15,636,252	10,394
Federal Funds	(3,867,401)	(3,411,582)	455,819

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the Department has implemented, or proposes to implement, new rules that impact projected Medicaid expenditures.	

Department Request: This request is the supplemental companion to R-6 that was submitted with the November 1 budget request. It includes the FY 2011-12 fiscal impact of the proposals contained in R-6. The table on the next page and the narrative following the table summarize the components of the request.

	FY 2011-12				FY 2012-13				Implementation
	TOTAL	General Fund	Cash Funds	Federal Funds	TOTAL	General Fund	Cash Funds	Federal Funds	Date
Department Request									
Hospital Provider Fee Financing	0	(15,700,000)	15,700,000	0	0	(15,700,000)	15,700,000	0	Jan-11
Physician Administered Drug Pricing and Unit Limits	(359,305)	(175,555)	(4,097)	(179,653)	(416,472)	(203,488)	(4,748)	(208,236)	Jul-11
Reimbursement Rate Alignment for Developmental Screeni	(1,620,574)	(791,810)	(18,477)	(810,287)	(2,092,701)	(1,022,490)	(23,860)	(1,046,351)	Aug-11
Preterm Labor Prevention	131,615	65,807	0	65,808	(902,736)	(451,368)	0	(451,368)	Aug-11
Expansion of Physician Administered Drug Rebate Program	(1,738,620)	(869,310)	0	(869,310)	(2,418,276)	(1,209,138)	0	(1,209,138)	Oct-11
Synagis Prior Authorization Review	(211,253)	(103,217)	(2,409)	(105,627)	(419,772)	(205,100)	(4,786)	(209,886)	Nov-11
Seroquel Restrictions	(694,210)	(339,190)	(7,915)	(347,105)	(1,931,172)	(943,568)	(22,018)	(965,586)	Jan-12
Dental Efficiency	(603,812)	(295,022)	(6,884)	(301,906)	(1,641,594)	(802,081)	(18,716)	(820,797)	Jan-12
Ambulatory Surgical Centers	(500,000)	(244,299)	(5,701)	(250,000)	(1,000,000)	(488,599)	(11,401)	(500,000)	Jan-12
Augmentive Communication Devices	(184,500)	(90,146)	(2,104)	(92,250)	(492,000)	(240,391)	(5,609)	(246,000)	Jan-12
Public Transportation Utilization	(615,598)	(300,780)	(7,019)	(307,799)	(209,574)	(102,398)	(2,389)	(104,787)	Jan-12
Pharmacy Rate Methodology Transition	(1,000,000)	(488,599)	(11,401)	(500,000)	(4,000,000)	(1,954,394)	(45,606)	(2,000,000)	Apr-12
Home Health Care Cap	(652,941)	(319,026)	(7,444)	(326,471)	(4,117,163)	(2,011,640)	(46,941)	(2,058,582)	Apr-12
Home Health Therapies Cap	(60,601)	(29,609)	(691)	(30,301)	(382,453)	(186,866)	(4,360)	(191,227)	Apr-12
Continuation of Nursing Facility Reduction	0	0	0	0	(9,024,677)	(4,512,338)	0	(4,512,339)	Jul-12
Durable Medical Equipment Preferred Provider	0	0	0	0	(1,150,732)	(562,246)	(13,120)	(575,366)	Jul-12
Utilization Management Vendor Funding	250,000	62,500	0	187,500	500,000	125,000	0	375,000	Jul-11
TOTAL	**(7,859,799)**	**(19,618,256)**	**15,625,858**	**(3,867,401)**	**(29,699,322)**	**(30,471,105)**	**15,496,446**	**(14,724,663)**	
Staff Recommended Changes									
Dental Efficiency - allow time for slower implementation	(301,906)	(147,511)	(3,442)	(150,953)	0	0	0	0	
Ambulatory Surgical Centers - assume no FY 11-12 savings	500,000	244,299	5,701	250,000	0	0	0	0	
Home Health Care Cap - do not implement	652,941	319,026	7,444	326,471	4,117,163	2,011,640	46,941	2,058,582	
Home Health Therapies Cap - do not implement	60,601	29,609	691	30,301	382,453	186,866	4,360	191,227	
Subtotal - Staff Recommended Changes	**911,636**	**445,423**	**10,394**	**455,819**	**4,499,616**	**2,198,506**	**51,301**	**2,249,809**	
NEW TOTAL with staff recommended changes	**(6,948,163)**	**(19,172,833)**	**15,636,252**	**(3,411,582)**	**(25,199,706)**	**(28,272,599)**	**15,547,747**	**(12,474,854)**	

Hospital Provider Fee Financing: Prior to the Hospital Provider Fee the Department would certify public expenditures (CPE) by government-owned or operated outpatient hospitals to draw additional federal funds to the upper payment limit (UPL) set by the federal government as the maximum allowable Medicaid reimbursement. The Department would then retain a portion of the federal funds matched through the CPE process to offset the need for General Fund in the Medical Services Premiums line. The Hospital Provider Fee takes government owned or operated outpatient hospitals to the UPL, eliminating the CPE for these entities. Instead, the Department proposes retaining some of the Hospital Provider Fee to offset the need for General Fund in the Medical Services Premiums line.

Staff Recommendation: ***Staff recommends approval of the request.*** This use of the Hospital Provider Fee was specifically authorized by HB 09-1293. It appears that the FY 2011-12 appropriation did not include the refinancing of the General Fund from the Hospital Provider Fee due to an oversight. Although staff recommends the request, see the staff comments about inconsistent withholding from certified public expenditures under the recommendation on S-10.

Physician Administered Drug Pricing and Unit Limits: The Department proposes reduced rates for risperidone to match Medicare rates. The Department also increased rates for haloperidol decanoate and fluphenazine decanoate to match Medicare rates, but the Department corrected billing unit limits for these drugs to generate net savings. All three drugs are used to treat schizophrenia.

Staff Recommendation: ***Staff recommends approval of the request.*** The corrected billing unit limits addressed technical billing problems and should not impact medically necessary access to the drugs. The rate adjustments made Medicaid reimbursement more consistent with Medicaid.

Reimbursement Rate Alignment for Developmental Screenings: The Department reduced the rates paid for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. The Department also limited the number of screenings per year and the age of clients eligible for the screenings.

Staff Recommendation: ***Staff recommends approval of the request.*** The limits on screenings appear targeted at repeats due to uncoordinated care. The Department reports that the limits comply with federal and industry standards and exceptions will be granted for medical necessity. The Department used a combination of Medicare rates and private insurance rates as the index for the Medicaid rates, since some of the services are not frequently provided to Medicare clients.

Preterm Labor Prevention: The Department extended coverage to include alpha hydroxyprogesterone caproate injections that reduce the occurrence of preterm labor. There is approximately a six-month delay between implementation of the program and expected clinical effectiveness. Thus, there will be an increase in expenditures for the drug in FY 2011-12, but the Department anticipates that avoided costs related to preterm labor will result in a net savings in FY 2012-13.

Staff Recommendation: ***Staff recommends approval of the request.*** This expands Medicaid coverage, rather than contracting it. The Department cited a study from the New England Journal of Medicine as the basis for the projected efficacy of the drug in preventing preterm labor.

Expansion of the Physician Administered Drug Rebate Program: The Department expanded the list of physician-administered drugs eligible for rebates. Also, the Department is performing outreach to providers to ensure that they provide sufficient information to the Department for the Department to claim the rebates.

Staff Recommendation: ***Staff recommends approval of the request.*** The primary potential impediment to the Department achieving the projected additional drug rebates is getting providers to submit bills properly with sufficient information for the Department to claim the rebates. The Department conservatively assumed that rebates for drugs recently added to the eligible list would be collected at 50 percent of the rate for drugs on the list prior to the expansion. Also, the Department did not include retroactive rebates, but it is possible the Department will be able to collect rebates for drugs administered prior to the expansion that was implemented in September of 2011.

Synagis Prior Authorization: The Department has increased prior authorization review requirements for this drug to ensure only appropriate dosages are utilized. The drug is commonly prescribed as a prophylactic to reduce the likelihood of hospitalization from respiratory syncytial virus (RSV).

Staff Recommendation: ***Staff recommends approval of the request.*** The prior authorization review requirements are intended to limit doses to the level recommended by the American Academy of Pediatrics. The Department doesn't have detailed clinical data to support the projected savings, and instead made extrapolations from the impact of increased prior authorization requirements implemented in West Virginia and Tennessee for different drugs. While the estimating methodology is not very precise, staff views it as sufficiently conservative to recommend the proposed reduction in funding.

Seroquel Restrictions: The Department is implementing procedures to prevent the utilization of Seroquel for off label use. Seroquel is designed to treat schizophrenia and mood disorders, but is sometimes prescribed for off-label use as a sleep aid or anxiety reducer.

Staff Recommendation: ***Staff recommends approval of the request.*** The Department reports there are other drugs available to aid sleep and to reduce anxiety with proven effectiveness and lower costs.

Dental Efficiencies: The Department is limiting orthodontics coverage to cases where the client has a severely handicapping malocclusion, requiring prior authorization review for preparatory diagnostics (casts, x-rays, etc), and converting from upfront reimbursements to installment payments.

Staff Recommendation: ***Staff recommends assuming half of the projected savings in FY 2011-12.*** There are two components to the projected savings. Converting upfront reimbursements to installment payments avoids paying for services that are not rendered or services for clients who are no longer eligible. The second part of the savings is due to tightening coverage limits. At the hearing the Department described the proposal as limiting coverage to cases where speech or the ability to eat is significantly impaired. The Department indicates that Colorado's current orthodontic coverage limits are worded more ambiguously than limits in other states, and that Colorado's orthodontic expenditures significantly exceed orthodontic expenditures in states with more precise limits. The Department did not detail the portion of the projected savings attributable to the stricter definition of the orthodontic service limits, and so further work would need to be done if the JBC wants to exclude this from the projected savings. In the hearing responses the Department reported: "The Department is working with stakeholders to establish reimbursement methodologies and clear definitions of qualifying criteria for this benefit to ensure clients have access to services when appropriate." This hearing response was submitted January 4, but the Department's savings estimate assumes the tighter coverage limits are in place January 1. Staff recommends reducing the projected savings to one quarter of the fiscal year, rather than half of the fiscal year, to ensure that the Department doesn't rush through negotiations with stakeholders on the parameters of the coverage limit, since the coverage limit has the potential to negatively impact clients. Staff recommends approving the request, but potentially revisiting it if the implementation results in significant issues with access to coverage.

Ambulatory Surgical Centers: The Department initiated a pilot project to shift outpatient surgery utilization from outpatient hospitals to less costly ambulatory surgical centers. In the pilot program ambulatory surgical centers perform enhanced outreach to surgeons participating in Medicaid to encourage the migration of services to the ambulatory surgical center setting. The Department hopes to implement changes in reimbursements to further provide incentives.

Staff Recommendation: ***Staff does not recommend the request.*** The goal is appropriate, but based on the Department's description of progress to date, staff is not convinced that this idea is far enough along to expect a shift in utilization during FY 2011-12.

Augmentative Communication Devices: The Department is performing outreach to increase utilization of tablet computers instead of more expensive traditional devices for people with impairments that hinder their ability to produce or comprehend verbal or visual communication.

Staff Recommendation: ***Staff recommends approval of the request.*** This proposal has no negative impact on clients.

Public Transportation Utilization: The Department is lowering base funding and adding potential bonus payments for meeting performance goals in the contracts with non emergent medical transportation providers to increase the utilization of public transportation in the Denver-metro area.

Staff Recommendation: ***Staff recommends approval of the request.*** This may make accessing health services less convenient for some clients, but it is hard to assess the degree. All clients will have access to transportation. The Department is reducing the contract with the transportation provider for the Denver metro area and offering incentives if the contractor achieves performance goals regarding the utilization of public transportation. The majority of the savings in FY 2011-12 is attributable to a one-time switch from prospective to retrospective payment of the transportation provider.

Pharmacy Rate Methodology Transition: The Department proposes switching from using the average wholesale price (AWP) for drugs to determine pharmaceutical reimbursement rates to using the costs of ingredients, as measured by the wholesale acquisition cost (WAC) or state maximum allowable cost (SMAC), plus the costs of dispensing. A recent lawsuit found flaws in the AWP and the company that produced the index is no longer publishing it. The Department expects the change in reimbursement methodology will reduce total expenditures.

Staff Recommendation: ***Staff recommends approval of the request.*** Criticism aimed at this proposal has made a big deal that the projected $4.0 million savings in FY 2012-13 ($2.0 million General Fund) has been preordained by the Department before the Colorado-specific studies of wholesale acquisition cost and dispensing costs are complete. Also, the Department has been criticized for burying a provider rate reduction in a budget the executive branch has described as not including any provider rate reductions. Both criticisms have some merit. However, to the extent that the Department gave guidance to the contractor that the goal of the Colorado-specific pricing was to be cost neutral less $4.0 million dollars, staff is more concerned that the Department biased the floor of the study, rather than the ceiling, based on the preliminary data about drug pricing presented by the Department at the hearing. The reason the Department is changing the drug pricing methodology in the first place is that the courts found the Average Wholesale Price, which was used by many state Medicaid programs and private insurers to set reimbursement rates, artificially inflated costs resulting in inappropriately high reimbursement levels.

Home Health Care Cap: The Department proposes limiting the number of hours of skilled care a patient can receive in the home health setting to eight per day, starting in April 2012. In FY 2010-11 the limit would have impacted 459 clients.

Staff Recommendation: ***Staff does not recommend the request.*** The Department indicates that, "Meeting the eight hour limit without negatively impacting those clients whose utilization exceeds the cap will require home health agencies to be more efficient with time spent attending a client's needs." However, the Department doesn't present any evidence to suggest that current home health services are inefficient, or that they could be condensed to provide the same level of service in a shorter period of time. It could be that a large portion of the skilled home health services that exceed 8 hours per day are driven by client needs. If this is the case, the Department will either end up granting a large number of exceptions for medical necessity, or deny appropriate coverage if the process for granting exceptions is too strict. The former would eat away at the projected savings and the later could result in increased expenditures if clients resort to seeking services in a more costly

setting, such as a nursing home. Staff is concerned both that the Department will not achieve the projected savings and that the policy could have significant negative impacts on some clients.

Home Health Therapies Cap: The Department proposes limiting the number of home health visits for therapy to 48 visits per calendar year, starting in April 2012.

Staff Recommendation: ***Staff does not recommend the request.*** The staff recommendation is based on similar concerns as those expressed relative to the proposed home health care cap.

Utilization Management Vendor Funding: The Department requests funding for the Department's contracted utilization management vendor to perform additional prior authorization reviews for the savings initiatives in this request.

Staff Recommendation: ***Staff recommends approval of the request.*** This increase in funding for the utilization management vendor is necessary to perform the enhanced prior authorizations described in several of the strategies above.

Supplemental Request, Department Priority #6
Child Health Insurance Program Reauthorization Act (CHIPRA) Bonus Payment True-up

	Request	Recommendation
Total	$0	$0
General Fund	(5,633,177)	(5,633,177)
Federal Funds	5,633,177	5,633,177

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made.* Specifically, the request reflects new information about bonus payments available to Colorado pursuant to CHIPRA.	

Department Request: The Department proposes using additional bonus payments from the federal government for meeting outreach and retention performance goals for children in the Medicaid and Children's Health Insurance Program (CHP+) to offset the need for General Fund in the Medicare Modernization Act State Contribution Payment line item.

Staff Recommendation: ***Staff recommends the request.***