Schedule 7
Summary of FY 05-06 Change Requests

Department Name: Department of Health Care Policy and Financing
Submission Date: November 1, 2004
Number of Decision Items: 12
Number of Base Reduction Items: 2
Number of Non Prioritized Items: 6

Total Impact of FY 05-06 Change Requests					$215,483,670	(2.00)	$121,862,087	($45,403)	($34,996,428)	$128,663,414
Priority #	**Title**	**Tab #**	**Page Number**	**IT Request?**	**Total Request (FY 05-06)**	**FTE**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 05-06 Decision Items										
DI - 1	Request for FY 05-06 Medical Services Premiums	1	G.1-1	No	$220,022,390	0.00	$111,823,155	$4,331	$42,729	$108,152,175
DI - 2	Request for FY 05-06 Medicaid Community Mental Health Services	2	G.2-1	No	($33,872,502)	0.00	$4,077,113	$0	($41,988,938)	$4,039,323
DI - 3	Fund Children's Basic Health Plan Medical Premium for Caseload and Rate Changes	3	G.3-1	No	$18,473,175	0.00	$0	$0	$6,570,044	$11,903,131
DI - 4	Adjust Children's Basic Health Plan Dental	4	G.4-1	No	$537,193	0.00	$0	$0	$188,017	$349,176
DI - 5	Adjust Children's Basic Health Plan Trust Fund	5	G.5-1	No	$2,532,019	0.00	$2,581,753	($49,734)	$0	$0
DI - 6	Implementation of the Medicare Modernization Act	6	G.6-1	No	$0	0.00	$0	$0	$0	$0
DI - 7	Fiscal Agent Fixed Price Contract Adjustments	7	G.7-1	Yes	$2,111,772	0.00	$656,088	$0	$169,069	$1,286,615
DI - 8	Nursing Facility Audits	8	G.8-1	No	$233,350	0.00	$116,675	$0	$0	$116,675
DI - 9	MMIS Federally-Mandated Reprocurement	9	G.9-1	Yes	$579,600	0.00	$56,221	$0	$6,086	$517,293
DI - 10	Fund Colorado Benefits Management System Maintenance	10	G.10-1	Yes	$103,888	0.00	$35,709	$0	$16,235	$51,944
DI - 11	Funding for Hospital and Federally Qualified Health Clinic Audits to Increase Recoveries	11	G.11-1	No	$0	0.00	$0	$0	$0	$0
DI - 12	Move Case Management from Mental Health Community Programs to Medical Services Premiums	12	G.12-1	No	$0	0.00	$0	$0	$0	$0
Decision Item Subtotal					**$210,720,885**	**0.00**	**$119,346,714**	**($45,403)**	**($34,996,758)**	**$126,416,332**
FY 05-06 Base Reduction Items										
BRI - 1	Balance Mental Health FTE to Department Need	13	G.13-1	No	$0	(2.00)	$0	$0	$0	$0
BRI - 2	Drug Utilization Review Fund Split Correction	14	G.14-1	No	($265,000)	0.00	$0	$0	$0	($265,000)
Base Reduction Item Subtotal					**($265,000)**	**(2.00)**	**$0**	**$0**	**$0**	**($265,000)**
FY 05-06 Non-Prioritized Items										
NP - 1	DHS - Division of Youth Corrections Population Impacts on Contract Placements	15	G.15-1	N/A	$516,692	0.00	$258,346	$0	$0	$258,346
NP - 2	DHS - Increase the Number Served of Specific Targeted Populations	15	G.15-2	N/A	$2,599,163	0.00	$1,299,582	$0	$0	$1,299,581
NP - 3	DHS - Child Welfare Services Block Increase	15	G.15-3	N/A	$1,865,256	0.00	$932,628	$0	$0	$932,628
NP - 4	DHS - Colorado Benefits Management System Contract Increase	15	G.15-4	N/A	$63,975	0.00	$33,467	$0	$330	$30,178
NP - 5	DHS - Mutli-use Network	15	G.15-5	N/A	$4,568	0.00	$2,284	$0	$0	$2,284
NP - 6	DHS - Vehicle Replacements and Vehicle Reconciliation	15	G.15-6	N/A	($21,869)	0.00	($10,934)	$0	$0	($10,935)
Non-Prioritized Items Subtotal					**$5,027,785**	**0.00**	**$2,515,373**	**$0**	**$330**	**$2,512,082**
TOTAL					**$215,483,670**	**(2.00)**	**$121,862,087**	**($45,403)**	**($34,996,428)**	**$128,663,414**

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI-1	**OSPB Approval:**		**Date:**	
Program:	Medical Assistance Office	**Statutory Citation:**	26-4-104 (1), and 26-4-201 (1), C.R.S. (2004)		
Request Title:	Funding for Medical Services Premiums				

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	1,868,658,515	1,934,644,559	0	1,934,644,559	1,934,334,218	220,022,390	2,154,356,608	0	2,154,356,608	220,022,390
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	936,641,159	0	936,641,159	936,172,614	111,823,155	1,047,995,769	0	1,047,995,769	111,823,155
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	4,331	76,511	0	76,511	4,331
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	42,729	30,537,842	0	30,537,842	42,729
	FF	985,803,486	967,749,482	0	967,749,482	967,594,311	108,152,175	1,075,746,486	0	1,075,746,486	108,152,175
(2) Medical Services Premiums	**Total**	1,868,658,515	1,934,644,559	0	1,934,644,559	1,934,334,218	220,022,390	2,154,356,608	0	2,154,356,608	220,022,390
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	936,641,159	0	936,641,159	936,172,614	111,823,155	1,047,995,769	0	1,047,995,769	111,823,155
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	4,331	76,511	0	76,511	4,331
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	42,729	30,537,842	0	30,537,842	42,729
	FF	985,803,486	967,749,482	0	967,749,482	967,594,311	108,152,175	1,075,746,486	0	1,075,746,486	108,152,175

Letter Notation:

Cash Fund name/Number, Federal Fund Grant Name: CF: Provider Fees and Service Fees Fund. CFE: Certified Public Expenditures and Breast and Cervical Cancer Prevention and Treatm FF: Title XIX

IT Request: o Yes X **No (If yes and request includes more than 500 programming hours, attach IT Project Plan)**

Request for New or Replacement Vehicles: ☐ Yes X **No**

Request Affects Other Departments: o Yes X **No** (If Yes, List Other Departments Here:)

Schedule 6
Change Request for FY 05-06

Department: Health Care Policy and Financing **Dept. Approval by:** Lisa Esgar **Date:** November 1, 2004

Priority Number: DI - 2 **OSPB Approval:** **Date:**

Program: Behavioral Health Benefits **Statutory Citation:** 26-4-119, C.R.S. (2004); 26-4-123, C.R.S. (2004)

Request Title: Request for FY 05-06 Medicaid Community Mental Health Services

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	0	190,534,208	0	190,534,208	190,697,536	(33,872,502)	156,825,034	0	156,825,034	(33,872,502)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	74,247,941	0	74,247,941	74,329,605	4,077,113	78,406,718	0	78,406,718	4,077,113
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	41,992,061	0	41,992,061	41,992,061	(41,988,938)	3,123	0	3,123	(41,988,938)
	FF	0	74,294,206	0	74,294,206	74,375,870	4,039,323	78,415,193	0	78,415,193	4,039,323
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (1) Medicaid Mental Health Capitation Base Payments	**Total**	0	140,624,800	0	140,624,800	140,624,800	13,233,833	153,858,633	0	153,858,633	13,233,833
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	70,312,400	0	70,312,400	70,312,400	6,611,117	76,923,517	0	76,923,517	6,611,117
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	3,123	3,123	0	3,123	3,123
	FF	0	70,312,400	0	70,312,400	70,312,400	6,619,593	76,931,993	0	76,931,993	6,619,593
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (1) Mental Health Services for Breast and Cervical Cancer Patients	**Total**	0	71,175	0	71,175	71,175	(71,175)	0	0	0	(71,175)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	24,911	0	24,911	24,911	(24,911)	0	0	0	(24,911)
	FF	0	46,264	0	46,264	46,264	(46,264)	0	0	0	(46,264)
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (1) Mental Health Institute Rate Refinance Adjustment	**Total**	0	3,097,499	0	3,097,499	3,097,499	(3,097,499)	0	0	0	(3,097,499)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	1,548,750	0	1,548,750	1,548,750	(1,548,750)	0	0	0	(1,548,750)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	1,548,749	0	1,548,749	1,548,749	(1,548,749)	0	0	0	(1,548,749)

Schedule 6
Change Request for FY 05-06

Department: Health Care Policy and Financing **Dept. Approval by:** Lisa Esgar **Date:** November 1, 2004

Priority Number: DI - 2 **OSPB Approval:** **Date:**

Program: Behavioral Health Benefits **Statutory Citation:** 26-4-119, C.R.S. (2004); 26-4-123, C.R.S. (2004)

Request Title: Request for FY 05-06 Medicaid Community Mental Health Services

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (1) Alternatives to Inpatien Hospitalization at the Mental Health Institute at Pueblo	**Total**	0	852,311	0	852,311	852,311	(852,311)	0	0	0	(852,311)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	426,155	0	426,155	426,155	(426,155)	0	0	0	(426,155)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	426,156	0	426,156	426,156	(426,156)	0	0	0	(426,156)
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (1) Alternatives to Inpatien Hospitalization at the Mental Health Institute at Fort Logan	**Total**	0	783,191	0	783,191	783,191	(783,191)	0	0	0	(783,191)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	391,595	0	391,595	391,595	(391,595)	0	0	0	(391,595)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	391,596	0	391,596	391,596	(391,596)	0	0	0	(391,596)
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (1) Alternatives to the Fort Logan Aftercare Program	**Total**	0	310,702	0	310,702	310,702	(310,702)	0	0	0	(310,702)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	155,351	0	155,351	155,351	(155,351)	0	0	0	(155,351)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	155,351	0	155,351	155,351	(155,351)	0	0	0	(155,351)
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (2) Other Medicaid Mental Health Payments, Medicaid Mental Health Fee for Service Payments*	**Total**	0	2,827,380	0	2,827,380	2,990,708	(24,307)	2,966,401	0	2,966,401	(24,307)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	1,413,690	0	1,413,690	1,495,354	(12,153)	1,483,201	0	1,483,201	(12,153)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	1,413,690	0	1,413,690	1,495,354	(12,154)	1,483,200	0	1,483,200	(12,154)

Schedule 6
Change Request for FY 05-06

Department: Health Care Policy and Financing **Dept. Approval by:** Lisa Esgar **Date:** November 1, 2004

Priority Number: DI - 2 **OSPB Approval:** **Date:**

Program: Behavioral Health Benefits **Statutory Citation:** 26-4-119, C.R.S. (2004); 26-4-123, C.R.S. (2004)

Request Title: Request for FY 05-06 Medicaid Community Mental Health Services

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (2) Other Medicaid Mental Health Payments, Medicaid Mental Health Child Placement Agency	**Total**	0	7,440,901	0	7,440,901	7,440,901	(7,440,901)	0	0	0	(7,440,901)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	7,440,901	0	7,440,901	7,440,901	(7,440,901)	0	0	0	(7,440,901)
	FF	0	0	0	0	0	0	0	0	0	0
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, (2) Other Medicaid Mental Health Payments, Medicaid Anti-Psychotic Pharmaceuticals	**Total**	0	34,526,249	0	34,526,249	34,526,249	(34,526,249)	0	0	0	(34,526,249)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	34,526,249	0	34,526,249	34,526,249	(34,526,249)	0	0	0	(34,526,249)
	FF	0	0	0	0	0	0	0	0	0	0

See Double Alpha Exhibits for calculations. See the Assumptions and Calculations document in Volume II for a detailed description of the request.

* See DI 16 for further adjustments to this line in FY 05-06.

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: CFE: Breast and Cervical Cancer Prevention and Treatment Fund FF: Title XIX

IT Request: ☐ Yes ☑ No (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ es ☑ o (If Yes, List Other Departments Here:)

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:** November 1, 2004
Priority Number:	DI-6	**OSPB Approval:**		**Date:**
Program:	Benefits Coordination Section, Information Technology Contract Monitoring Section, Rates Section, Budget Division, Controller and Operations Division	**Statutory Citation:**	26-4-302 (a), C.R.S. (2004)	
Request Title:	Implementation of the Medicare Modernization Act			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 03-04	Appropriation FY 04-05	Supplemental Request FY 04-05	Total Revised Request FY 04-05	Base Request FY 05-06	Decision/ Base Reduction FY 05-06	November 1 Request FY 05-06	Budget Amendment FY 05-06	Total Revised Request FY 05-06	Change from Base in Out Year FY 06-07
							See "M" Headnote				See "M" Headnote
Total of All Line Items	**Total**	1,868,658,515	1,934,644,559	0	1,934,644,559	1,934,334,218	0	1,934,334,218	0	1,934,334,218	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	936,641,159	0	936,641,159	936,172,614	0	936,172,614	0	936,172,614	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	0	72,180	0	72,180	0
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	0	30,495,113	0	30,495,113	0
	FF	985,803,486	967,749,482	0	967,749,482	967,594,311	0	967,594,311	0	967,594,311	0
(2) Medical Services Premiums							See "M" Headnote				See "M" Headnote
	Total	1,868,658,515	1,934,644,559	0	1,934,644,559	1,934,334,218	0	1,934,334,218	0	1,934,334,218	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	936,641,159	0	936,641,159	936,172,614	0	936,172,614	0	936,172,614	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	0	72,180	0	72,180	0
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	0	30,495,113	0	30,495,113	0
	FF	985,803,486	967,749,482	0	967,749,482	967,594,311	0	967,594,311	0	967,594,311	0

Note:	The Change Request is for a Headnote revision to the FY 05-06 Long Bill
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX
IT Request: **Yes** **X No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments:	**No**

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI – 6
Change Request Title:	Implementation of the Medicare Modernization Act
Long Bill Line Item(s)	(2) Medical Services Premiums
State and Federal Statutory Authority:	26-4-302 (a), C.R.S. (2004); Federal Register / Vol. 69, No. 148 / Tuesday, August 3, 2004 / Proposed Rules

Summary of Request (Alternative A): The Department requests temporary budgetary flexibility to implement the federal Medicare Modernization Act, Part D, Voluntary Drug Benefit program that will begin on January 1, 2006. Specific authorization in the "M" Headnote is requested. The impact to the Medical Services Premiums from the "clawback" provision and the reduction to the Medicaid pharmacy benefit for dual eligibles is discussed, but no dollar changes are requested.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: On December 8, 2003, President Bush signed the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Act) that provides a voluntary prescription drug benefit to Medicare beneficiaries. This multi-faceted bill contains several components that will significantly impact Colorado's Medicaid program, providing savings in some areas, and new or increased expenditures in others.

For all states, the Medicare Modernization Act changes the way pharmaceutical drugs are provided, moving fiscal responsibility from Medicaid to Medicare for persons who are "dual eligible," that is, eligible for both Medicare and Medicaid. The federal definition of a fully dual eligible client is one who is Medicare eligible who also receives, at minimum, Medicaid prescription drug benefits.[1] Currently, Colorado Medicaid pays for the pharmaceutical needs of these clients who are eligible for both programs. Under the new Part D of the Medicare Prescription Drug bill, Medicare will pay for the drug costs of this segment of the Medicaid population. This will create cost savings to the states because the federal government will pay for the drug benefits, but states are also required to use some of the pharmacy savings to pay the federal government. The legislation outlines a phased-down state contribution approach for what is commonly referred to as the "clawback" provision. The clawback represents a large percentage of what the state share would have been if the Part D Medicare benefit had not passed. The phased-down contribution is the monthly state payment to the federal government of General Fund, to be paid on a decreasing proportion of inflated 2003 pharmaceutical costs, beginning in 2006 at 90% and decreasing each year until January 2015, when it reaches 75% and will be maintained at this level.

Although the Part D drug benefit is a federal program, only 50% federal financial participation will be available to fund the new administrative responsibilities of states that will be required to implement the federal program under the Act. The administrative responsibilities are still under discussion, but are likely to include processing applications for low income subsidies, assisting Medicare beneficiaries in completing forms, sending notices of determinations and redeterminations regarding subsidies, providing required data to the federal government for the calculation of the clawback, and screening clients applying for the Medicare benefit for applicable Medicaid programs.

The challenge in presenting this Change Request is that although the Department attempts to be proactive in making its request, many important components have yet to be identified by the federal Centers for Medicare and Medicaid Services. The federal

[1] Conference call with the Centers for Medicare and Medicaid Services, June 24, 2004.

government has proposed rules, but these rules are not final and are subject to extensive revision. The Department commented on the proposed rules on October 1, 2004. The Department cannot accurately project the costs based on the preliminary federal guidance or on the proposed rules, as many fundamental pieces remain unanswered.

The new Medicare benefit is scheduled for implementation on January 1, 2006. Colorado Medicaid clients who are also eligible for Medicare will stop receiving the comprehensive Medicaid drug benefit on December 31, 2005 and receive a limited Medicare benefit on January 1, 2006. Although the federal government is discussing all of the procedures needed to coordinate this transition, it seems that some dual eligible clients will not have certain current drugs covered by their Prescription Drug Plan. This will require them to access an extensive "exceptions process" to attempt to receive those drugs. In those cases, the client may or may not be authorized for that specific drug. It is likely that Colorado dual eligible clients will be exposed to more required fees, penalties, and copayments than they currently experience under the Medicaid benefit.

The Department believes that a Colorado State statute revision would be needed to comply with this federal law. Section 26-4-302, C.R.S (2004) identifies a pharmacy benefit as a service under the Colorado Medical Assistance Act:

> *Basic services for the categorically needy - optional services. (1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program: (a) Prescribed drugs;*

The federal law allows states to cover certain excluded drugs (SEC. 103. MEDICAID AMENDMENTS. (d) (2):

> *(2) COVERAGE OF CERTAIN EXCLUDABLE DRUGS.—In the case of medical assistance under this title with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is*

> *enrolled in a prescription drug plan under part D of title XVIII or an MA–PD plan under part C of such title, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.*

Without a clarification in Colorado statute that the Medical Assistance Program no longer covers pharmaceuticals for dual eligibles, confusion could be created by the two standings laws.

General Description of Alternative:

This alternative requests temporary budgetary flexibility in order for the Department to implement the federal Medicare Modernization Act of 2003. The types impacts are identified below. No dollar changes are requested at this time.

The Act moves the responsibility of funding the prescription drug needs from Medicaid to Medicare for the dual eligible population, resulting in probable savings to Colorado in both General Fund and federal funds. However, these savings are offset by the "clawback" that is the mandated state payment back to the federal government for a percentage of the estimated prescription drug costs of the dual eligible population. These payments will be 100% General Fund.

For the Department's December 2003 Budget Hearing with the Joint Budget Committee, the Department estimated possible savings from not providing the full pharmacy benefit to dual eligibles, and roughly estimated the cost of the "clawback." These estimates are now out of date, because they do not exactly follow the recently released proposed federal regulations. These were provided for a "ballpark" picture only. New estimates cannot be updated at this time due to the planned changes for the final regulations and the undecided assumptions about the savings and the clawback by the federal government.

The Department requires revision to the typical "M" Long Bill Headnote in order to achieve this flexibility. The "M" Headnote under the current Long Bill, HB 04-1422, reads as follows:

> *(d) Where the letter "(M)" appears directly to the right of the general fund or general fund exempt figure, that general fund or general fund exempt appropriation . . . is used to support a federally supported program and is the maximum amount of general fund or general fund exempt moneys that may be expended in that program, except where otherwise provided. In the event that additional federal funds are available for the program, the combined general fund or general fund exempt amount noted as "(M)" shall be reduced by the amount of federal funds earned or received in excess of the figure shown in the "federal funds" column for that program. In the event that the federal funds earned or received are less than the amount shown in the "federal funds" column, the combined general fund or general fund exempt amount noted as "(M)" shall be reduced proportionately. Where general fund or general fund exempt support is required as a condition for the acceptance of federal funds and the state matching requirements are reduced, the combined general fund or general fund exempt amount noted as "(M)" shall be reduced proportionately. . . It is intended that the general fund or general fund exempt amount and the federal funds amount shall be expended in equally proportioned amounts throughout the year.*

Because the Department cannot at this time predict a) how much the General Fund clawback payment will be in FY 05-06, b) what the administrative costs for administering the federal program will be, c) how much Medicaid enrollment will increase due to additional screening and assistance for Medicare beneficiaries, or d) what other Medicaid services may increase due to a more limited or more difficult to negotiate drug benefit, the Department requests the authority to adjust funding splits without violating the "M" Headnote provision. The following revision is requested:

> *Where the letter "(M)" appears directly to the right of the general fund or general fund exempt figure, that general fund or general fund exempt appropriation . . . is used to support a federally supported program and is the maximum amount of general fund or general fund exempt moneys that*

> *may be expended in that program, except where otherwise provided. In the event that additional federal funds are available for the program, the combined general fund or general fund exempt amount noted as "(M)," **except for the Department of Health Care Policy and Financing's Medical Services Premiums line item for the purpose of compliance with the Medicare Modernization Act of 2003**, shall be reduced by the amount of federal funds earned or received in excess of the figure shown in the "federal funds" column for that program. In the event that the federal funds earned or received are less than the amount shown in the "federal funds" column, the combined general fund or general fund exempt amount noted as "(M)," **except for the Department of Health Care Policy and Financing's Medical Services Premiums line item for the purpose of compliance with the Medicare Modernization Act of 2003**, shall be reduced proportionately. Where general fund or general fund exempt support is required as a condition for the acceptance of federal funds and the state matching requirements are reduced, the combined general fund or general fund exempt amount noted as "(M)," **except for the Department of Health Care Policy and Financing's Medical Services Premiums line item for the purpose of compliance with the Medicare Modernization Act of 2003**, shall be reduced proportionately. . . It is intended that the general fund or general fund exempt amount and the federal funds amount shall be expended in equally proportioned amounts throughout the year.*

The Department would offer to report all actual impacts due to this "M" Headnote revision to the Joint Budget Committee on a quarterly basis after implementation of the federal law.

Because the Department will be obligated to pay pharmacy claims far into the fiscal year, for dates of service prior to the implementation of the Act, and because there will not be enough actual data available at any time in FY 04-05 or FY 05-06 to project the impact to FY 05-06 or FY 06-07 from the law, due to the January 1, 2006 implementation date, the

flexibility in the revised "M" Headnote for the Medical Services Premiums for FY 05-06 would:

- Allow the Department to pay the 100% General Fund clawback out of the Medical Services Premiums in FY 05-06 and the beginning of FY 06-07, until a Supplemental Request can be submitted for FY 06-07. Currently, the majority of the Medical Services Premiums is funded by 50% federal financial participation. If the "M" Headnote is not modified, then payment of the clawback at 100% General Fund would result in the General Fund being "reduced proportionately" to the reduction in federal match drawn (0%). This creates an illogical situation.

- Prevent decreasing the Medicaid funding for pharmacy in the Medical Services Premiums during FY 05-06 so that the Department could ensure that there are sufficient funds to pay for the clawback, medical services pending any possible federal delay, changes in projections due to federal regulations, and changes in projections due to administrative processes in Colorado. Any General Fund savings would revert at the end of FY 05-06, and the corresponding federal funds would not be drawn.

- Prevent significant errors in budgeting and the loss of spending authority due to misjudged appropriations. The Department expects that even if the program is implemented on time on January 1, 2006, there will be a lag until the reduction to Medicaid pharmacy services is fully experienced. The data is expected to vary significantly across the initial months due to the ramp up nature of the Medicare benefit. The data from these lag months cannot be used for trend purposes. This phenomenon makes exact budgeting impractical until FY 06-07.

- Allow the Department to reconcile the events in the February 15, 2007 Budget Request. At that time, the Department will submit a Supplemental Request for FY 06-07 and a Budget Request Amendment for FY 07-08 to budget for both the estimated pharmacy savings and the clawback commitment. Hopefully, these estimates would be based on six months of normalized data. The Department would

request a separate line item for the clawback at that time, and propose a reduction to the Medical Services Premiums based on the pharmacy benefit for dual eligibles. The Department does not recommend any General Fund reduction until Supplemental Requests are submitted for FY 06-07.

- Authorize temporary flexibility in the Medical Services Premiums to fund administrative costs occurring in FY 05-06 due to implementation of the Medicare Modernization Act. Because a net General Fund savings is expected in FY 05-06 if the bill is implemented on January 1, 2006 (this amount is not known), even after paying the clawback, the Department requests temporary authority to use the Medical Services Premiums to fund administrative costs, until the Supplemental Request is submitted in FY 06-07. Administrative costs would be identified separately in that Supplemental, along with the clawback and the reduction on pharmacy costs identified above.

  Administrative costs may include the following:

  - Training for Medicaid eligibility sites;
  - Funding for temporary or consultant staff to assist in the implementation;
  - Basic operating costs to support determinations and notification to affected clients and basic office needs to support staff; and
  - System or operational changes to comply with any federal requirements for subsidy application and determination processing (the State's role here is unknown).

  The Department agrees to report administrative spending in FY 05-06 and FY 06-07 (until a Supplemental Request is submitted) to the Joint Budget Committee on a quarterly basis after implementation of the federal law.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period for Medicare Drug Benefit Impact to Colorado	April 2004 - January 2006
Expected Federal Policy Defined for Information System Requirements	December 2004
Clawback Payments Begin	January 2006
Full Medicaid Pharmacy Coverage for Dual Eligibles Ends	January 2006

Calculations for Alternative's Funding: Updated calculations are not available at this time due to the lack of specificity that still exists in the federal requirements.

Impact on Other Areas of Government: There may be impacts to other areas of government due to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, but this Change Request is directed to the affect on the Department's budget.

Assumptions for Calculations: The Department does not know how much administrative funding is needed in FY 05-06. However, some administrative costs will be required. The Department proposes for FY 05-06 to temporarily fund any administrative costs from the estimated General Fund savings in the Medical Services Premiums. Administrative costs would receive 50% federal funds.

Concerns or Uncertainties of Alternative: Uncertainties will continue as the implementation date of the Act nears, and as the Centers for Medicare and Medicaid Services makes specific decisions and provides direction to the States on the many complex components of the Act. The anticipated need has been estimated to ensure that the administration can be implemented in time to comply with the federal requirements, but it is important to realize that some of the exact functions and costs are unknown. Additionally, State policy makers may make ancillary or additional decisions that will affect Colorado's approach to the implementation other than what has been discussed and presented in this request.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: The alternative of status quo is not an option for the Department. Federal law mandates that states implement the Medicare Modification Act on January 1, 2006 as a condition of receiving federal financial participation.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: The true implications of not implementing the Federal Medicare Prescription Drug, Improvement, and Modernization Act are not known, but the failure to implement it would put the State in noncompliance with federal law. It is probable that the Department could lose its federal match for the Medicaid program if it does not comply with this law. If administrative funding is not appropriated, there will not be enough funding to support the Department's compliance of the Act.

Supporting Documentation

Analytical Technique: A return on investment is expected if this temporary budgetary authority is approved. There will be administrative costs, clawback payments, and reductions in pharmacy services, but these cannot be quantified at this time. However, it is expected that it will result in some General Fund savings after full implementation.

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative	Estimated Federal Funds Lost by Failure to Implement the Act
A	$0
B	$1,436,294,873

Estimated federal match loss is total federal funds from HB 04-1422, Long Bill, and Special Bills for FY 04-05 less Children's Basic Health Plan appropriations.

Statutory and Federal Authority:

Federal Register / Vol. 69, No. 148 / Tuesday, August 3, 2004 / Proposed Rules

§ 423.904 Eligibility determinations for low-income subsidies. (a) General rule. The State agency must make eligibility determinations and redeterminations for low-income premium and cost-sharing subsidies in accordance with § 423.774. (b) Notification to CMS. The State agency must inform CMS of cases where eligibility is established or redetermined, in a manner determined by CMS. (c) Screening for eligibility for Medicare cost-sharing and enrollment under the State plan. States must— (1) Screen individuals who apply for subsidies under this part for eligibility for Medicaid programs that provide assistance with Medicare cost-sharing specified in section 1905(p)(3) of the Act. (2) Offer enrollment for the programs under the State plan (or under a waiver of the plan) for those meeting the eligibility requirements. (3) Notify deemed subsidy eligibles of their subsidy eligibility in accordance with the requirements of § 423.34(d). (d) Application form and process. (1) Assistance with application. No later than July 1, 2005, States must make available— (i) Low-income subsidy application forms; (ii) Information on the nature of, and eligibility requirements for, the subsidies under this section; and (iii) Assistance with completion of low-income subsidy application forms. (2) Completion of application. The State must require an individual or personal representative applying for the low-income subsidy to— (i) Complete all required elements of the application and provide documents, as necessary, consistent with paragraph (3) of this section; and (ii) Certify, under penalty of perjury or similar sanction for false statements, as to the accuracy of the information provided on the application form. (3) The application process and States. (i) States may require submission of statements from financial institutions for an application for low-income subsidies to be considered complete; and (ii) May require that information submitted on the application be subject to verification in a manner the State determines to be most cost-effective and efficient.

(4) Other information. States must provide CMS with other information as specified by CMS that may be needed to carry out the requirements of the Part D prescription drug benefit. § 423.908. Phased-down State contribution to drug benefit costs assumed by Medicare. This subpart sets forth the requirements for State contributions for Part D drug benefits based on dual eligible drug expenditures. § 423.910 Requirements. (a) General rule. Each of the 50 States and the District of Columbia is required to provide

for payment to the Secretary a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.

26-4-302, C.R.S. (2004) *Basic services for the categorically needy - optional services. (1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program:*
(a) Prescribed drugs . . .

Department Objectives Met if Approved:

1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

2.1 To expand areas of potential financial recovery such as third party insurance (that should be a primary payer) and cases of fraud and abuse.

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI - 3	**OSPB Approval:**		**Date:**	
Program:	Child Health Plan Plus Division	**Statutory Citation:**	26-19-109 (5) (a), C.R.S. (2004), and 26-19-109 (6), C.R.S. (2004)		
Request Title:	Fund Children's Basic Health Plan Medical Premium for Caseload and Rate Changes				

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	51,777,408	59,011,563	0	59,011,563	59,321,419	18,473,175	77,794,594	0	77,794,594	18,473,175
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	18,222,477	20,654,047	0	20,654,047	20,762,497	6,570,044	27,332,541	0	27,332,541	6,570,044
	FF	33,554,931	38,357,516	0	38,357,516	38,558,922	11,903,131	50,462,053	0	50,462,053	11,903,131
(4) Indigent Care Program: Children's Basic Health Plan Premium Costs	**Total**	51,777,408	59,011,563	0	59,011,563	59,321,419	18,473,175	77,794,594	0	77,794,594	18,473,175
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	18,222,477	20,654,047	0	20,654,047	20,762,497	6,570,044	27,332,541	0	27,332,541	6,570,044
	FF	33,554,931	38,357,516	0	38,357,516	38,558,922	11,903,131	50,462,053	0	50,462,053	11,903,131

Footnote: Department requests that a Long Bill footnote does not require Department to manage to average monthly caseload.

Cash Fund name/number, Federal Fund Grant name: CF: Annual Enrollment fees of CBHP enrollees CFE: Tobacco Litigation Settlement and Fund 11G, CBHP Trust Fund
FF: RSC 7400, Title XXI

IT Request: **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 3
Change Request Title:	Fund Children's Basic Health Plan Medical Premium for Caseload and Rate Changes
Long Bill Line Item(s)	(4) Indigent Care Program: Children's Basic Health Plan Premium Costs
State and Federal Statutory Authority:	The Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) 26-19-109 (5) (a) (I), C.R.S. (2004), and 26-19-109 (6), C.R.S. (2004)

Summary of Request (Alternative A): This request is to increase the total funds appropriation for the Children's Basic Health Plan (also known as the Child Health Plan Plus) medical costs by $18,473,175 from the base request of $59,321,419. This Decision Item assumes there will be no enrollment cap for women or children starting in FY 04-05 and that enrollment in the program will be allowed to grow naturally. The requested caseload in FY 05-06 is 50,524 children and 2,264 births. Also requested is a revision to the Long Bill footnote to not require the Department to manage to the caseload.

The Cash Funds Exempt are drawn from the Children's Basic Health Plan Trust Fund. Please see November 1, 2004 Change Request #DI – 5 "Adjust Children's Basic Health Plan Trust Fund" for the General Fund contribution needed to support this program.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Children's Basic Health Plan, marketed as the Child Health Plan Plus, is a program that provides affordable health insurance to children under age 19 in low-income families (under 185% of the federal poverty level) who do not qualify for Medicaid and do not

have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration. The federal government implemented this program in 1997, giving states a two-to-one match on State expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. The Plan also has an extensive self-insured network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization.

In October 2002, under an expansion authorized by HB 02-1155 and a federal demonstration waiver, the program began offering prenatal, delivery, and postpartum services to pregnant women earning up to 185% of the federal poverty level who are not eligible for Medicaid.

Due to budget balancing, enrollment into the Prenatal and Delivery Program was suspended from May 2003 through June 2004, with SB 03-291. The Prenatal and Delivery Program stopped funding care in November 2003, when the remaining prenatal care, deliveries, and postpartum care became a responsibility of the State-Only Prenatal Program, until all enrolled women had delivered and received two months postpartum care. Also, the children's program was capped in November 2003. In July 2004, both programs began accepting new applicants again.

The appropriation for FY 04-05 was based on reopening the program for women and lifting the enrollment cap for children in July 2004. HB 04-1422 (FY 04-05 Long Bill) appropriated funds for 47,600 children and 874 births. HB 04-1447 increased the appropriation to accommodate children who were no longer eligible for Medicaid due to the implementation of SB 03-176. SB 03-176 denies Medicaid coverage to legal immigrants as an optional population for Medicaid benefits. The final appropriation for FY 04-05 is for 47,884 average member months of child health care[1] and 874 deliveries.

[1]Calculations assumed that HB 04-1447 would be implemented in January, increasing the Long Bill appropriation of 46,700 by additional 568 children. 47,884 = 47,600+(568/2)

The annualization of HB 04-1447 increases the base request for FY 05-06 by $309,856 to $59,321,419 total funds. Please see the Assumptions and Calculations section in Volume II of this Budget Request for more information regarding the Base Request for FY 05-06.

General Description of Alternative: This Alternative seeks:

- The funding necessary to have natural enrollment growth for children and women.
- To adjust the rates for medical services in accordance with actuarial projections.
- A Long Bill footnote that does not require the Department to manage to the caseload.

Summary of Request			
	FY 04-05 Appropriation	**FY 05-06 Request**	**Percent Change in Rate**
Children's caseload	47,884	50,524	
Children's blended rate[2]	$90.92	$101.44	11.6%
Prenatal caseload	797	1,618	
Prenatal blended rate[2]	$345.30	$317.36	-8.1%
Number of deliveries	874	2,264	
Delivery blended rate[2]	$3,965	$4,475.47	12.9%

Calculations to support this request can be found at tab Attachment 1 in this binder.

I. Description of Alternative Related to Children's Caseload

Due to the enrollment cap in FY 03-04, recent trends cannot be used to project enrollment after the cap was lifted in July 2004. The FY 05-06 enrollment projection is based on the July 2004 actual enrollment of 38,608 and assumes a growth rate of 819 per month in FY 04-05 and 359 per month in FY 05-06. These growth rates correspond to the actual growth experienced between October 2001 and October 2003. New enrollment ceased in November 2003, so this is the most recent historical data set useful for forecasting caseload growth with no enrollment cap. Furthermore, the enrollment level in July 2004 was similar to the October 2001 enrollment of 38,344.

[2]The blended rate is the weighted average of the self-insured network and the health maintenance organization rates.

An additional adjustment was made in January 2005 to include 568 children from HB 04-1447, which are assumed to become eligible for the Children's Basic Health Plan when SB 03-176 is implemented. The average monthly enrollment projected in this request is 43,399 in FY 04-05 and 50,524 in FY 05-06. See Table G at Tab Attachment 1.

II. Description of Alternative Related to Children's Rates

This request recommends increasing the appropriated medical rates in accordance with rates recommended by a contracted actuary.

In FY 05-06, the Department estimates that 65% of children will be enrolled in health maintenance organizations with the remaining 35% enrolled in the self-insured network. The cost structure differs for these two models of providing health care services. Thus, the contracted actuary analyzes and recommends separate rates for each category.[3] The rate analysis for the self-insured network is presented first, followed by the analysis for the health maintenance organizations that contract with the Children's Basic Health Plan. Note that the final Long Bill appropriation is set based on a "blended" per member per month rate that is based on the weighted average of the health maintenance organization rate and the self-insured network rate. The weighting is built on the estimated ratio of those enrolled in health maintenance organizations versus those in the self-insured network. The presentation of this weighted rate follows the discussion of the requested rate for health maintenance organizations.

An informational narrative follows that describes how the actuary calculated the rate.

Self-insured Network Rate

The purpose of the self-insured network is to provide services to children until they enroll in a selected health maintenance organization, and to those children who do not have

[3]"Colorado Child Health Plan+ Fiscal Year 2005-2006 Rate Development" by *Leif Associates, Inc.*, July 16, 2004.

geographic access to a health maintenance organization. The self-insured network capitated payment includes the following components:

- Estimated medical care costs
- Medical management costs
- Risk insurance costs

Estimated Medical Care Costs for Children

Medical care costs are the costs of claims paid and do not include any costs related to administering the network. The Department contracts with an actuary to estimate future medical costs based on an evaluation of historical medical cost. The actuary's analysis for the self-insured network is based on experience in calendar year 2003. Adjustments were made for claims incurred but not reported, and risk-insurance stop loss recoveries received. A smoothing factor was also applied to reduce the impact that claims over $50,000 have the various age categories. This is to prevent a few big claims from skewing the average for the whole age group.

The actual claims cost per member per month for 2003 is derived by matching membership with unit costs and utilization by age group. For comparison, these costs are also displayed for 2001 and 2002 in Table 1.

Table 1
Self-insured Network Rate for Children – Base Claim Cost

Age	2001 Per Member Per Month Base Claim Cost	2002 Per Member Per Month Base Claim Cost	2003 Per Member Per Month Base Claim Cost	Projected FY 05-06 Per Member Per Month Base Claim Cost
Under 2	$85.71	$84.92	$102.61	$122.22
2 through 6	$41.01	$46.41	$48.94	$60.08
7 through 18	$55.89	$63.42	$66.81	$84.48
Combined	$54.86	$60.94	$64.88	$80.80

The base claim cost from 2003 is then projected forward to the mid-point of FY 05-06 based on historical experience. The projected changes are based on observed changes in utilization and unit cost between 2001 and 2003. Utilization is a count of the number of services performed, such as number of visits to a provider. Unit cost adjustments capture changes in the average mix of services rendered. Table 2 shows a summary of the trend factors, where utilization and unit cost factors are combined by service type.

Table 2
Self-insured Network Rate – Service Utilization and Unit Cost

Type of Service	**Utilization Projected Annual Change**	**Unit Cost / Mix of Service Projected Annual Change**	**Total Claim Cost Projected Annual Change**	**Basis for Projection** (Trends are Annualized)
Inpatient Hospital	0.0%	0.0%	0.0%	Actual trend over 2001-2003 was negative. This negative is not expected to continue into the future.
Outpatient Hospital	1.2%	8.1%	9.4%	Actual trend over 2001-2003
Lab and Radiology	13.3%	10.0%	24.6%	Actual trend over 2001-2003
Physician (non-capitated)	10.1%	2.9%	13.2%	Actual trend over 2001-2003
Primary Care Physician (capitated)	N/A	N/A	2.6%	Published 2000-2003 Consumer Price Index for Denver-Boulder-Greeley
Mental Health/ Substance Abuse	5.3%	1.1%	6.5%	Actual trend over 2001-2003
Drugs	9.2%	6.1%	15.9%	Actual trend over 2001-2003
Other Services	14.1%	8.6%	23.9%	Great volatility in actual trend by service category due to small utilization and overall cost; assumed actual trend over 2001-2003

Note: Percentages in the table are multiplicative. For example the Outpatient Hospital growth of 9.4% = (1+1.2%) x (1+8.1%) -1

The next step is to reduce the claims cost to adjust for member copays. Families above 150% of the federal poverty line have a higher copay than families below this threshold. The calculation of emergency room utilization includes an estimated 10% reduction in utilization for the greater than 150% of federal poverty level category due to the higher copay in effect. All other copay cost impacts are calculated assuming a savings only from the collection of the copay, not from a reduction in utilization. Table 3 indicates the impact of copayments on the projected claims cost.

Table 3
Self-insured Network Rate for Children - Copays

Age	FY 05-06 Projected Per Member Per Month Base Claim Cost	FY 05-06 Projected Per Member Per Month Claim Cost After Copay Adjustments[4]
Under 2	$122.22	$121.22
2 through 6	$60.08	$59.35
7 through 18	$84.48	$83.67
Combined	$80.80	$80.00

$80.00 per member per month is the medical claims cost component of the recommended self-insured network rate for FY 05-06.

Medical Management Cost

The medical management cost component of the self-insured network is negotiated with the contractor. These costs are not estimated by the actuary. The Department provides an estimate for these costs. The estimated medical management cost for FY 05-06 is $25.83. This cost includes:

a) Claims Processing and Utilization Management Services. This includes the maintenance of the electronic files for provider reimbursement, customer and provider service, utilization management, quality initiatives, and network reporting.

[4] The adjustments for copays differ by federal poverty level, age, and service.

b) Provider Network Administration. All managed care networks, as well as the Children's Basic Health Plan's self-insured network, require the following provider administration services: recruitment, contracting, training, management, and provider relation activities for the self-insured network.

c) Behavioral Health Management. The vendor is responsible for all aspects of behavioral health management, including a provider network that is separate from the State's network, providing a negotiated fee schedule, adjudicating claims, and all components of behavioral provider network management. This is usually provided through a subcontract with a specialized vendor.

d) Pharmacy Benefits Management. The vendor is responsible for all aspects of pharmacy benefits management, including a pharmacy network that is separate from the State's network, a formulary, adjudicating claims, and all components of pharmacy benefits management. This is usually provided through a subcontract with a specialized vendor.

Table 4 indicates the historical rates for this component.

Table 4
Self-insured Network Rate for Children – Medical Management

	FY 03-04 Assumption for Appropriation	**FY 04-05 Assumption for Appropriation**	**FY 05-06 Assumption for Request**	**Percent Increase Over FY 04-05**
Medical Management Services	$22.88	$23.32	$25.83	10.8%

Risk Insurance Costs

The Risk Insurance component is not estimated by the actuary. The Department provides an estimate for these costs. The estimated medical management cost for FY 05-06 is $2.47.

The Children's Basic Health Plan is responsible for all costs incurred by its members, including any extraordinary health care services. While the per member per month

medical cost includes some variability in costs per client, a single child with catastrophic health care claims (such as for a life-threatening illness or severe auto accident) could cost the program potentially hundreds of thousands of dollars. Unlike Medicaid, the Children's Basic Health Plan is not an entitlement program and the Department does not have overexpenditure authority for this program; the Children's Basic Health Plan must pay all claims incurred through its annual appropriation. Presently, the Department mitigates this risk by purchasing reinsurance. Reinsurance protects insurers from catastrophic claims by paying for claims over a certain dollar amount. Reinsurance premiums are paid by a per-member-per-month charge. Like the State, health maintenance organizations are responsible for covering claims for catastrophic cases enrolled in their plans, and often use reinsurance coverage to mitigate their financial risk in this area as well.

Reinsurance rates vary from year to year, and are heavily based on health care trends. The Children's Basic Health Plan uses the State approved broker to purchase reinsurance at the best possible rates. Table 5 indicates the historical rates for this component.

Table 5
Self-insured Network Rate for Children – Risk Insurance

	FY 03-04 Assumption for Appropriation	**FY 04-05 Assumption for Appropriation**	**FY 05-06 Assumption for Request**	**Percent Increase Over FY 04-05**
Risk Insurance	$3.59	$2.39	$2.47	3.3%

Table 6 summarizes all the components of the self-insured network rate for children. This rate is weight-averaged with the health maintenance organization rate described below for the final blended rate for children. Individual components of the analysis are not necessarily subject to adjustment without an actuary assessing the impact to the other components.

Table 6 Total Self-insured Network Rate for Children				
	FY 03-04 Assumption for Appropriation	**FY 04-05 Assumption for Appropriation**	**FY 05-06 Assumption for Request**	**Percent Increase Over FY 04-05**
Medical Claims	$67.52	$73.69	$80.00	8.6%
Medical Management Services	$22.88	$23.32	$25.83	10.8%
Risk Insurance	$3.59	$2.39	$2.47	3.3%
Total Self-Insured Network Per Member Per Month	$93.99	$99.40	$108.30	9.0%

Health Maintenance Organization Rate

The medical premium rate (the capitation rate) for health maintenance organizations includes costs for medical care, claims management, provider network administration, and behavioral health management. The following summary describes how the requested medical capitation rate of $97.74 per member per month for health maintenance organizations is derived by the actuary.

The HMO rate was calculated using the same methodology as in the self-insurance calculation. The actuary's analysis for the HMO rate is based on claims experienced in calendar year 2003. Separate adjustments were made for each HMO for claims incurred but not reported, and risk-insurance stop loss recoveries received by the HMOs.

The actual claims cost per member per month for 2003 was derived by matching membership with unit costs and utilization. The actuary arrived at a 2003 base claim cost of $70.25 per member per month for the health maintenance organizations. The same calculations were done for calendar year 2002, which yielded a base claims cost of $63.07. An analysis of cost changes between the two years revealed that the actual increase was due to unit cost increases of 2.7% and utilization increases of 8.5%.

Utilization is a count of the number of services performed, such as number of visits to a provider. Unit cost adjustments capture changes in the average mix of services rendered. The total increase from 2002 to 2003 was 11.4%. Using the 2003 actual claims cost as a base, and an annual growth rate of 11.4%, the FY 05-06 projected base claims cost is expected to be $91.95 before adjusting for medical management expenses and copays. The calculation is $91.95 = $70.25 x $(1 + 11.4\%)^{2.5}$, however, some rounding is involved. Table 7 portrays the historical actual costs.

Table 7
Health Maintenance Organization Rate for Children – Actual Claim Cost

2001 Per Member Per Month Actual Claim Cost	2002 Per Member Per Month Actual Claim Cost	2003 Per Member Per Month Actual Claim Cost	Projected FY 05-06 Per Member Per Month Projected Claim Cost
$63.33	$63.07	$70.25	$91.95

Because capitation expenses were not provided to the actuaries by age band, the per member per month projections for the self-insured network were used to derive the average cost by age group and adjust for copays which reduced the average for FY 05-06 to $91.02. Table 8 indicates the adjustment.

Table 8
Total Health Maintenance Organization Rate for Children - Copays

FY 05-06 Per Member Per Month Projected Claim Cost	FY 05-06 Per Member Per Month Projected Claim Cost After Copay Adjustments
$91.95	$91.02

The health maintenance organizations were asked to submit medical management expenses such as reinsurance premiums, utilization management expenses, and any other expenses not directly related to medical costs. In 2003, these medical management costs for health maintenance organizations averaged 7.4% of total medical claims costs. Applying this same percentage of medical management costs to the FY 05-06 per member per month claim cost after copays result in an additional cost to the health

maintenance organizations of $6.72. Adding this amount to $91.02 results in a final health maintenance organization requested rate of $97.74 per member per month. Table 9 summarizes the steps resulting in the final requested rate. This rate is weight-averaged with the self-insured network rate described above for the final blended rate for children. Prior year rates are included for comparison.

Table 9
Health Maintenance Organization Rate for Children

Medical Premiums for Health Maintenance Organizations	FY 03-04 Appropriation	FY 04-05 Assumption for Appropriation	FY 05-06 Assumption for Request	Percent Increase Over FY 04-05
Per Member Per Month Projected Claim Cost	N/A	$81.52	$91.95	12.8%
Per Member Per Month Projected Claim Cost After Copay Adjustments	N/A	$80.73	$91.02	12.7%
Projected Per Member Per Month Administrative Costs	N/A	$6.56	$6.72	2.4%
Total Per Member Per Month	$84.93	$87.29	$97.74	11.9%

The Blended Rate

The final Long Bill appropriation is calculated using a "blended" per member per month rate that is based on the weighted average of the health maintenance organization rate and the self-insured network rate. The weighting is based on the ratio of those enrolled in health maintenance organizations versus those in the self-insured network. In FY 05-06, the Department estimates that 65% of children will be enrolled in a health maintenance organization with the remaining 35% enrolled in the self-insured network.[5] This blended rate is displayed in Table 10 below. The blended rate for children is calculated as $104.44 = ($97.74 x 65%) + ($108.30 x 35%).

[5]The 65% to 35% split was estimated by the Department based on the caseload experienced from July 2003 to March 2004. This percentage does fluctuate, but over time, the health maintenance organization percentage seems to have decreased to 65% from 70% used in last year's estimates.

The Department pays a capitated rate per member per month to the participating HMOs based on the assumptions for the appropriation. The actual medical costs experienced typically vary from the capitated rate that is appropriated, however the HMOs bear the risk. For the self-insured network, the Department bears the risk if actual medical costs vary to the appropriation. As described above, the actuary uses the actual historical cost data as a basis to calculate the recommended rate. Variances to prior year's appropriation are the result of projected changes in unit cost and utilization based on the population's actual medical cost history.

Table 10
"Blended" Medical Premium for Health Maintenance Organizations and Self-Insured Network for Children

	FY 02-03 Supplemental Appropriation	**FY 03-04 Appropriation**	**FY 04-05 Assumption for Appropriation**	**FY 05-06 Request**	**Percent Increase Over FY 04-05 Appropriation**
Total Per Member Per Month	$80.74	$87.65	$90.92	**$101.44**	11.6%

FY 02-03 $80.74 rate source is Supplemental Bill SB 03-203 footnote #58
FY 03-04 $87.65 rate source is SB 03-291 Section (4) Appropriation's clause
FY 04-05 $90.92 rate source is HB 04-1422 Long Bill footnote #41

III. Description of Alternative Related to the Prenatal and Delivery Program

A. Prenatal Caseload

Enrollment in the prenatal program was suspended in May of 2003 and reopened in July 2004. The prenatal caseload projection assumes that enrollment from July 2004 to January 2005 will resemble the 7 months of historical enrollment during the original start up of the program. A monthly growth rate of 8.8% was assumed for the remained of FY 04-05. This was the monthly growth rate in February 2003, two months before new enrollment ceased. The caseload projection for FY 05-06 uses the FY 04-05 projection as a base and projects a decline in monthly growth leveling off at 2.7% per month by March of 2006. The average monthly caseload for pregnant women is 1,618. The deliveries were projected using the projected enrollment and some assumptions about how long the

average woman is enrolled before delivery. Please see the explanation of prenatal caseload in the Assumptions for Calculations section of this request for a more details.

B. Prenatal Rates

The rate requested for women's prenatal and postpartum medical care is recommended by the contracted actuary. Rates were calculated separately for the self-insured network and the health maintenance organizations. Like the children's plan discussed earlier, a blended rate is used to calculate the requested appropriation. The narrative that follows is informational, and describes how the actuary calculated the rate.

The data used to calculate the base rate for both the self-insured network and the health maintenance organizations was from calendar year 2003. First, the actuary adjusted the data for claims incurred but not reported and stop loss recovery. This was used to calculate the base claims cost per member per month for 2003.

The next step was to project the 2003 per member per month claims cost into FY 05-06 using trend factors. Because the prenatal program was new in 2003, there was no actual trend data that could be used for the prenatal program. For the self-insured network, the same trend factors were used for the prenatal program as the children's medical plan. Please see Table 2 for a detailed breakdown of the trend factors. The health maintenance organization 2003 base cost was projected forward into FY 05-06 using a 2.7% annual unit cost increase, which is the same as that used in the calculation for the children's rate. Finally, the rates were adjusted for copays and the estimates for administrative costs were applied from the calculations done for the children's rate analysis.

The final projections for the self-insured network for FY 05-06 are $4,346.15 per delivery and $353.30 per member per month. The projected costs for the health maintenance organizations are $4,594.84 per delivery and $284.18 per member per month. The weighted average, blended rate of the self-insured rates and HMO rates is used for budgeting the prenatal expenditures. The actual caseload experience in FY 02-03 was used to calculate the weighting, based on the actual number of member months for HMO

and the self-insured network in 2003. The average is calculated at 52% HMO and 48% self-insured network. See Table J-2 in tab Attachment 1 for calculations of the blended rate. Table 11 illustrates the blended rates.

The recommended rate for FY 05-06 is based on actual medical cost experienced in 2003. The previous prenatal rate assumptions used for the FY 04-05 Appropriations were derived without the benefit of actual program experience. The rate request for deliveries is higher than the FY 04-05 rate assumptions, however the request for the monthly rate for women is lower than the FY 04-05 rate.

Table 11
Prenatal and Delivery Rate Summary

Cost Component	FY 04-05 Assumption for Appropriation	FY 05-06 Blended Rate for Request	Percent Change
One time labor and delivery fee	$3,965.00	$4,475.47	12.9%
Per member per month cost for all other services	$345.30	$317.36	-8.1%
Blended, weighted combined rate[6] - not used for any Change Request calculations	$888.49	$931.29	4.8%

IV. Description of Alternative Related to Long Bill Footnote

Typically, the Long Bill footnotes have provided clarity around the assumptions for per member costs and caseload. Since the inception of the program, average monthly caseload totals provided in the footnote have been treated as caps for the program. That is, although enough funding may be available to cover an increasing caseload, the Department would still pursue a Supplemental Request should the average monthly caseload number be exceeded.

[6]The actuary produces a weighted combined per member per month rates for delivery/other prenatal services - one for HMOs, and one for Self-insured networks. The combined rates are weighted because they take into account that not all women will have deliveries while in the Children's Basic Health Plan Prenatal and Delivery Program. Applying the FY 05-06 assumptions for enrollment in HMOs of 52% and Self-insured Network of 48%, a blended, weighted combined rate was calculated for both FY 04-05 and FY 05-06 for purposes of comparison. The FY 04-05 rate calculation is: $888.49 = ($912.94 x 52% + $862.00 x 48%). The FY 05-06 rate calculation is: $931.29 = ($942.00 x 52% + $919.69 x 48%).

During the unpredictable time of the FY 03-04 enrollment caps being lifted, there are a great many uncertainties in the Department's projection of caseload. A number of one-time events are occurring in FY 04-05, and the effect on caseload is not known at this time. Therefore, the Department requests that the footnote not ask the Department to control to any caseload amount, but rather to the dollar appropriation like other Long Bill line items. After the Department resolves initial issues regarding eligibility reporting in the Colorado Benefits Management System and works on correlating new report data, it will continue to report caseload monthly to the Joint Budget Committee, so the information would still be at hand.

Implementation Schedule:

Task	Month/Year
Contract Negotiations for FY 05-06	March and April 2005
Premium Contracts Written	April 2005
Premium Contracts Signed	May 2005
New Premium Contracts Effective	July 2005

Calculations for Alternative's Funding:

Summary of Request FY 05-06 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt from the Children's Basic Health Plan Trust Fund**	**Federal Funds**
Total Request FY 05-06 (column 7) See Table D at Tab Attachment 1	$77,794,594	$27,332,541	$50,462,053
FY 05-06 Incremental Change Request (column 6)	$18,473,175	$6,570,044	$11,903,131
Subtotal below for FY 05-06 Base Request (column 5)	$59,321,419	$20,762,497	$38,558,922
FY 04-05 Appropriation (column 4)	*$59,011,563*	*$20,654,047*	*$38,357,516*
HB 04-1447 Legal Immigrants FY 05-06 impact	*$309,856*	*$108,450*	*$201,406*

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt from the Children's Basic Health Plan Trust Fund**	**Federal Funds**
FY 06-07 Incremental Request (column 10)	$18,473,175	$6,570,044	$11,903,131

Impact on Other Areas of Government: Financing the Children's Basic Health Plan, including prenatal, relieves the Colorado Indigent Care Program burden to some degree.

Assumptions for Calculations: Table D at tab Attachment 1 provides the calculations for the projected children's medical premiums cost in FY 05-06 of $61,501,855. Table J-2 in tab Attachment 1 provides the calculations for the projected Prenatal and Delivery Program cost in FY 05-06 of $16,292,739. These total to $77,794,594 indicated above.

Table G at tab Attachment 1 develops the children's caseload projection calculations.

Graph 1.0 at tab Attachment 1 depicts the children's enrollment developed in Table G. Please see the Assumptions for Calculations section for an explanation of the children's caseload projection.

Table H at tab Attachment 1 calculates the monthly enrollment for women in the prenatal program. Table I at tab Attachment 1 develops the number of deliveries projected for FY 05-06 based on the women's caseload projection.

Rates: Self-Funded Network

The data sources on which the rates were based are as follows:

- Medical claims data provided by Anthem;
- Pharmacy claims administered and provided by Anthem Pharmacy Management;
- Mental health claims data provided by Horizon Behavioral Services, for claims paid before July 22, 2003;

- Mental health claims data provided by Anthem Behavioral Health, for claims paid after July 22, 2003;
- Membership data provided by ACS Healthcare Solutions; and
- FY 03-04 medical, pharmacy, and mental health claims budgeted administration rate, including network administration.

Rates: HMO

The actuarial rates were developed using actual claims data, total dollars paid for medical claims, pharmacy claims data, and actual reinsurance recoveries from the HMOs in the program for 2003. Also used in the analysis was membership data provided by ACS Healthcare Solutions.

Assumptions for Children's Caseload Projection

FY 04-05 Projection Table G at tab Attachment I
The starting point for the FY 04-05 children's caseload projection is the July 2004 actual enrollment of 38,608[7]. Because enrollment into the program was capped from November 2003 though June 2004, the enrollment during this period cannot be used to project enrollment growth in FY 04-05. Instead, the average monthly growth rate from October 2001 to October 2002 was used to project the FY 04-05 enrollment growth. The actual enrollment was 38,344 in October of 2001, which is similar to the July 2004 enrollment of 38,608. The October 2003 enrollment was 48,177. This is an average monthly growth of 819 or (48,177-38,344) / 12. This average monthly growth rate of 819 was applied to the base of 38,608 to develop the FY 04-05 projection. In addition, enrollment was increased by 568 children in January 2004 to account for legal immigrants from HB 04-1447. The average enrollment for FY 04-05 is projected to be 43,399.

[7] Includes an adjustment for retroactivity. 38,608 children's enrollment was reported in a letter to Joint Budget Committee staff on September 20, 2004.

FY 05-06 Projection Table G at tab Attachment I
The starting point for the FY 05-06 caseload projection is the caseload projected for June 2005 of 48,190. The 48,190 from June 2005 includes the adjustment of 568 for children from HB 04-1447 discussed above. The average monthly growth rate from October 2002 to October 2003 was used to grow the 48,190 for the FY 05-06 projection. This is the most recent data set that is not affected by the enrollment cap in FY 03-04. Also, historical data suggests that enrollment growth slows considerably at levels above 50,000, particularly in the absence of marketing. Actual enrollment grew from 48,177 in October 2002 to 52,484 in October 2003. That is a monthly growth rate of 359 or (52,484-48,177) / 12. The average monthly enrollment is projected to be 50,524 in FY 05-06.

Assumptions for Prenatal Caseload Projections

Discussion of the Enrollment Projections (Table H at tab Attachment 1)
The Prenatal and Delivery Program was in operation from October 2002 to May 2003 before the enrollment into the program ceased. The FY 04-05 projection assumes that the reopening of the program in July 2004 will resemble the startup of the program in 2002. An 8.8% growth per month was used to project enrollment for the remainder of FY 04-05 (5 months). This was the monthly growth rate in February 2003, which was two month before enrollment was halted. Enrollment growth was higher in April 2003 due to an influx of applications from women trying to enroll before new enrollments were stopped in May. The projected FY 04-05 average monthly enrollment for women is 717. The Department assumes that growth rates projected for FY 04-05 are unsustainable for FY 05-06, because FY 04-05 is the first year of operation after enrollment in the program was suspended in FY 03-04. Monthly growth projected at the end of FY 04-05 is 8.8%. The FY 05-06 caseload projection assumes a steady decline in growth until March of 2006 when the growth rate is assumed to level out at 2.7% per month for the remainder of the year. The 2.7% equilibrium growth is based on an average of the monthly growth rates for the children's program from the second and third years of operation (FY 99-00 and FY 00-01). In FY 99-00, the average monthly growth rate was 2.6% and in FY 00-01 the average monthly growth rate was 2.8%. The average monthly enrollment projected for FY 05-06 is 1,618.

Discussion of Delivery Projection (Table I at tab Attachment 1)
The FY 04-05 projection for deliveries uses the 874 deliveries assumed in the FY 04-05 appropriation. There is not sufficient historical data to develop a better estimate for FY 04-05 at this time. Due to the startup of the program women will enter the program at various stages of pregnancy. The number of deliveries for FY 05-06 was projected using the enrollment figures and some assumptions about how long women would be in the program on average before they deliver. The assumptions are as follows:

1) Women are entitled to sixty days of postpartum care;
2) Due to presumptive eligibility, 30% of women will be determined ineligible two months after starting the program. In the FY 04-05 Change Request[8], the Department assumed 30% based on the actual FY 02-03 experience; and
3) On average, women enter the program in their fifth month of pregnancy.

Based on these assumptions, a monthly schedule was developed to estimate when the deliveries will occur based on the projected enrollment. The schedule starts each month with the previous month's enrollment. First, due to presumptive eligibility, subtract 30% of the women who started the program two months ago. These are women who started the program with presumptive eligibility, but were later determined ineligible. Next, subtract the women who delivered three months ago. Women are entitled to two months of postpartum care. Then, add the women who begin the program this month. The result is the caseload for the month. On average, women enter the program in their fifth month of pregnancy. However, some of these women will later be determined "not eligible" before their delivery date. So, the projected number of deliveries for the month is based on the number of new women enrolled five months ago, less 30% for women who were later determined not eligible.

[8]November 3, 2003 Budget Request, #DI-2, page H.2-25.

Assumptions for the Calculation of the Total Request (Table D at tab Attachment 1)

The Children's Basic Health Plan Premium Costs line item is funded though Cash Funds Exempt from the Children's Basic Health Plan Trust Fund and matching federal funds. The Trust is funded in part by annual enrollment fees collected from clients in the Children's Basic Health Plan. These are Cash Funds and are not eligible for a federal match. The projection of annual enrollment fees to be collected in FY 05-06 is based on ratio of actual enrollment fees collected per average enrollment in FY 03-04. Table D at tab Attachment 1 delineates the funding splits for the Children's Basic Health Plan Premium Costs line item.

Concerns or Uncertainties of Alternative: The Department has no historical experience from which to estimate the volume of new enrollment into the program once the enrollment cap is lifted July 2004. The accuracy of caseload projections for FY 05-06 depends heavily on the volume of new enrollment in FY 04-05.

Actuarial projections of claims costs for FY 05-06 are based on data from 2003. If the case-mix changes significantly over time, it will affect medical costs.

Instability in health maintenance organizations' participation in the program may result in higher costs than projected. The actuarial projections of claims cost are based on information provided by the four HMOs currently participating in the program.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: The base request for FY 05-06 is $59,321,419 consisting of $20,762,497 in Cash Funds Exempt from the Children's Basic Health Plan Trust Fund and $38,558,922 in federal funds. The base appropriation is sufficient to fund the projected children's caseload assuming no rate adjustment at a cost of $55,123,705 ($90.92 x 12 x 50,524), however the remaining $4,197,714 is insufficient to support the projected prenatal and delivery caseload. The federal waiver for the adult prenatal program does not allow the children's

program to be capped as long as adults are being served in the program. Enrollment into the prenatal program would need to be limited in some way to avoid overspending the FY 05-06 base appropriation. The remaining $4,197,714 could support approximately 658[9] deliveries assuming 7 months of prenatal/postpartum care per delivery and no rate adjustment.

Calculations for Alternative's Funding: There would be no change in funding with this alternative

Concerns or Uncertainties of Alternative: *Concerns Related to Capitation*

- Prenatal care is very important to the development of healthy children. Without funding to cover prenatal care, the medical cost for newborns could increase.

Concerns Related to No Rate Increase

- Rate increases are necessary to fund the costs of providing services.

Supporting Documentation

Analytical Technique: Cost/Benefit Analysis

Cost/Benefit Analysis	Incremental Costs	Benefits (Total Caseload)		
		Children	Women	Deliveries
Alternative A (recommended)	$18,473,175	50,524	1,618	2,264
Alternative B (not recommended)*	$0	50,524	384	658

* The 384 in average monthly enrollment for women is based on 658 deliveries times 7 months per delivery, divided by 12 months.

The costs of Alternative A are higher, but Alternative A provides health care to more clients. Alternative A is the recommended alternative because it provides coverage for an additional 1,606 deliveries and an additional average monthly enrollment of 1,234

[9] 658 = $4,197,714/ ($3,965 per delivery + ($345.30 per month x 7 months) It is uncertain how a prenatal enrollment cap would be administered at this time, or when it would need to be implemented. The estimate of 658 deliveries is shown here for purposes of comparison.

women. Alternative A also allows for rate adjustments and avoids suspending enrollment into the Prenatal and Delivery program.

Quantitative Evaluation of Performance - Compare all Alternatives:

Medicaid per capitas are still significantly higher than annualized per member per month costs for the Children's Basic Health Plan. The table below compares an estimated cost per Medicaid child in comparison to the cost for a child in the Children's Basic Health Plan. All numbers are estimates.

FY 05-06 Children's Basic Health Plan Monthly Medical Premiums[10] for Children	FY 05-06 Children's Basic Health Plan Monthly Dental Premiums for Children	Children's Basic Health Plan Monthly Medical Dental, and Mental Health Cost Annualized	Medicaid Per Capita Cost	Children's Basic Health Plan Rate as a Percent of Medicaid Per Capita
$101.44	$11.82	$1,359.12	$1,554.57	87.4%
Attachment 1, Table D	Attachment 1, Table D	=($101.44 + $11.82)*12	FY 04-05 Exhibit O in the February 16, 2004 Budget Request, before financing ($1,390.94) + $11.91[11] mental health capitation * 12. Increased by 1.35%[12] for FY 05-06	$1,359.12 / $1,554.57 * 100

Statutory and Federal Authority:

Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj). SEC. 2101. [42 U.S.C. 1397aa] (a) PURPOSE-*The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage…*

[10]Including mental health services.
[11]February 16, 2004 Mental Health Capitation Supplemental #NP-S23, Attachment 2. FY 04-05 Budget column for Children ($30,324,880) + FY 04-05 Amendment column ($585,610) ÷ FY 04-05 member months for children (2,596,352).
[12]Percent change of FY 04-05 from FY 03-04 for Eligible Children from Exhibit U from the February 16, 2004 Budget Request.

26-19-109 (5) (a) (I), C.R.S (2004) . . .*Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan . . .*

26-19-109 (6), C.R.S (2004) *The state department shall provide a child who is no longer eligible for the state's Medicaid program…with the appropriate notice of the opportunity to choose to be enrolled in the* [Children's Basic Health] *plan prior to the child's disenrollment from Medicaid.*

Department Objectives Met if Approved: 1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

3.1 To improve customer satisfaction with programs, services, and care.

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI - 4	**OSPB Approval:**		**Date:**	
Program:	Child Health Plan Plus Division	**Statutory Citation:**	26-19-107 (1) (a) (II), C.R.S. (2004)		
Request Title:	Adjust Children's Basic Health Plan Dental				

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	5,405,336	5,658,981	0	5,658,981	5,697,526	537,193	6,234,719	0	6,234,719	537,193
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	1,891,868	1,980,644	0	1,980,644	1,994,135	188,017	2,182,152	0	2,182,152	188,017
	FF	3,513,468	3,678,337	0	3,678,337	3,703,391	349,176	4,052,567	0	4,052,567	349,176
(4) Indigent Care Program: Children's Basic Health Plan Dental Benefit Costs	**Total**	5,405,336	5,658,981	0	5,658,981	5,697,526	537,193	6,234,719	0	6,234,719	537,193
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	1,891,868	1,980,644	0	1,980,644	1,994,135	188,017	2,182,152	0	2,182,152	188,017
	FF	3,513,468	3,678,337	0	3,678,337	3,703,391	349,176	4,052,567	0	4,052,567	349,176

Letter Notation:
Cash Fund name/number, Federal Fund Grant name: CFE: Tobacco Litigation Settlement and Fund 11G, CBHP Trust Fund FF: RSC 7400, Title XXI
IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI – 4
Change Request Title:	Adjust Children's Basic Health Plan Dental
Long Bill Line Item(s)	(4) Indigent Care Program: Children's Basic Health Plan Dental Benefit Costs
State and Federal Statutory Authority:	The Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) and 26-19-107 (1) (a) (II), C.R.S. (2004)

Summary of Request (Alternative A): This request is to increase the Children's Basic Health Plan Dental Benefit Costs appropriation by $537,193 from the FY 05-06 Base Request of $5,697,526. The increase is needed to support growing enrollment and a rate adjustment based on an annual actuarial review. The requested rate is $11.82 and the estimated FY 05-06 caseload for dental is 43,956.

This line item is funded by 35% Cash Funds Exempt through the Children's Basic Health Plan Trust Fund, and by 65% matching federal funds. Please see DI – 5 Adjust Children's Basic Health Plan Trust Fund for an explanation of the General Fund contributions requested to support the Trust Fund.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The dental benefit for children was added to the Children's Basic Health Plan on February 1, 2002. This benefit is managed through a capitated contract with Delta Dental, a dental plan administrator. As such, the contracted administrator bears the risk associated with the dental benefit. The plan administrator has an extensive statewide

network with over seven hundred providers. The Children's Basic Health Plan dental benefit is fairly comprehensive, but limits each child to $500 worth of services per year.

Rate History
The initial FY 01-02 Children's Basic Health Plan Dental Benefit Costs appropriation assumed: 1) a benefit cost per eligible of $9.95 per month (this rate was derived by dividing Medicaid dental costs by the number of Medicaid clients eligible for dental services), and 2) administrative costs of $1.00 per eligible per month. This resulted in a total rate of $10.95 per member per month. While the total funds appropriated for this benefit were adjusted for changes in caseload each year, the initial rate remained constant at $10.95 per member per month until FY 04-05.

A Budget Request Amendment (BAS – 4, Rate Increase for Children's Basic Health Plan Dental, January 23, 2004) was approved for FY 04-05 to adjust the rate to $11.31 based on an actuarial review of historical dental costs for the Program, and to cover increased costs for providers. To derive the $11.31 for FY 04-05 the actuary reviewed actual dental claims incurred between June 2002 and May 2003 for children in the Children's Basic Health Plan. The actual base claims cost for that period was $9.45 vs. the $9.95 assumed in the appropriation. The actuary then adjusted for unit cost trends, coinsurance, the $1.00 administration fee, and a 1% risk insurance adjustment. The actuary also adjusted for pent-up demand for services since enrollment was capped prior to July 2004.

Per Member Per Month Rate Development for FY 04-05

Dental Rate Component	Request
(1) Base Period (June 2002 – May 2003) Claims Costs	$9.45
(2) FY 04-05 Projected Claims Costs (8% growth trend)	$10.34
(3) Claims Costs with Coinsurance Adjustment	$10.11
(4) Plus Global Administration Fee	$1.00
(5) Plus 1% Risk Insurance Factor	$0.12
(6) Equals Claims Costs (Without Pent-Up Demand Factor)	$11.23
(7) Plus Pent-Up Demand Factor	$ 0.08
(8) Equals Recommended Dental Rate	**$11.31**

An annual unit cost trend factor of 8% was applied from the base period through FY 04-05. Since the base period ended in May, this trend factor must actually be applied for 13 months to be carried through FY 03-04 or 25 months to carry through FY 04-05. This rate was selected by the actuary for two reasons. The dental carrier increased its fee schedule 8% for all lines of business, effective July 2003, and had notified the Department of its intent to do the same again in July 2004. Thus, the actuary deemed that it would be reasonable to assume a fee schedule change of the same magnitude the following fiscal year. Secondly, the actuary cited the "Health Trend Report", developed by SHPS, Inc., noting that projected nationwide dental annual trend factors for the third quarter of 2003 were 8.5% for preferred provider plans.

The actuary's recommended rate for FY 05-06 was developed in much the same way that the FY 04-05 rate was developed with a two main exceptions. First, there was no pent-up demand factor applied. Secondly, the trend factor used to develop the FY 05-06 rate was based on the actual historical growth in claims cost. This is the first time that the actuary has had access to more than one year of claims data to derive a historical trend factor. This increases the accuracy of the projection.

General Description of Alternative:

This Alternative seeks to increase the appropriation for FY 05-06 to adjust for changes in caseload and rates. This Alternative supports a projected dental caseload of 43,956 in average monthly enrollment, and a rate of $11.82 per member per month. The caseload projection for FY 05-06 for enrollment in the dental program is based on the caseload projection for medical premiums (see November 1, 2004 Change Request # DI-3 "Fund Children's Basic Health Plan Medical Premium for Caseload and Address Rate Changes"). The requested rate adjustment is based on an actuarial review of historical dental claims costs.

Caseload Adjustment

Children who qualify for the Children's Basic Health Plan are eligible to receive dental benefits as well as medical benefits. There are consistently fewer members enrolled in the dental program than in the medical plan, because new members do not receive dental coverage during their pre-HMO enrollment period. For this reason, the Department

estimates that dental caseload will be 87% of the medical caseload. In FY 05-06, average monthly enrollment in the medical plan is projected to be 50,524. The FY 05-06, dental projection is therefore 87% of this figure, or 43,956 in average monthly enrollment

Rate Adjustment

The adjustment to the dental rate requested in this Alternative will provide an actuarially projected rate for FY 05-06. The recommended rate of $11.82 was calculated using claims data supplied by Delta Dental and membership data provided by ACS Healthcare Solutions from March 2003 to February 2004. First, the claims data was adjusted for claims incurred but not reported. The claims data was then matched with the membership data to delineate unit cost and utilization by age and by income level. This was used to establish a base cost per member per month for the year ending February 29, 2004. The average cost per member per month for all ages and all income levels was $9.77 in the base period.

To project this cost into FY 05-06, the actuary applied the historical growth experienced in utilization and unit cost to the base per member per month rate. The historical annual growth rate experienced between the midpoint of the year ended May 31, 2003 and the midpoint of the year ended February 29, 2004 was 1.4% for unit cost and 3.4% for utilization. By applying these growth rates to the base cost of $9.77, the base cost was projected for FY 05-06. The base cost projected for FY 05-06 is $10.92 per member per month. The calculation for projecting the historical cost forward is: $10.92 = $9.77 * $((1+1.4\%) * (1+3.4\%))^{2.42}$. Some rounding is involved. The exponential value of 2.42 is used to calculate the growth over the 29 months between the midpoint of the base period and the midpoint of FY 05-06. 2.42 = 29 months / 12 months in a year.

This rate was then adjusted for member coinsurance, which reduces the average cost to $10.69. An administrative cost of $1.01 per member per month is then added to the $10.69 to get $11.70. The $1.01 is based on non-claims costs supplied by the contractor in response to the Department's original Request for Proposal in 2002. The cost estimate has since been adjusted by $.01 for inflation. The $1.01 includes the contractor's costs for the following:

- Claim Processing
- Utilization Management
- Network Access
- Network Administration
- Customer Service
- Programming and Systems
- Marketing
- Other Administrative costs

Finally, a 1% fully insured risk factor is applied to the rate. Since the dental premium rate is capitated, the contractor assumes all risks related to actual dental costs. The 1% fully insured risk factor compensates for that risk. The resulting rate of $11.82 (calculated as $11.70 * (1+1%)) is the recommended dental rate for FY 05-06. Table 1 below summarizes the requested rate for FY 05-06. The appropriated rate for FY 03-04 and FY 04-05 are shown for comparison.

Table 1: Dental Rates Per Member Per Month

FY 03-04 Appropriation	FY 04-05 Appropriation[1]	FY 05-06 Request	Requested Increase
$10.95	$11.31	$11.82	4.5%

The Department pays this capitated rate per member per month to the contractor based on the appropriation. The actual claims cost experienced typically vary from the capitated rate that is appropriated, however the contractor bears the risk. As described above, the actuary uses the actual historical cost data as a basis to calculate the recommended rate. Variances to prior year's appropriation are the result of projected changes in unit cost and utilization based on the population's actual dental cost history.

The adjusted caseload for dental benefits requested is 43,956 children and the requested rate is $11.82 per member per month. The total request for FY 05-06 is $6,234,719,

[1]Budget Request Amendment #BAS – 4, "Rate Increase for Children's Basic Health Plan Dental," January 23, 2004 was approved for FY 04-05 to raise the appropriated rate from $10.95 to $11.31. See Figure Setting, pg. 122, March 9 2004.

calculated as 43,956 * 12 * $11.82. This is an increase in total funds of $537,193 over the base request of $5,697,526. The Cash Funds Exempt portion of the incremental request is $188,017, which is 35% of the increase.

Implementation Schedule:

Task	Month/Year
Contract Negotiations for FY 05-06 Dental Rates	March and April 2005
Premium Contracts Written	April 2005
Premium Contracts Signed	May 2005
New Premium Contracts Effective	July 2005

Calculations for Alternative's Funding:

Summary of Request FY 05-06 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt from the Children's Basic Health Plan Trust Fund**	**Federal Funds**
Total Request FY 05-06 (column 7)	$6,234,719	$2,182,152	$4,052,567
FY 05-06 Change Request (column 6)	$537,193	$188,017	$349,176
Subtotal below for FY 05-06 Base Request (column 5)	$5,697,526	$1,994,135	$3,703,391
FY 04-05 Appropriation (column 4)	*$5,658,981*	*$1,980,644*	*$3,678,337*
Annualization of HB 04-1447 Legal Immigrants	*$38,545*	*$13,491*	*$25,054*

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt from the Children's Basic Health Plan Trust Fund**	**Federal Funds**
Total Request FY 06-07 (column 9)	$6,234,719	$2,182,152	$4,052,567
FY 06-07 impact of FY 05-06 Change Request (column 10)	$537,193	$188,017	$349,176
Subtotal below for FY 05-06 Base Request (column 5)	$5,697,526	$1,994,135	$3,703,391

Table D at tab Attachment 1 shows the calculations for the FY 05-06 requested total appropriation and the funding slits. The Cash Funds Exempt come from the Children's Basic Health Plan Trust Fund.

Impact on Other Areas of Government: None

Assumptions for Calculations:

Caseload

A detailed explanation of the FY 05-06 caseload projection for the children is available in the Assumptions for Calculations section of November 1, 2004 Change Request #DI – 3, "Fund Children's Basic Health Plan Medical Premium for Caseload and Address Rate Changes." The children's caseload requested for the medical premiums is 50,524 in average monthly enrollment. The dental caseload projection is estimated to be 87% of 50,524, or 43,956.

The 87% factor was estimated by comparing actual enrollment in the dental program to enrollment in the medical program in FY 02-03. Without adjusting for this phenomenon, expenditures would be over-estimated. While reimbursement for medical care through the Plan's self-insured network is allowed from the date the application is complete, capitated benefits through the Plan's health maintenance organizations and dental program are not. Enrollment into these capitated plans is dependent upon the date of application approval. For those who apply and are found eligible before the 23rd of the month, capitations are paid to health maintenance organizations and the dental contractor in time for children to enroll with these plans effective the first day of the month immediately following. For those determined eligible after the 23rd of the month, capitations and enrollment into these plans does not occur until the first day of the month thereafter. Thus, the dental capitation is always paid for fewer children than are actually enrolled in the Children's Basic Health Plan. Table 2 demonstrates this effect. The same factor was used to estimate FY 05-06.

Table 2
Comparison of Children Capitated for the Dental Benefit and Actual Caseload

	Caseload as Presented in November 1, 2003 Change Requests	Actual Children Under Dental Capitation	Ratio of Capitated Children to Caseload
July 2002	44,618	39,684	88.9%
August 2002	45,864	39,861	86.9%
September 2002	46,857	40,659	86.8%
October 2002	48,177	40,736	84.6%
November 2002	48,734	41,411	85.0%
December 2002	49,258	43,087	87.5%
January 2003	50,492	44,356	87.8%
February 2003	50,930	44,426	87.2%
March 2003	51,192	44,936	87.8%
April 2003	51,603	44,896	87.0%
May 2003	51,875	45,370	87.5%
June 2003	53,118	46,476	87.5%
Fiscal Year Average	**49,393**	**42,992**	**87.0%**

Concerns or Uncertainties of Alternative: *Caseload*
The caseload projections are based on lifting the enrollment cap in FY 04-05. The Department has no prior experience with removing an enrollment cap. Growth could be faster than expected due to pent-up need in the community. Therefore, caseload projections were based on historical data prior to the enrollment cap.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: The base request for FY 05-06 is $5,697,526 consisting of $1,994,135 in Cash Funds Exempt from the Children's Basic Health Plan Trust Fund and $3,703,391 in federal funds. This amount is insufficient to allow natural enrollment growth in the children's dental program. Enrollment in the dental plan would need to be capped in order to avoid

overspending the appropriation. The FY 05-06 base request would serve 41,980[2] children at the $11.31 rate rather than the 43,956 children that is requested.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Capping the program would delay needed dental care for some children.

With no rate increase to cover increasing costs, the dental contractor may be forced to choose between running the program at a loss, reducing the coverage, or terminating the contract. If the contract was terminated, the Department would go out to bid for a new contractor, however the cost is not likely to be lower, because the requested rates are actuarially sound.

Supporting Documentation

Analytical Technique: Cost/ Benefit Analysis

Cost/Benefit Analysis	Incremental Cost Total Funds	Benefits (Average Monthly Caseload)
Alternative A (recommended)	$537,193	43,956
Alternative B (not recommended)	$0	41,980

The costs of Alternative A are higher, but Alternative A provides dental care to more children.

Quantitative Evaluation of Performance - Compare all Alternatives: Alternative A is the recommended alternative because 1,976 more children per month can receive dental coverage.

[2] 41,980 = ($5,697,526 base request / ($11.31 per month * 12 months)

Statutory and Federal Authority:

Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj). SEC. 2101. [42 U.S.C. 1397aa] *(a) PURPOSE.-The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage…*

26-19-107 (1) (a) (II), C.R.S. (2004) (1) *In addition to any other duties pursuant to this article, the department shall have the following duties: (a) (II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that: (A) An adequate number of dentists are willing to provide services to eligible children; and (B) The financial resources available to the program are sufficient to fund such services.*

Department Objectives Met if Approved:

1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

3.1 To improve customer satisfaction with programs, services, and care.

Schedule 6

Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI - 5	**OSPB Approval:**		**Date:**	
Program:	Child Health Plan Plus Division	**Statutory Citation:**	26-19-105 (1) (2), C.R.S. (2004)		
Request Title:	Adjust Children's Basic Health Plan Trust Fund				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 03-04	FY 04-05	FY 04-05	FY 04-05	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 06-07
Total of All Line Items	**Total**	18,754,047	24,456,100	0	24,456,100	21,494,086	2,532,019	24,026,105	0	24,026,105	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,143,543	3,296,346	0	3,296,346	0	2,581,753	2,581,753	0	2,581,753	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	149,618	210,400	0	210,400	210,400	(49,734)	160,666	0	160,666	(49,734)
	CFE	17,460,886	20,949,354	0	20,949,354	21,283,686	0	21,283,686	0	21,283,686	0
	FF	0	0	0	0	0	0	0	0	0	0
(4) Indigent Care Program: Children's Basic Health Plan Trust Fund	**Total**	18,754,047	24,456,100	0	24,456,100	21,494,086	2,532,019	24,026,105	0	24,026,105	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,143,543	3,296,346	0	3,296,346	0	2,581,753	2,581,753	0	2,581,753	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	149,618	210,400	0	210,400	210,400	(49,734)	160,666	0	160,666	(49,734)
	CFE	17,460,886	20,949,354	0	20,949,354	21,283,686	0	21,283,686	0	21,283,686	0
	FF	0	0	0	0	0	0	0	0	0	0

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: CF: Annual enrollment fees of CBHP enrollees CFE: Tobacco Litigation Settlement and Fund 11G, CBHP Trust Fund

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI – 5
Change Request Title:	Adjust Children's Basic Health Plan Trust Fund
Long Bill Line Item(s)	(4) Indigent Care Program: H.B. 97-1304 Children's Basic Health Plan Trust
State and Federal Statutory Authority:	26-19-105 (1) (2), C.R.S. (2004)

Summary of Request (Alternative A): This request is for $2,581,753 of General Fund for Children's Basic Health Plan Trust to support program expenses in FY 05-06. Also requested is a decrease in the appropriation for Cash Funds equal to $49,734 for annual enrollment fees. The General Fund requested here is the minimum needed to fund the Children's Basic Health Plan medical, prenatal, dental, and administration Decision Items at the requested level and maintain solvency of the Trust.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Children's Basic Health Plan Trust Fund supports the State's share of the Children's Basic Health Plan expenditures. It is funded primarily through Tobacco Master Settlement Appropriations and General Fund; however, enrollment fees from clients of the program, and interest earnings on the Fund's balance, also serve to subsidize the Trust. Therefore, appropriations to the Trust do not reflect the total balance in the Trust. The Trust operates like a bank account, with revenues and expenditures.

Revenues to the Trust Fund include the following:

- General Fund appropriations
- Tobacco Master Settlement appropriations (Cash Funds Exempt)
- Annual enrollment fees from program enrollees (Cash Funds)
- Interest earnings

Expenditures from the Trust Fund include the following:

- The State's share of the Children's Basic Health Plan Medical Premiums line item
- The State's share of the Children's Basic Health Plan Dental Benefit Costs line item
- The State's share of the Children's Basic Health Plan Administration line item
- The State's share of the Department's internal administrative costs (goes to various line items identified with letternotes in the Long Bill)

General Fund

Prior to the Supplemental for FY 01-02 (HB 02-1370), the Trust had been appropriated $8,603,720 in General Fund each year. As a result of HB 02-1370, the General Fund appropriation was eliminated for FY 01-02 to help balance the State's budget. General Fund appropriations have since been the minimum needed to cover the program appropriations and maintain solvency of the Trust. In FY 02-03, the final General Fund appropriation was $2,598,210. The General Fund appropriation for FY 03-04 was $1,143,543, and $3,296,346 in FY 04-05.

Tobacco Master Settlement Appropriations

In FY 02-03, the Children's Basic Health Plan's portion of the Tobacco Master Settlement allocation was $17,500,000. SB 03-019 (Tobacco Settlement Program Audit Costs) reduced the appropriation for FY 03-04 by $23,459 in order to fund the State Auditor's Office review of costs for Tobacco Settlement programs. HB 04-1331 further reduced the appropriation by $15,848 to go to the Department of Public Health and Environment to cover costs associated with providing oversight to the tobacco settlement funded programs. SB 03-282 (2003 Tobacco Bill) increased the appropriation by $1,000,000 for a final FY 03-04 appropriation of $18,460,693 of tobacco settlement

funding. For FY 04-05, HB 04-1421 (2004 Tobacco Bill) allocated additional tobacco settlement funding to the Trust Fund for a total appropriation of $20,949,354. However, tobacco settlement funds are updated based on revenue projections, therefore actual allocations to the Trust may vary from the appropriation if tobacco settlement revenues are higher or lower than expected. Estimates of the actual allocations for tobacco settlement revenues provided by the Office of State Planning and Budgeting in August 2004, are $20,620,238 for FY 04-05 and $21,283,686 for FY 05-06.

Annual Enrollment Fees
Annual enrollment fees are collected from clients who are over 150% of the federal poverty level. The actual fees collected can vary depending on the current client mix. These fees are Cash Funds, and are not eligible for a federal match. The FY 05-06 base request is a continuation of the FY 04-05 appropriation for annual enrollment fees of $210,400. Annual enrollment fees were projected for this Change Request using the FY 03-04 actual enrollment fees per average monthly enrollment.

Interest Earnings
Another source of revenue is interest earnings on funds in the Trust. The General Fund requested in this Decision Item would also earn interest in FY 05-06 that would be used to support program expenditures.

Expenditures from the Trust
The expenditures from the Trust include the State's share of three Children's Basic Health Plan line items for Administration, Premium Costs, and Dental Benefit Costs, as well as the State's share of the Department's "internal" administration expenses. The internal administrative funding goes to various lines in the Long Bill. The State's share is paid from the Trust and shows up in those lines as Cash Funds Exempt.

General Description of Alternative: This Alternative seeks additional General Fund to support the State's share of the Children's Basic Health Plan appropriation requested in November 1, 2004 Change Requests # DI-3, #DI-4, and an increase in internal administration funding in this #DI-5. Also requested is an adjustment in the appropriation for annual enrollment fees based on

FY 03-04 actual collections per client. Table A at tab Attachment 1 calculates the Trust Fund balance for FY 03-04, FY 04-05, and the request year, FY 05-06. The General Fund requested is $2,581,753. The General Fund requested is the minimum necessary to support these changes and the Trust FY 05-06 ending balance will be $0 if the request is approved. This alternative assumes that in the absence of its approval, no General Fund would be appropriated in FY 05-06.

Please see the following Decision Items in this November 1, 2004 Budget Request for a full explanation of requested Children's Basic Health Plan changes:

- DI-3 Fund Children's Basic Health Plan Medical Premium for Caseload and Rate Changes
- DI-4 Adjust Children's Basic Health Plan Dental

Program costs are expected to increase in FY 05-06 due to projected enrollment growth and requested rate adjustments. In FY 02-03 and FY 03-04, enrollment caps were placed on the Children's Basic Health Plan. The FY 05-06 caseload projections assume enrollment is allowed to grow naturally beginning in July 2004. Table A at tab Attachment 1 delineates the total appropriation requested and the General Fund contribution necessary to support the request.

Internal Administration

The request for internal administration funding is not included in the Children's Basic Health Plan Administration line item of the Long Bill. This is because the State's share of the internal administration for the Children's Basic Health Plan is paid through the Trust and is appropriated to various line items in the Long Bill. This piece of the request does not affect any other Children's Basic Health Plan line items other than the Trust Fund. The following Long Bill line items receive funding from the Trust for internal administration:

- Personal Services
- Health, Life and Dental

- Short-term Disability
- Salary Survey and Senior Executive Survey
- Performance-based Pay
- Operating Expenses
- Legal Services and Third Party Recovery Legal Services

These line items include salaries and benefits for FTEs in the Department associated with administering the Children's Basic Health Plan as well as the Department's operating expenses and legal services costs. These line items are adjusted through the Base Budget Request if they are affected by Common Policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule Implementation line item of the Long Bill is also partially funded by the Trust Fund. This request is to ensure there is enough funding in the Trust Fund to pay for these expenses. Since the Trust Fund balance is projected to be zero at the end of FY 05-06, it is important that this funding is appropriated in addition to the other line items for the Children's Basic Health Plan.

In addition to the Long Bill line items above, a portion of the following November 1, 2004 Change Requests also require funding from the Trust Fund. These items are also considered part of internal administration for the Children's Basic Health Plan:

- DI-7 Fiscal Agent Fixed Price Contracts
- DI-9 Medicaid Management Information System Federally-Mandated Reprocurement

Please see these Change Requests for a full explanation of the requested change.

Implementation Schedule: The implementation of this request would result in a fully funded Children's Basic Health Plan Trust Fund effective July 1, 2005.

Calculations for Alternative's Funding: See the Assumptions for Calculations section of this request for more information about the following table.

Line	**Summary of Request FY 05-06** Matches Schedule 6	Total Funds	General Fund	Cash Funds	Cash Funds Exempt
1	HB 04-1422 Long Bill Appropriation	$20,983,142	$3,296,346	$210,400	$17,476,369
2	HB 04-1421 (Allocation of Tobacco Master Settlement Money)	$3,472,958	$0	$0	$3,472,958
3	FY 04-05 Appropriation (line 1 + line 2) (Column 4)	$24,456,100	$3,296,346	$210,400	$20,949,354
4	HB 04-1421 (out-year impact)	$381,479	$0	$0	$381,479
5	Zero Out General Fund Contribution	($3,296,346)	($3,296,346)	$0	$0
6	True-up Tobacco allocation*	($47,147)	$0	$0	($47,147)
7	FY 05-06 Base Request (sum of Lines 1 though 5) (Column 5)	$21,494,086	$0	$210,400	$21,283,686
8	FY 05-06 Change Request (Column 6)	$2,532,019	$2,581,753	($49,734)	$0
9	FY 05-06 Total Request (Column 7)	$24,026,105	$2,581,753	$160,666	$21,283,686

*This includes a reduction for State Auditors fees of ($37,521) and Department of Public Health and Environment oversight of ($9,626).

Table A at tab Attachment 1 calculates the Trust Fund request.

See Table B at tab Attachment 1 for calculations of the estimated interest earnings for the Trust Fund. The base appropriations and beginning balance are projected to earn interest.

Please see Table C at tab Attachment 1 for calculations on the projected FY 04-05 Expenditures, Table D for calculations on the requested FY 05-06 expenditures, and Table E for calculations on the State's share of internal administration.

Impact on Other Areas of Government: None

Assumptions for Calculations: Assumptions for Summary of Request table (matches Schedule 6) under the Calculations for Alternative's funding section.

- For the FY 05-06 Base Request, $21,283,686 of Tobacco Litigation Settlement funding was estimated by the Office of State Planning and Budgeting in August 2004.

- Line 5 adjusts the General Fund base contribution to zero. The assumption was made that without this Change Request, zero General Fund would be appropriated to the Trust. The full amount of General Fund needed to fund program expenditures is requested in this Change Request on line 8.
- Line 6 adjusts the Tobacco Settlement funding for updated revenue projections. Updated allocations were provided by the Office of State Planning and Budgeting in August 2004.
- The FY 05-06 Total Request for Cash Funds on line 9 is $160,666. This is based on the collections in FY 03-04 of $3.18 per client times 50,524 in average monthly enrollment for projected for children in FY 05-06. The Change Request (shown in row 8) is a decrease in annual enrollment fees of ($49,734) from the base of $210,400 (shown in row 7).
- $2,581,753 in General Fund requested is the minimum needed to cover the requested expenses and maintain solvency in the Trust. This is illustrated in Table A at tab Attachment 1.

Assumptions for Table A, at tab Attachment 1 - Children's Basic Health Plan Trust Fund Analysis.

- Line A (Beginning Balance) - FY 03-04 is the actual beginning balance. FY 04-05 is the ending balance for FY 03-04 on line N. FY 05-06 is the ending balance projected for FY 04-05 in line N.
- Line B (General Fund Appropriation) - Equals Long Bill plus Special Bills General Fund appropriations to the Trust. See the Assumptions and Calculations section in this November 1, 2004 Budget Request regarding this line item's appropriation.
- Line C (Tobacco Master Settlement) – FY 03-04 is the actual funds allocated to the Trust. FY 04-05 and FY 05-06 are the amounts estimated by the Office of State Planning and Budgeting for tobacco settlement funds allocated to the Trust.
- Line D (Interest Earnings) – See assumptions for Table B below
- Line E (Annual Enrollment Fees) – FY 03-04 is actual collections of $149,618 for the estimated[1] 47,125 (Table G) in average monthly enrollment for FY 03-04.

[1]Retroactivity may still change actual caseload.

$149,618/47,125 = $3.18 fee per enrollee. FY 04-05 and FY 05-06 are based on the $3.18 per enrollee times projected membership of 43,399 and 50,524 respectively.

- Line F (Miscellaneous Revenues) and Line G (Accounts Payable Reversions) – actual revenues to the Trust.
- Line H (Federal Match Earnings) – These figures are the same as Line L. Federal funds are only earned as the State match is spent.
- Line J (Cash Funds Exempt Expenditure) – FY 03-04 is actual expenditures. FY 04-05 comes from Table C at tab Attachment 1 and FY 05-06 comes from Table D at tab Attachment 1.
- Line K (Internal Administration) - FY 03-04 is actual expenditures. FY 04-05 and FY 05-06 come from Table E at tab Attachment 1.
- Line L (Federal Match Expenditures) – FY 03-04 is actual expenditures. FY 04-05 comes from Table C at tab Attachment 1 and FY 05-06 comes from Table D at tab Attachment 1.
- Line O (General Fund Request) – FY 05-06 is the amount needed to make the Trust balance $0.
- Line P (Interest on General Fund) – FY 05-06 is from Table B at tab Attachment 1.

Assumptions for Table B at tab Attachment 1

- Actual interest earnings in FY 03-04 were $410,642. These were interest earnings on a base of $25,936,922 comprised of the beginning balance, General Fund appropriation, tobacco settlement funds, and annual enrollment fees (lines A, B, C and E of Table A at tab Attachment 1).
- The ratio of earnings to the base was 1.6% in FY 03-04. 1.6% = ($410,642/ $25,936,922). The balance in the Fund fluctuates throughout the year as payments are made from the Trust, so the ratio of 1.6% does not reflect the actual interest rate, but is useful for projecting interest earnings on the base.
- An estimated interest rate increase of 0.55% was applied to the base of 1.6% to arrive at a final interest earned ratio of 2.15%. The increase is to account for rising interest rates in the market place. See the footnote in Table B for calculations of the 0.55% increase.

- The base for FY 04-05 is $29,444,494 composed of the beginning balance, General Fund appropriation, tobacco settlement funds, and annual enrollment fees (lines A, B, C and E of Table A at tab Attachment 1). Interest earnings in FY 04-05 are projected to be $633,057 based on the 2.15% interest earned ratio times the base of $29,444,494.
- In FY 05-06, earnings on the base of $28,676,466 are projected to $616,544 using the 2.15% ratio.
- If the request for $2,581,753 in General Fund is approved, additional interest earnings of $55,508 are projected using the 2.15% ratio.

Concerns or Uncertainties of Alternative: Concerns related to Trust Revenues

- Annual enrollment fees are estimated using the FY 03-04 experience at $3.18 per member. In reality, enrollment fees vary by income level and are influenced by the number of renewals and number of new members.
- Interest earnings fluctuate based on the market rates. The interest projected is based on the interest earned in FY 03-04.
- The requested $2,581,753 in General Fund would leave a fund balance of $0. This means there is no extra money reserved to cover the program appropriations if interest rates decline or if the annual enrollment fees collected are less than estimated.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would appropriate no General Fund to the Children's Basic Health Plan Trust Fund for FY 05-06 and to maintain the current appropriation for annual enrollment fees at $210,400. With no General Fund contribution in FY 05-06, the Children's Basic Health Plan Trust Fund would be unable to support the program expenditures requested in #DI-3 "Fund Children's Basic Health Plan Medical Premium for Caseload and Rate Changes," and #DI-4 "Adjust Children's Basic Health Plan Dental." There would be no increase to the internal administration expenses requested in this Change Request. With no change in the appropriation for any of the Children's Basic Health Plan line items, there would be a remaining Trust Fund balance of $4,502,486 at the end of FY 05-06.

Calculations for Alternative's Funding: The following table lays out the funding for this alternative.

Calculations for Funding Trust Fund (Alternative B)	
Beginning Balance	$7,232,114
General Fund Appropriation	$0
Tobacco Master Settlement Appropriation to Trust	$21,283,686
Interest Earnings	$616,544
Annual Enrollment Fees	$210,400
Total Funds Available	**$29,342,744**
Administration Line Item FY 05-06 Base Request	$1,947,089
Premiums Cost Line Item FY 05-06 Base Request	$20,762,497
Dental Benefits Cost Line Item FY 05-06 Base Request	$1,994,135
Internal Administration (Various Line Items) FY 05-06 Base Request	$136,537
Total Expenditures at the Base Request Level	**$24,840,258**
Remaining Trust Fund Balance (Funds available minus Expenditures)	**$4,502,486**

Assumptions for Calculations: The following assumptions were used to calculate the funding for Alternative B:

- The Trust's beginning balance and Tobacco Master Settlement funding is the same as under Alternative A.
- Revenues to the Trust do not include any General Fund appropriation.
- Interest earnings assume no General Fund transferred into the Trust for FY 05-06 (see Table B at tab Attachment 1).
- Annual enrollment fees were assumed to continue at the FY 04-05 appropriation level.
- Alternative B assumes no increase in appropriation for the Children's Basic Health Plan program line items, and no increase in spending authority for internal administration. The expenditures are based on the Base Request for each line item.
- With no increase in spending authority, and no General Fund appropriation, the Trust would have a remaining balance of $4,502,486 at the end of FY 05-06.

Concerns or Uncertainties of Alternative: Concerns related to not funding the requested changes

- This alternative would not allow for actuarially sound rate adjustments necessary to cover the costs of providing medical and dental services.
- The federal waiver for the adult prenatal program does not allow the children's program to be capped as long as adults are being served in the program. Therefore under this alternative, enrollment into the Prenatal Program would need to be limited first.
- Prenatal care is cost-effective; better prenatal care, results in better mortality and morbidity rates for newborns. With no funding to cover prenatal care, the medical cost for newborns could increase.
- This alternative would not allow for an increase in the appropriation for dental benefits and might therefore require limiting enrollment into the dental program.
- Revenues for annual enrollment fees are likely overstated at FY 05-06 base request level.

Supporting Documentation

Analytical Technique: Cost / Benefit Analysis

Cost / Benefit Analysis	Incremental Costs	Benefits (Total Average Monthly Caseload)			
		Children's Medical	Children's Dental	Women	Annual Deliveries
Alternative A (Recommended)	$2,581,753 of General Fund and ($49,734) of annual enrollment fees	50,524	43,956	1,618	2,264
Alternative B (Not Recommended)*	$0	50,524	41,980	384	658

* See the Alternative B for DI-3 and DI-4 in this Budget Request for calculations of these caseload figures.

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A supports an additional average monthly enrollment of 1,976 children for dental care, 1,234 pregnant women, and 1,606 deliveries. Alternative A is therefore the recommended alternative.

Statutory and Federal Authority:

26-19-105 (1) (2), C.R.S. (2004) *(1) A fund to be known as the children's basic health plan trust is hereby created and established in the state treasury. All moneys deposited in the trust and all interest earned on moneys in the trust shall remain in the trust for the purposes set forth in this article, and no part thereof shall be expended or appropriated for any other purpose. (2) All or a portion of the moneys in the trust shall be annually appropriated by the general assembly for the purposes of this article and shall not be transferred to or revert to the general fund of the state at the end of any fiscal year.*

Department Objectives Met if Approved:

1.2 To support timely and accurate client eligibility determination.

1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

3.1 To improve customer satisfaction with programs, services, and care.

Table A

Children's Basic Health Plan Trust Fund Analysis

For FY 05-06 Change Request #DI - 5 "Adjust Children's Basic Health Plan Trust Fund"

		Actual	Estimated	Requested	
	TRUST REVENUES	**FY 03-04**	**FY 04-05**	**FY 05-06**	**Source**
A	Beginning Balance	$6,183,068	$5,389,901	$7,232,114	Actual and N
B	General Fund Appropriation	$1,143,543	$3,296,346		Appropriations
C	Tobacco Master Settlement Appropriation to Trust	$18,460,693	$20,620,238	$21,283,686	Appropriations
D	Interest Earnings	$410,642	$633,057	$616,544	Table B Attachment I
E	Annual Enrollment Fees	$149,618	$138,009	$160,666	Footnote 1
F	Miscellaneous Revenues (Overpayment and Subrogation)	$48,831	$0	$0	Actual
G	Accounts Payable Reversions from FY 02-03	$38,286	$0	$0	Actual
H	Federal Match Earnings	$40,612,680	$40,789,031	$57,618,789	Footnote 2
I	**Total Revenues**	**$67,047,361**	**$70,866,582**	**$86,911,799**	Sum A:H
	TRUST EXPENDITURES				
J	Program Cash Funds Exempt Estimated Expenditures	20,908,697	$22,708,900	$31,461,782	Footnote 2
K	Internal Administration Cash Funds Exempt Estimated Expenditures	$136,083	$136,537	$468,489	Table E Attachment 1
L	Federal Match Expenditures	40,612,680	$40,789,031	$57,618,789	Footnote 2
M	**Total Expenditures**	**$61,657,460**	**$63,634,468**	**$89,549,060**	Sum K:L
N	**Remaining Balance**	**$5,389,901**	**$7,232,114**	**($2,637,261)**	I - M
O	**Total General Fund Appropriation Requested in Change Requests**			**$2,581,753**	
P	Additional Interest Earnings if General Fund is Appropriated			$55,508	Table B Attachment I
Q	**Final Ending Balance of Trust Fund**			**$0**	N + O + P

1. Annual enrollment fees for FY 04-05 and FY 05-06 were estimated using the FY 03-04 experience of $3.18 per average monthly enrollment.

2. Figures for FY 03-04 are actual expenditures, while figures for FY 04-05 and FY 05-06 are projections. See Table C and D in Attachment I.

Table D

FY 05-06 Children's Medical, Prenatal, Dental, Administration Request and Funding Splits			Total CBHP Expenditures
FY 05-06 CBHP Children's Medical Expenditures	**Reference**		
FY 05-06 Enrollment Estimate	**Table G**	**50,524**	
Medical Premium PMPM[1]		$101.44	
Total Children's Medical Expenditures		**61,501,855**	
Annual Enrollment Fee Collection Per Enrollee[2]		$3.18	
Total Annual Enrollment Fee Collections (Cash Funds[3])		$160,666	
Expenditures To Be Matched by Federal Funds		$61,341,189	
Title XXI Federal Funds		$39,871,773	
Cash Funds Exempt[4]		$21,630,082	
FY 05-06 CBHP Prenatal Services Expenditures	**Table J-2**	**$16,292,739**	
Title XXI Federal Funds		$10,590,280	
Cash Funds Exempt		$5,702,459	
FY 05-06 Children's Basic Health Plan Premiums Costs		**$77,794,594**	**$77,794,594**
Title XXI Federal Funds		$50,462,053	$50,462,053
Cash Funds Exempt[4]		$27,332,541	$27,332,541
FY 05-06 CBHP Dental Expenditures			
FY 05-06 Enrollment Estimate	**Table G**	50,524	
Percentage of Caseload Capitated for Dental Benefit		87.0%	
Children Capitated for the Dental Benefit		43,956	
Dental Premium PMPM[1]		**$11.82**	
FY 05-06 Children's Basic Health Plan Dental Benefit Costs		**$6,234,719**	**$6,234,719**
Title XXI Federal Funds		$4,052,567	$4,052,567
Cash Funds Exempt		$2,182,152	$2,182,152
FY 05-06 Children's Basic Health Plan Administration	**Table F**	**$4,181,207**	**$4,181,207**
Title XXI Federal Funds		$621,890	$621,890
Title XIX Federal Funds		$1,612,228	$1,612,228
Cash Funds Exempt		$1,947,089	$1,947,089
FY 05-06 Internal Administration Expenditures		**$1,338,540**	**$1,338,540**
Title XXI Federal Funds		$870,051	$870,051
Cash Funds Exempt[5]	**Table E**	$468,489	$468,489
Internal Administration Cash Funds Exempt			$468,489
All other Cash Funds Exempt			$31,461,782
Title XXI and Title XXI Federal Funds			$57,618,789
Total Children's Basic Health Plan Expenditures			**$89,549,060**

[1] Please see the Change Request for Premiums and Dental for a detailed explanation of these rates.

[2] Annual enrollment fees per enrollee is estimated based on the actual collections for FY 03-04 ($3.18 =$149,618 / 47,125 in enrollment)

[3] Cash Funds from annual enrollment fees are not eligible for a federal match.

[4] Cash Funds from annual enrollment fees are included in the Cash Funds Exempt shown here.

[5] This is the State match for Internal Administration. It is paid for through the Trust Fund, but is allocated as Cash Funds Exempt to other line items in the Long Bill.

Table E

Internal Administration Appropriation and Request		
	FY 04-05 Appropriation	**FY 05-06 Request**
Personal Services	$124,599	$220,471
Health, Life, and Dental	$2,247	$10,172
Short-term Disability	$193	$315
Salary Survey and Senior Executive Survey	$1,393	$4,827
Performance-based Pay	$795	$2,206
Operating Expenses	$582	$582
Legal Services and Third Party Recovery Legal Services	$5,409	$5,409
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Maintenance costs for Security Rule	$1,319	$119
Fiscal Agent Fixed Price Contract Adjustments[1] (November 1, 2004 #DI-7)	$0	$218,222
Medicaid Management and Information System Federally-Mandated Reprocurement (November 1, 2004 #DI-9)	$0	$6,086
Technical Adjustment to Balance to Department's Budget Request[2]	$0	$80
Total	**$136,537**	**$468,489**

[1]See Line B and Line J in the Summary for Request FY 05-06 table located in the Assumptions for Calculations section of the November 1, 2004 #DI-7 Fiscal Agent Fixed Price Contract Adjustments.

[2]After the Department's Budget was balanced, it was discovered that the request for Internal Administration was too high by $80, due to a late adjustment to Amortization Equalization Disbursement (AED). As a result, this adjustment was added.

Table F

Children's Basic Health Plan Administration Line Item					
Line	**External Administration Costs**	**FY 04-05 Appropriation**	**FY 05-06 Base**	**FY 05-06 Incremental Request**	**FY 05-06 Total Request**
1	Children's Operating Costs	$3,638,229	$3,638,229	$0	$3,638,229
2	Outreach and Client Education	$100,500	$100,500	$0	$100,500
3	Prenatal Implementation Costs Budgeted	$144,178	$0	$0	$0
4	Prenatal Operational Costs Budgeted	$125,478	$125,478	$0	$125,478
5	**Subtotal Primary Administration (sum of lines 1 - 4)**	**$4,008,385**	**$3,864,207**	**$0**	**$3,864,207**
6	Actuary	$92,000	$92,000	$0	$92,000
7	Quality Assurance	$125,000	$125,000	$0	$125,000
8	Claims Audit	$100,000	$100,000	$0	$100,000
9	Transition legal immigrants from Medicaid to CBHP HB 04-1447	$6,455	$0	$0	$0
10	**Subtotal Professional Services (sum of lines 6 - 9)**	**$323,455**	**$317,000**	**$0**	**$317,000**
11	**Total External Administration (line 5 + line 10)**	**$4,331,840**	**$4,181,207**	**$0**	**$4,181,207**

FY 05-06 External Funding Splits				
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 65%**
Outreach And Client Education (Line 2)	$100,500	77.3%	$77,687	$50,497
Eligibility and Enrollment (Line 1)	$3,638,229	12.0%	$436,587	$283,782
Professional Services (Sum of Lines 6 through 9)	$317,000	100.0%	$317,000	$206,050
Prenatal (Line 3 + Line 4)	$125,478	100.0%	$125,478	$81,561
Total Title XXI	$4,181,207		$956,752	$621,890
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 50%**
Outreach And Client Education (Line 2)	$100,500	22.7%	$22,814	$11,407
Eligibility and Enrollment (Line 1)	$3,638,229	88.0%	$3,201,642	$1,600,821
Professional Services (Sum of Lines 6 through 9)	$317,000	0.0%	$0	$0
Prenatal (Line 3 + Line 4)	$125,478	0.0%	$0	$0
Total Title XIX	$4,181,207		$3,224,456	$1,612,228

Table G

Children's Basic Health Plan Children's Caseload Projection for FY 05-06

Total Enrollment Trend								
	Historical Monthly Enrollment						Projection	Request
	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05[1]	FY 05-06[2]
Jul	8,263	19,233	25,221	35,741	44,618	51,846	38,608	48,550
Aug	8,956	20,397	25,489	36,711	45,864	51,844	39,427	48,908
Sep	9,649	20,889	25,826	37,284	46,857	51,626	40,247	49,267
Oct	10,347	21,906	26,431	38,344	48,177	52,484	41,066	49,626
Nov	11,082	22,698	27,383	38,977	48,734	50,882	41,886	49,985
Dec	11,704	22,944	27,958	39,247	49,258	49,001	42,705	50,344
Jan	12,649	23,652	28,887	40,052	50,492	47,428	44,093	50,703
Feb	13,798	23,997	30,528	40,324	50,930	45,282	44,912	51,062
Mar	15,074	24,491	31,795	41,646	51,192	43,087	45,732	51,421
Apr	16,603	24,801	33,073	42,690	51,511	41,689	46,551	51,780
May	17,341	25,015	34,163	43,351	51,399	40,634	47,371	52,139
Jun	18,436	25,196	34,907	43,745	51,564	39,700	48,190	52,498
Average Monthly Enrollment	12,825	22,935	29,305	39,843	49,216	47,125	43,399	50,524
Annual Growth[3]		36.7%	38.5%	25.3%	17.9%	-23.0%	21.4%	8.9%

[1] FY 04-05 caseload is based on actual caseload in July 2004 (adjusted for retroactivity) assuming growth of 819 children per month. This is based on the average growth experienced from October 2001 to Oct 2002. 819=(48,177-38,344)/12 In January, 2004 enrollment is increased by 568 to account for the implementation of S.B. 03-176

[2] FY 05-06 caseload is based on the FY 04-05 projection and assumes that growth declines to 359 children per month. This is based on the average monthly growth experienced between October 2002 and October 2003. 359=(52,484-48,177)/12.

[3] Annual Growth shown here is calculated as the growth from June to June.

Table H
Restored CHP+ Prenatal and Delivery Program

	FY 02-03 Historical Enrollment Growth for CHP+ Prenatal and Delivery	FY 02-03 Monthly Growth	FY 04-05 Estimate	FY 04-05 Monthly Growth	FY 05-06 Request	FY 05-06 Monthly Growth
July			190		1,235	7.6%
August			388	104.2%	1,319	6.8%
September			506	30.4%	1,399	6.1%
October	190		580	14.6%	1,475	5.4%
November	388	104.2%	631	8.8%	1,547	4.9%
December	506	30.4%	678	7.4%	1,613	4.3%
January	580	14.6%	753	11.1%	1,676	3.9%
February	631	8.8%	819	8.8%	1,733	3.4%
March	678	7.4%	891	8.8%	1,780	2.7%
April	753	11.1%	970	8.9%	1,828	2.7%
May			1,055	8.8%	1,878	2.7%
June			1,148	8.8%	1,928	2.7%
Total Member Months			**8,609**		**19,411**	
Average Monthly Enrollment			**717**		**1,618**	

1. Projected enrollment from July 2004 through January 2005 follows the historical pattern established from October 2003 through April 2004, during the program's initial start-up.

2. FY 05-06 caseload projection is based on a declining growth trend from 8.8% at the end of FY 04-05 to 2.7% in March of 2006. Growth is projected to remain at 2.7% for the remainder of the year. The 2.7% is the average monthly growth for the children's program in the second and third year of the program (FY 99-00 and FY 00-01).

Table I

FY 04-05 Projection of Prenatal Enrollment and Delivery														
		Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Totals
1	Last month's enrolment		190	388	506	580	631	678	753	819	891	970	1,055	
2	Less Women determined ineligible (30% after 2 months)			57	59	53	45	42	41	51	50	56	59	513
3	Less Women leaving the program (2 months after delivery)				17	35	46	53	58	62	69	82	98	520
4	Plus Women Starting the program	190	198	175	150	139	138	170	165	185	198	223	250	2,181
5	**Equals Monthly Enrollment**	**190**	**388**	**506**	**580**	**631**	**678**	**753**	**819**	**891**	**970**	**1,055**	**1,148**	**8,609**
6	**Number of Deliveries (see comment below)**	**17**	**35**	**46**	**53**	**58**	**62**	**69**	**82**	**98**	**107**	**118**	**129**	**874**

Due to the program start up, many women will enter the program late in their pregnancy, so deliveries are not assumed to occur 6 months after starting the program. Instead, the 874 deliveries appropriated in the Long Bill (HB 04-1422) were spread across the months based on monthly enrollment.

FY 05-06 Projection of Prenatal Enrollment and Delivery														
		Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Totals
1	Last month's enrollment	1,148	1,235	1,319	1,399	1,475	1,547	1,613	1,676	1,733	1,780	1,828	1,878	
2	Less women determined ineligible (30% after 2 months)	67	75	78	83	86	86	89	92	98	100	102	105	1,061
3	Less women leaving the program (2 months after delivery)	107	118	129	129	139	156	175	183	194	201	202	208	1,941
4	Plus women starting the program	261	277	287	288	297	308	327	332	339	349	354	363	3,782
5	**Equals Monthly Enrollment**	**1,235**	**1,319**	**1,399**	**1,475**	**1,547**	**1,613**	**1,676**	**1,733**	**1,780**	**1,828**	**1,878**	**1,928**	**19,411**
6	**Number of Deliveries (5 months after starting)**	**129**	**139**	**156**	**175**	**183**	**194**	**201**	**202**	**208**	**216**	**229**	**232**	**2,264**

Illustration of Logic based on June 2006 Figures		**Assumptions**
Line 1 in June = Line 5 in May	= 1,878	
Line 2 in June = line 4 in April x (1-30%) for women determined ineligible	= 349 x 30% = 105	30% are found ineligible after 2 months due to presumptive eligibility
Line 3 in June = Line 6 in March	= 208	Women leave the program 2 months after delivery
Line 4 in June = (Line 5 - Line 1 + line 2 + line 3) in June	= (1,928-1,878+105+208) = 363	This figure is backed into based on the enrollment projection and the number of women leaving the program
Line 5 in June = (projected caseload from table H in attachment 1)	=1,928	See Table H
Line 6 in June = line 4 in Feb - Line 2 in Apr	= (332-100)=232	Women enter the program in their 5th month of pregnancy on average

Note:
Percentage of women who are determined ineligible after presumptive eligibility is 30%

Table J

Table J-1 FY 04-05 Prenatal Program Estimate				
Cost of Medical Care PMPM[1]				$345.30
Member Months of Medical Care				**8,609**
Total Women's Medical Care				$2,972,688
Number of Deliveries				**874**
Cost of Delivery				$3,965.00
Total Costs of Deliveries				$3,465,410
Total Prenatal Estimate				**$6,438,098**
Federal Funds				$4,184,764
Cash Funds Exempt				$2,253,334

Table J-2 FY 05-06 Prenatal Program Request				
	HMO Rate	Self Funded Rate	Average Rate	
Cost of Medical Care PMPM[2]	$284.18	$353.30	$317.36	$317.36
Member Months of Medical Care				**19,411**
Total Women's Medical Care				$6,160,275
Number of Deliveries				**2,264**
Cost of Delivery	$4,594.84	$4,346.15	$4,475.47	$4,475.47
Total Costs of Deliveries[2]				$10,132,464
Client mix[3]	52%	48%	100%	
Total Prenatal Estimate				**$16,292,739**
Federal Funds				$10,590,280
Cash Funds Exempt				$5,702,459

[1] Rates and caseload in Table J-1 are taken from Figure Setting page 122, March 9, 2004.

[2] Rates for HMO and Self-funded network are calculated separately by the actuary. A blended rate is used for budgeting.

[3] The blended rate is a weighted average based on the actual number of member months for HMO and the Self-insured network in 2003. $317.36 = (52% x $284.18) +(48% x $353.50) and $4,475.47 = (52% x $4,594.84) + (48% x $4,346.15)

Schedule 6

Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI-7	**OSPB Approval:**		**Date:**	
Program:	Information Technology Contract Monitoring	**Statutory Citation:**	26-4-404 (1) (c), C.R.S. (2004); 26-4-403.7 (3) (b), C.R.S. (2004);		
Request Title:	Fiscal Agent Fixed Price Contract Adjustments		26-4-532 (7.5) (a), C.R.S. (2004)		

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 03-04	Appropriation FY 04-05	Supplemental Request FY 04-05	Total Revised Request FY 04-05	Base Request FY 05-06	Decision/ Base Reduction FY 05-06	November 1 Request FY 05-06	Budget Amendment FY 05-06	Total Revised Request FY 05-06	Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	39,244,399	49,980,422	0	49,980,422	50,186,693	2,111,772	52,298,465	0	52,298,465	2,111,772
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	5,010,178	4,921,626	0	4,921,626	4,939,899	656,088	5,595,987	0	5,595,987	656,088
	GFE	22,596	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	9,876,441	15,281,053	0	15,281,053	15,313,563	169,069	15,482,632	0	15,482,632	169,069
	FF	24,335,184	29,777,743	0	29,777,743	29,933,231	1,286,615	31,219,846	0	31,219,846	1,286,615
(1) Executive Director's											
Office, Medicaid	**Total**	18,397,622	20,263,222	0	20,263,222	20,464,057	1,960,998	22,425,055	0	22,425,055	1,960,998
Management	**FTE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Information System	**GF**	5,010,178	4,921,626	0	4,921,626	4,939,899	656,088	5,595,987	0	5,595,987	656,088
Contract	**GFE**	22,596	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	133,325	149,748	0	149,748	182,258	169,069	351,327	0	351,327	169,069
	FF	13,231,523	15,191,848	0	15,191,848	15,341,900	1,135,841	16,477,741	0	16,477,741	1,135,841
(5) Other Medical											
Services, SB 97-101	**Total**	20,846,777	29,717,200	0	29,717,200	29,722,636	150,774	29,873,410	0	29,873,410	150,774
Public School Health	**FTE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Services	**GF**	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	9,743,116	15,131,305	0	15,131,305	15,131,305	0	15,131,305	0	15,131,305	0
	FF	11,103,661	14,585,895	0	14,585,895	14,591,331	150,774	14,742,105	0	14,742,105	150,774

Letter Notation:

The amount of $350,217 CFE for FY 05-06 includes $218,222 from the Children's Basic Health Plan Fund, $267 from the Breast and Cervical Cancer Prevention and Treatment Fund, $2,347 from the Nurse Home Visitor Program in Department of Pubic Health and Environment, $97,981 from the Old Age Pension Fund in Department of Human Services, and $31,400 from the Colorado Autism Treatment Fund.

Cash Fund name/number, Federal Fund Grant name:	CFE: RSRC EBUD Children's Basic Health Plan Fund 11G, RSRC EBUE Breast and Cervical Cancer Prevention and Treatment Fund 15D, RSRC EBWJ Tobacco Litigation Settlement Cash Fund, RSRC ABIE Old Age Pension Fund from Department of Human Services, FF: Title XIX
IT Request: ☑ **Yes** ☐ **No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☑ **Yes** ☐ **No**	Department of Human Services for Old Age Pension Fund

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-7
Change Request Title:	Fiscal Agent Fixed Price Contract Adjustments
Long Bill Line Item(s)	(1) Executive Director's Office, Medicaid Management Information System Contract
State and Federal Statutory Authority:	26-4-404 (1) (c), C.R.S. (2004); 26-4-403.7 (3) (b), C.R.S. (2004); 26-4-532 (7.5) (a), C.R.S. (2004); §1903(a) of the Social Security Act [42 S.S.C. 1396b]; 42 C.F.R. §433.119(c)

Summary of Request (Alternative A): This request is for additional funding to cover essential costs for fiscal agent operations. During FY 03-04, the Department negotiated a fixed price contract to reduce projected costs. However, although the fixed price amount is less than if the Department continued under the prior methodology, additional funding is needed in order to pay all costs estimated for FY 05-06. The changes will require $2,111,772 in total additional funding for FY 05-06, with $656,088 in General Fund.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The need for additional funding for this purpose first was identified to the Joint Budget Committee in a placeholder submitted on the January 2, 2004 (see Schedule 9), although a request was not submitted during FY 03-04. While the Department took steps to reduce

the amount of additional funds needed to pay claims by moving to a fixed price contract, the Department cannot process all of the claims estimated for FY 05-06 without additional funding to meet operational costs.

Previously, contract amendments with the fiscal agent (Affiliated Computer Services, Inc, dba Affiliated Computer Services State Healthcare), required the Department to pay the fiscal agent a unit cost for claims in excess of 8 million. The amount of the unit cost times the estimated number of claims was calculated for budget purposes, but a spiking growth in volume occurred. The Department has analyzed what has caused the increase in claims.

During FY 02-03, three managed care organizations left the Medicaid market. Those organizations were United HealthCare, Kaiser Permanente, and Community Health Plan of the Rockies. In FY 03-04, Rocky Mountain Health Plans dropped coverage of health maintenance organization (HMO) clients in the metro area and restructured services on the western slope. This caused fee-for-service clients (hence, claims) to increase and the number of HMO clients to decrease.

Contracted medical services provided to clients in an HMO are covered in the capitation fee paid per client. Capitation payments are system generated based on client enrollment in health maintenance organizations. No unit cost was paid to the fiscal agent for processing capitation claims. Rather, the cost of claims processing for capitated services was imbedded in the contract's base cost. When HMO clients transitioned into a fee-for-service environment, fee-for-service claims volume increased. Under fee-for-service, every medical provider who supplies a client service causes a separate claim to be processed in the Medicaid Management Information System. Except for a base of 8,000,000 claims that was bid as the base contract with the current fiscal agent, these fee-for-service claims were paid to the fiscal agent on a unit cost basis. As fee-for-service claims increased, costs to the State increased accordingly. The number of claims

increased dramatically, and this increase is attributed to the shift to fee-for-service from HMOs.[1]

At the time of the bid that generated the current base assumptions, the General Assembly and the Department were encouraging a move toward capitated programs, which would have resulted in more of the Medicaid Management Information System required services being capitated. Over the years, due to legislative changes and policy changes, various functions have been added to the contract, with many changes resulting in different functions with an increased cost. Federal requirements, such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996, have also added costs. Consequently, costs have increased.

The last renewable contract year under the prior Request for Proposal will end November 30, 2006. The Department has worked with the federal Centers for Medicare and Medicaid Services since the summer of 2001 to secure an extension of the renewal date to December 2008[2]. On March 29, 2004, the Centers for Medicare and Medicaid Services officially denied Colorado's request for an extension. This affected the Department's ability to negotiate a more advantageous fixed price contract. The Centers for Medicare and Medicaid Services is requiring that the fiscal agent contract be reprocured and implemented by December 1, 2006. A separate Change Request is being submitted for reprocurement. This request, based on a negotiated fixed price with Affiliated Computer Services, is a short term plan until a new contract is reprocured. Cost containment was the main goal for those negotiations.

[1]The enrollment in health maintenance organizations has changed dramatically in recent years:
FY 00-01: 112,847 annual average
FY 01-02: 135,518 annual average
FY 02-03: 126,669 annual average
FY 03-04: 74,438 annual average
The source of the FY 03-04 number is the July 28, 2004 Monthly Report to the Joint Budget Committee. The other years have been calculated using the same methodology.

[2]The extension was requested because of the competing priorities of Colorado Benefits Management System, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the many budget reduction Medicaid Management Information System changes.

General Description of Alternative:

Due to the present cost structure described above, the Department has restructured the contract with the fiscal agent to include a fixed price covering most of the functions previously calculated under a unit price to arrive at the total needed funding. Functions to be covered within the fixed price are:

- Base Claims and what are known currently as Overage Claims;
- Encounter Claims;
- Capitations;
- School Health Claims;
- Non-pharmacy Prior Authorization Reviews;
- The Decision Support Subsystem;
- Certain known HIPAA remediation measures (e.g., Transaction and Code Sets); and
- Bulletin Board Services.

Pharmacy prior authorization reviews, postage, and changes required by special legislation are in addition to items covered by the fixed price. The Centers for Medicare and Medicaid Services has approved pharmacy prior authorization reviews at 50% federal financial participation. The current appropriations are at 75% federal financial participation. Therefore, as part of this request, a true-up of funding splits for pharmacy prior authorization reviews is requested.

The implementation date for beginning the new fixed price approach was March 1, 2004. FY 03-04 used the old methodology of payment by function for the months of July 2003 through February 2004. The months of March 2004 through June 2004 were covered by the fixed price arrangement. For FY 04-05, the new methodology of fixed price was used for calculating the payment amounts to the fiscal agent and funding amounts needed to assure operation for the entire fiscal year for the Medicaid Management Information System. The Department and the fiscal agent will continue the fixed price arrangement through FY 05-06 and the first five months of FY 06-07 until the contract ends on November 30, 2006.

Five components of the fixed price contract need adjustments to funding splits:

- Children's Basic Health Plan will contribute 3% to the fixed price component of the fiscal agent contract.
- Pharmacy Prior Authorization must be brought into compliance with the approved funding splits approved by the federal Centers for Medicare and Medicaid Services.
- Old Age Pension State Medical Program claims and School Health medical claims have been re-estimated to portray a more realistic expectation of the number of claims likely to be processed each fiscal year. These components are detailed in the tables found in the Calculations for Alternative's Funding section of this request.
- Statutory requirements also cause a shift in funding for the Breast and Cervical Cancer Prevention and Treatment claims. The statutory change is discussed in the Assumptions for Calculations section of this Change Request.
- A technical correction also is needed for funding splits related claims processing under HB 04-1219 for Community Transitions for Eligible Persons under the Home- and Community-Based Services for the Elderly, Blind, and Disabled waiver.

Each of these adjustments is described below.

Children's Basic Health Plan

Prior to the construction of the Colorado Benefits Management System and before the Health Insurance Portability and Accountability Act (HIPAA), the Children's Basic Health Plan was in its own system known as CCHAMP. Because of the cost of the HIPAA remediation, a decision was made to move part of the Children's Basic Health Plan processing to Medicaid Management Information System. Capitation payments to the Children's Basic Health Plan approved health maintenance organizations are now being paid by the fiscal agent. See Table A in the Calculations for Alternative's Funding section for the calculations of the contribution to the already existing portion of the fixed price component. Table G later in this document calculates the amount for the contribution to the additional needed funding for fixed price.

Pharmacy Prior Authorization Reviews

Table B in the Calculations for Alternative's Funding section illustrates the impact of the changing fund splits on the pharmacy prior authorization reviews.

Old Age Pension State Medical Program Claims

The Cash Funds Exempt amount of $146,876 from the Old Age Pension Fund is a portion of the fixed price. Table C shows the portion of the fund that is forecasted to be used during the requested fiscal year. Claims for Old Age Pension State Medical Program clients average approximately 1% of the total claims processed during a fiscal year. The unused portion would be removed from the Cash Funds Exempt funding because it is not needed to cover Old Age Pension State Medical Program claims and cannot be used to fund other activities in the fixed price. This Change Request adjusts the funding, resulting in a lower amount for Old Age Pension funded claims.

School Health Claims

The federal funds amount of $268,614 that is specifically allocated for School Health claims (federal funds drawn from certified public expenditures) is also a portion of the fixed price. Table D shows the portion of this special funding that is forecasted to be used for the fiscal year. Claims for school health services average approximately 1.25% of the total claims processed during a fiscal year. The unused portion ($146,138) is not needed to cover School Health Claims and cannot be used to fund other activities in the fixed price. This request adjusts the funding, resulting in a lower amount for School Health claims. This reduction from the Medicaid Management Information System Contract for School Health claims causes the corresponding federal funds to be added back to the line item titled "S.B. 97-101 Public School Health Services."

However**,** a funding discrepancy exists between the two program lines. The funding discrepancy was created during the submission of different Change Requests in prior years. Change Request, DI-1, titled "MMIS Contract Adjustments," submitted November

1, 2001, requested a reduction of $14,187 from $282,801 to $268,614 for claims processing of School Health Services in the program line of Medicaid Management Information System Contract. A subsequent addition in the S.B. 97-101 Public School Health Services program line was not made.

Change Request, DI-9, titled "Correct Funding for School Based Services", submitted November 1, 2002, requested a reduction of $9,551 from $282,801 to $273,250 for claims processing for School Based Health in the line item "S.B. 97-101 Public School Health Services" only. Thus, the appropriated amount for the processing of the claims has not been synchronized in the two program lines since FY 02-03. The difference between the appropriated amounts is $4,636.

To adjust for this discrepancy, the Department is requesting that $150,774 be added back to the line item titled "S.B. 97-101 Public School Health Services." However, only $146,138 should be reduced from the program line for "Medicaid Management Information System Contract." This will allow both line items to account for $122,476 in School Health claims. The Schedule 6 associated with the current Change Request reflects this correction.

Breast and Cervical Cancer Prevention and Treatment Program Claims

The Breast and Cervical Cancer Prevention and Treatment Program funding needs to change funding splits for FY 05-06 as required by 26-4-532 (7.5) (a), C.R.S. (2004). This would change the funding split by shifting $267 into General Fund. See Table E for the effects.

HB 04-1219 for Community Transition Services

The technical correction for funding splits related to HB 04-1219 for Community Transition Services for Eligible Persons under the "Home and Community Based Services for the Elderly, Blind, and Disabled Act" involves changing the percentage of federal financial participation from the 50% level that was inadvertently used as part of

the appropriations for HB 04-1219 to the correct level of federal financial participation at 75%. The Centers for Medicare and Medicaid Services use 75% as the standard funding split for claims processing. The correction will reduce the General Fund portion by half. See Table F to illustrate the effect.

Overall Increase to Meet Negotiated Contract

Table G illustrates the projection for the shortfall of the Fixed Price Amount, as shown in the Summary by Fiscal Year table on page 10. The shortfall calculations start with the amount of funding that would be available to the contract with the fiscal agent if the work required from the fiscal agent continued exactly as it has been in the past with no increases in claims processed and no allowance for conversion to the fixed price methodology for dealing with claims growth. Then the negotiated funding amount for fixed price plus the contract functions not included in fixed price are summed for the total funding need in FY 05-06. The gap in funding is the shortfall for FY 05-06.

Calculations for Alternative's Funding:

Summary of Request FY 05-06 for S.B. 97-101 Public School Health Services Line Item	Total Funds	General Fund	Federal Funds	Cash Funds Exempt
S.B. 97-101 Public School Health Services – Incremental Increase [matches column 6 on Schedule 6]	$150,774	$0	$150,774	$0

Summary of Request FY 05-06 for Medicaid Management Information System Contract Line Item	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
1. FY 05-06 November 1, 2004 Request for Medicaid Management Information Systems Contract [matches column 5 on Schedule 6]	$20,464,057	$4,939,899	$182,258	$15,341,900
2. Adjust Funding Splits for Children's Basic Health Plan Contribution [See Table A]	$558,807	$0	$195,583	$363,224
3. Adjust Funding Splits for Medicaid Contribution to the Fixed Price Component [See Table A]	($558,807)	($139,701)	$0	($419,106)
4. Adjust Funding Splits for Pharmacy Prior Authorization Reviews [see Table B]	$0	$272,761	$0	($272,761)
5. Adjust Funding Splits for Breast and Cervical Cancer Prevention and Treatment Program Claims [See Table E]	$0	$267	($267)	$0
6. Reduction in Old Age Pension Funding [see Table C]	($48,886)	$0	($48,886)	$0
7. Reduction in School Health Claims Funding [See Table D]	($146,138)	$0	$0	($146,138)
8. Technical Correction for Claims Processing Related to HB 04-1219 [See Table F]	$0	($75)	$0	$75
9. Additional Funds for Fixed Price Related to Medicaid – 97%	$2,091,341	$522,836	$0	$1,568,505
10. Additional Funds for Fixed Price Related to Children's Basic Health Plan – 3%	$64,681	$0	$22,639	$42,042
11. Subtotal Additional Funds for Fixed Price related to Claims Volume [See Table G] [also #9 + #10 above]	*$2,156,022*	*$522,836*	*$22,639*	*$1,610,547*
12. Total Revised FY 05-06 Budget Request (Sums #1 through #10)	**$22,425,055**	**$5,595,987**	**$351,327**	**$16,477,741**
13. Incremental to FY 05-06 November 1, 2004 Base Request (#12 minus #1) [matches column 6 on Schedule 6]	**$1,960,998**	**$656,088**	**$169,069**	**$1,135,841**

Table A: Funding Shift for Children's Basic Health Plan (CBHP) Contribution to Existing Fixed Price Contract	
FY 05-06 Total Fixed Price Contract Need (see Assumptions below)	$20,782,913
Minus Increase Needed to Fund Fixed Price (added separately in above table)	($2,156,022)
Existing Amount of Fixed Price Contract	$18,626,891
Times 3% for CBHP Contribution to Existing Fixed Price Contract	**$558,807**
Cash Funds Exempt for CBHP - 35% of 3%	$195,583
Federal Funds for CBHP - 65% of 3%	$363,224

Table B: Calculations for Adjusting Funding Splits for Pharmacy Prior Authorizations Review for FY 05-06				
Type of Prior Authorization Review	Total Funds	General Fund	Federal Funds	Funding Split*
High Risk Class of Drugs from 4% Budget Balancing Plan, February 14, 2003 Budget Request	$24,300	$6,075	$18,225	75% FFP
Generic Drug Mandate SB 03-011	$1,042,445	$260,612	$781,833	75% FFP
Drug Utilization Mechanism SB 03-294	$24,300	$6,075	$18,225	75% FFP
Subtotal Base Request	$1,091,045	$272,762	$818,283	75% FFP
50% FFP Approved	$1,091,045	$545,523	$545,522	50% FFP
Adjustment Needed	$0	$272,761	($272,761)	50% FFP

*FFP in the table above refers to the rate of federal financial participation.

Table C: Old Age Pension Fund (100% Cash Funds Exempt) for FY 05-06			
	Number of Claims	Total Funds Needed	Not Available for Other Functions
Expected Funded	290,826	$146,867	
Forecast Need	194,021	$97,981	($48,886)

Table D: School Health Claims (100% Federal Funds) for FY 05-06			
	Number of Claims	Total Funds Needed	Not Usable for Fixed Price
Expected Funded	531,909	$268,614	
Forecast Need	242,526	$122,476	($146,138)

Table D refers to funding for School Health claims in the program line of "Medicaid Management Information System Contract" only, not to the line item "S.B. 97-101 Public School Health Services" funding.

Table E: Breast and Cervical Cancer Prevention and Treatment Funding Shift for FY 05-06				
	Total Funds	**General Fund**	**Federal Funds**	**Cash Funds Exempt**
Historical Funding	$2,136	$0	$1,602	$534
Funding Shift	$2,136	$267	$1,602	$267

Table F: Technical Correction for Funding Splits on Claims Processing Related to HB 04-1219 for FY 05-06			
	Total Funds	**General Fund**	**Federal Funds**
Expected Appropriation at 50% FFP	$300	$150	$150
Corrected Appropriation at 75% FFP	$300	$75	$225
Net Change	$0	($75)	$75

*FFP in above table refers to Federal Financial Participation rate.

Table G: Overall Increase to Meet Negotiated Contract	FY 05-06
Base Funding	$20,464,057
Adjust for Old Age Pension Funding	($48,886)
Adjust for School Health Funding	($146,138)
Total A – Estimated Usable Appropriation with no Further Action	**$20,269,033**
Fixed Price Component*	$20,782,913
Postage	$351,377
Pharmacy Prior Authorization Reviews	$1,091,045
Development Costs	$197,500
Total B – Funding Need with Fixed Price	**$22,425,055**
Shortage of Funding for Fixed Price (Total A minus Total B)**	**($2,156,022)**
Portion of Shortage Attributed to Medicaid – 97%	**($2,091,341)**
Portion of Shortage Attributed to Children's Basic Health Plan – 3%	**($64,681)**

*Amount quoted by Affiliated Computer Services in Spring 2004 as needed for fixed price portion of new contract in FY 05-06.
** Numbers in this row are in Summary of Request table on page 9.

Impact on Other Areas of Government: Adjusting the funding for the Old Age Pension component will affect the Department of Human Services because Old Age Pension funding is Cash Funds Exempt, originally funded to the Department of Human Services. For several fiscal years, the amount from the Old Age Pension has been $146,867. The FY 05-06 need is estimated at $97,981. Therefore, $48,886 could be returned to the Old Age Pension Fund for other uses by the Department of Human Services. All other funding adjustments are in the Department of Health Care Policy and Financing funds.

Assumptions for Calculations: For FY 05-06, the fixed price need was negotiated as $1,698,743 (rounded) per month for July through November, increasing to $1,755,600 (rounded) per month for December through June, resulting in $20,782,913 total for fixed price. Postage adds $351,377 beyond fixed price. Pharmacy prior authorization reviews add $1,091,045 above fixed price. Autism services for children prior authorization reviews add $2,220. The total Medicaid Management Information System needed funding, including fixed price, is $22,425,055. After other Long Bill action, changes in funding split for pharmacy prior authorization reviews and reductions for Old Age Pension State Medical Program claims and School Health claims, the available funding is $20,269,033. The shortfall for fixed price will be $2,156,022.

The appropriated funding for FY 04-05 is $20,263,222. Out year impacts of special legislation increases the FY 05-06 base request to $20,464,057 as outlined in the Assumptions and Calculations in Volume II of the November 1, 2004 Budget request.

Certain funding for special programs exists in the current appropriation for the Medicaid Management Information System, and the use of special funding has been limited to claims processing costs for the particular programs funded.

- $146,867 Cash Funds Exempt is from the Old Age Pension Fund originally appropriated to the Department of Human Services, and it is used only to cover claims processed for medical services provided to Old Age Pension State Medical Program clients.

- $534 of Cash Funds Exempt from the Breast and Cervical Cancer Treatment Fund has been used to cover claims processing for clients in the Breast and Cervical Cancer Program, with $1,602 federal funds.
- The Nurse Home Visitor program has $2,347 Cash Funds Exempt originally appropriated to the Department of Public Health and Environment, with $7,041 federal funds.
- $268,614 of 100% federal funds is designated for School Health claims covering services provided to Medicaid qualified students.

These special funding appropriations continue to be limited to the specific programs for which the funding was made available. Reductions in funding for the Old Age Pension Fund and School Health Claims have been requested to ensure the correct funding for the remaining activities.

Before funding for the line item "S.B. 97-101 Public School Health Services" is appropriated, administrative costs are reduced from the federal funds and put into applicable administrative lines. One of these lines is the Medicaid Management Information System Contract line item. If a portion of the administrative funds are no longer needed, then the dollars that were drawn from the schools' certified funds should be returned to the "S.B. 97-101 Public School Health Services" line item where they can be used to fund services.

Due to the variability in volume, pharmacy prior authorization reviews have been negotiated as an add-on above the fixed price. As policy changes occur, the number of drugs included in the review process may change. Therefore, pharmacy prior authorization reviews are calculated separately. The amount of $1,091,045 is considered the base amount for pharmacy prior authorization reviews and is described in the Assumptions and Calculations section of the November 1, 2004 Budget Request, Volume II.

Funding splits for pharmacy prior authorization reviews have been appropriated at 25% General Fund and 75% federal funds. The Centers for Medicare and Medicaid Services

has determined that pharmacy prior authorization reviews must be paid at 50% General Fund and 50% federal funds.

Postage is an add-on above the fixed price because postage is a pass through cost to the Department. The amount used for postage in this request is the amount that had been allocated in previous years for postage since there has been no postage increase recently. It is difficult to predict if and when the United State Postal Service will implement a postal rate increase. Therefore, leaving postage outside the fixed price allows flexibility in dealing with actual postage costs. The amount of $351,377 is considered the base amount for postage and is described in the Assumptions and Calculations section of the November 1, 2004 Budget Request, Volume II.

Future special legislation passed by the General Assembly may require computer program system changes within the Medicaid Management Information System in order to incorporate the new activities required by law. Such costs for completed Legislative Sessions are identified in Table G earlier in this request as development costs and are described in the Assumptions and Calculations section of the November 1, 2004 Budget Request, Volume II. This type of additional cost will also remain as an add-on to the fixed price.

For the purpose of this request, the Children's Basic Health Plan contribution to the total costs is 3% using Cash Funds Exempt (35% of funding) and federal financial participation (65% of funding). Using the same percentage as other line items in the Department that also have a contribution from the Children's Basic Health Plan, this percentage is determined by the percentage of capitations paid for the Children's Basic Health Plan in the Medicaid Management Information System compared to the total forecasted claims and capitations paid. This methodology is still being examined to ensure that it is the best method to accurately account for the appropriate mix of funds.

The same funding for FY 06-07 is requested at this time until the need for a Change Request is determined to address any potential cost variances identified in the competitive bid and award process.

Concerns or Uncertainties of Alternative: If claims volumes increase or decrease significantly and unexpectedly in the near future, the fixed price cost may have to be renegotiated.

Uncertainties in cost still exist in the areas of pharmacy prior authorization reviews and postage, so currently appropriated amounts have been used as estimates for the request.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative is not to increase funding for the fiscal agent under any methodology. This alternative is not recommended.

When the available funding is exhausted, claims processing would cease. This would cause the fiscal agent to stop paying claims on an estimated date of May 27, 2006 for FY 05-06, before the June 30, 2006 fiscal year end. Providers would not be paid if claims were not processed; providers would not be enrolled; prior authorization reviews would not be conducted; and medical providers would not be able to contact or be contacted by the fiscal agent.

Calculations for Alternative's Funding: No change in funding with this Alternative.

Concerns or Uncertainties of Alternative: Claims held by the fiscal agent because of lack of funding, if held for more than thirty days, would cause a violation of the Department's obligation to process claims within thirty days of receipt per the federal State Medicaid Manual, Part 11, Chapter 3, Section 11325. In Colorado, the Medicaid Management Information System is a certified system because it meets the requirements of the Code of Federal Regulations and the State Medicaid Manual. If the system no longer met those requirements, there would be a risk that it would be decertified and the federal financial participation rate could be lowered, causing a further funding crisis. Certification raises the federal financial participation from 50% to 75% for most cost elements.

This Alternative would also cause a statutory violation or conflict with HB 04-1264, which requires the Department to pay all claims according to normal billing cycles, regardless of funding needs. A conflict would be created if there is no funding to pay the fiscal agent to process claims and pay providers, yet the Department would be required to process the claims.

Supporting Documentation

Analytical Technique:

A cost/benefit analysis has been completed, and the results of the analysis are shown in the chart below. This analysis will demonstrate which alternative will have sufficient expenditures to produce an advantageous result.

Cost/Benefit	Alternative A	Alternative B
Cost	$1,960,998 additional total funds for Fixed Price with $656,088 additional needed in General Fund (add back to "SB 97-101 Public School Health Services" is a separate amount.)	No additional costs
Benefit	Allows processing of 19,402,086 projected claims, or more if necessary	No Benefit - instead a liability because funding is insufficient to process all expected claims
Benefit	Permits claims processing through June 30, 2006 and satisfies 26-4-404 (1) (c), C.R.S. (2004), or HB 04-1264, requirements not to interrupt the normal provider payment schedule	No Benefit - instead a liability because it will be necessary to stop claims processing by May 27, 2006 (estimated date funding will be fully expended)
Benefit	Stabilizes funding needs for FY 05-06	No Benefit - instead a liability because it leaves a gap of funding needed but not covered

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A offers the most effective option for handling all claims processing, regardless of volume, while permitting continued operations for the full fiscal year at a

known total cost. Alternative B stops payment and claims processing before the fiscal year end. Alternative A is the preferred alternative.

Statutory and Federal Authority:

26-4-404 (1) (c), C.R.S. (2004) *(1) (c) The State Department shall exercise its overexpenditure authority under Section 24-7-109, C.R.S., and shall not unintentionally interrupt the normal provider payment schedule unless notified jointly by the Director of the Office of State Planning and Budgeting and the State Controller that there is the possibility that adequate cash will not be available to make payments to providers and for other State expenses. If it is determined that adequate cash is not available and the State Department does interrupt the normal payment cycle, the State Department shall notify the Joint Budget Committee of the General Assembly and any affected providers in writing of its decision to interrupt the normal payment schedule.*

26-4-403.7 (3) (b), C.R.S. (2004) *(3) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that: (b) Adequate financing is available to facilitate the implementation and maintenance of the system. Financing may include, but is not limited to, federal funds, appropriations, from the general fund, provider transactions fees, or any other financing mechanism which the state department may impose, and grants or contributions from public or private entities*.

26-4-532 (7.5) (a), C.R.S. (2004) For *fiscal year 2005-06, the general assembly shall appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1) C.R.S., to such program.*

§1903 (a) of the Social Security Act [42 U.S.C. 1396b] (a) . . . *the Secretary . . . shall pay to each State which has a plan approved under this title . . . (3) an amount equal to – (B) 75 per centum of so much of sums expended during such quarter as attributable to the*

operation of system (whether such system are operated directly by the State or by another person under a contract with the State . . . which are approved by the Secretary…

42 C.F.R. §433.119(c) *[Centers for Medicare and Medicaid Services] will issue to each Medicaid agency, by the end of the first quarter after the review period, a written notice informing the agency whether its system is reapproved or disapproved. If the system is disapproved, the notice will also include—(1) [Centers for Medicare and Medicaid Services'] decision to reduce [federal financial participation] for system operations, and the percentage to which it is reduced, beginning with the next quarter.*

Department Objectives Met if Approved:

1.3 To assure payments in support of the programs are accurate and timely.

1.5 To accurately project, report, and manage budgetary requirement to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI - 8	**OSPB Approval:**		**Date:**	
Program:	Nursing Facilities Section	**Statutory Citation:**	26-4-410 (1) (a) (I), C.R.S. (2004) and 26-4-502 (1), C.R.S. (2004)		
Request Title:	Nursing Facility Audits				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 03-04	FY 04-05	FY 04-05	FY 04-05	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 06-07
Total of All Line Items	**Total**	861,144	864,150	0	864,150	864,150	233,350	1,097,500	0	1,097,500	233,350
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	430,572	432,075	0	432,075	432,075	116,675	548,750	0	548,750	116,675
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	430,572	432,075	0	432,075	432,075	116,675	548,750	0	548,750	116,675
(1) Executive Director's Office	**Total**	861,144	864,150	0	864,150	864,150	233,350	1,097,500	0	1,097,500	233,350
Nursing Facility Audits	**FTE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	430,572	432,075	0	432,075	432,075	116,675	548,750	0	548,750	116,675
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	430,572	432,075	0	432,075	432,075	116,675	548,750	0	548,750	116,675

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE:
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-8
Change Request Title:	Nursing Facility Audits
Long Bill Line Item(s)	(1) Executive Director's Office: Nursing Facility Audits
State and Federal Statutory Authority:	26-4-410 (1) (a) (I), C.R.S. (2004) and 26-4-502 (1), C.R.S. (2004)

Summary of Request (Alternative A): The Department is statutorily required to audit costs reported by Medicaid nursing facilities for rate setting purposes. The Department conducts a competitive procurement once every five years to obtain professional audit services needed to perform this function. The current procurement period expired on June 30, 2003. A new procurement was conducted in FY 03-04 to continue audit services for the five-year period beginning July 1, 2004. The successful bid for the audit services increased the yearly cost by $233,350, with 50% federal financial participation, beginning in FY 04-05. Therefore, the request is for $233,350 total funds for FY 05-06 at 50% federal financial participation.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department contracts with an independent accounting firm to perform audits of nursing facility cost reports. The Medicaid "Financial and Statistical Report of Nursing Homes" (MED-13) determines which costs are reasonable, necessary, and patient related to subsequently set rates based on those costs. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care

for Medicaid clients, in accordance with State and federal statutes. The audit services contract is competitively bid every five years.

The Department issued a Request for Proposal in FY 98-99 and a new contract was awarded effective July 1, 1999. However, the winning contractor's bid was $45,316 over the appropriated FY 99-00 amount of $818,834. A Supplemental Request for FY 99-00 and Budget Amendment for FY 00-01 #3A were approved to increase the funding (see Figure Setting, March 6, 2000 Pages 58-59). The amount continued through the five years of the contract. The Department managed the contract by adjusting the number of field audits, desk audits, and rate calculations.

The number of audits in the contract bid had increased to 220 in FY 99-00. The increase in workload reflected changes in nursing facility ownership, new facilities entering the program, and mergers. For the five-years of the contract, the base appropriation amount was $864,150, with the final year being FY 03-04. The same amount was appropriated for FY 04-05.

Having a five-year contract provides high accuracy and consistency in developing nursing facility rates annually. Without changing the statutory rate methodology, any reduction in the scope, complexity, or quality of nursing facility audit services would result in higher reimbursement rates, on average, for nursing facilities.

The contract is administered at a flat monthly rate. This flat reimbursement system was implemented by the Department in 1998 to simplify accounting, contract management and budgeting procedures that gave rise to significant problems in the past. Thus, vendors must submit a fixed price bid for the entire contract period. This fixed price system allows funding for this function to be requested on a continuation basis throughout the five-year period. Detailed requirements are necessary to continue a rigorous evaluation of nursing facility costs each year.

A competitive procurement began in FY 03-04 to issue a new five-year contract to begin FY 04-05. The Department had two bidders. Myers & Stauffer, the contractor for the

past 10 years, was selected through the State-approved procurement process based on a combination of technical audit requirements and cost. The contract is a 27% increase over the current appropriation.

General Description of Alternative: This request is for an increase to the nursing facility audit contract, increasing the base appropriation by $233,350 in FY 05-06. The increase is due to increased costs as estimated by the winning bidder, Myers & Stauffer.

The Department's ability to continue the current savings in medical premiums of approximately $4.5 million and the approximately $4 to $1 savings to cost of audits ratio is greatly affected by the quality of the auditor. Rigorous auditing standards were required of the successful bidder to maintain these ratios.

Implementation Schedule:

Task	Month/Year
Contract signed for FY 04-05 appropriation amount (9 month contract)	May 2004
Contract extension for FY 05-06 written	March 2005
Extension of contract signed	Signed April 2005
Extension of contract effective	July 1, 2005; may be annually renewed through FY 08-09

Calculations for Alternative's Funding:

Summary of Request FY 05-06 and FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
November 1 Request (Column 7)	$1,097,500	$548,750	$548,750
Incremental Request for contract (Column 6 and Column 10)	$233,350	$116,675	$116,675
FY 05-06 Base Request (Column 5)	$864,150	$432,075	$432,075

The basis of the increase is the successful procurement award of April 2004.

Impact on Other Areas of Government: No other areas of government are affected.

Assumptions for Calculations: The requested increase to the contract (27%) is based on the successful bid for the contract in April 2003.

FY 05-06 Base Request	$864,150	
New contract amount	$1,097,500	
Difference	$233,350	27%

The following tables show the assumptions used to calculate the average savings per day for the five-years of the contract and the nursing facility costs and their growth over the same five-year period to comparing Alternatives A and B using a cost effectiveness analysis.

Per diem savings are provided each year by the audit contractor and nursing facility costs are from the February 16, 2004 Final Request for Medical Services Premiums Exhibit ET. For each year and for each nursing facility, the auditor compiles the cost per patient per day calculated before the audit and the cost per patient per day (per diem) rate calculated after the audit of costs. The two rates are compared and the differences in the rates computed. The average of that difference, between the rate before the audit and after the audit, is the average per diem savings due to the audit for that year. Savings per diem are realized when the auditor that can effectively identify costs that are not allowed per Medicaid regulations or are misallocated.

Year	Per Diem Savings
FY 98-99	($0.77)
FY 99-00	($1.54)
FY 00-01	($1.49)
FY 01-02	($0.90)
FY 02-03	($1.43)
Average	($1.23)

Year	Actual Nursing Facility Costs
FY 98-99	$339,247,796
FY 99-00	$352,309,732
FY 00-01	$351,301,425
FY 01-02	$377,241,370
FY 02-03	$380,354,855

Average Growth is calculated by subtracting the first and last year of data finding the percent increase and then dividing the five years of growth by five.	
$41,107,059	5 year Growth from FY 98-99 to FY 02-03
12.12%	Growth Percentage for five years
2.42%	Average Growth per Year

Concerns or Uncertainties of Alternative: There are no concerns or uncertainties with this alternative.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: Maintain the current funding level for nursing facility audits.

Calculations for Alternative's Funding: No change in funding for this line item with this alternative. However, lowering the number, decreasing the quality, or reducing the number of site visits will result in increased costs in the Medical Services Premiums.

Concerns or Uncertainties of Alternative: The current contractor placed a bid for this contract under state-approved procurement procedures, and was awarded the contract based on the requirements in the Request for Proposal. The Department cannot make obligations without an appropriation. If the appropriation is not increased to address the contractual winning bid, the contract is estimated to run for 9 months, instead of 12, and would perform about 25% fewer audits. In this case, the Department would attempt to target audits, to the extent possible, to where there has been a high degree of variability over the years.

The result would be higher Medicaid premium costs, as fewer errors will be found that would lower the costs to Medicaid. A weaker audit program will also increase the likelihood of fraud.

Supporting Documentation

Analytical Technique:

Cost Effectiveness Analysis

Audits each year are examined and the auditors calculate the changes in per diem rates for each facility. A per patient per day savings rate for all audits is then calculated each year. For this analysis, the average of the last five-year period available was used to estimate the rate for FY 05-06. The five year average savings per day rate was increased by the growth rate projected for nursing home costs for the same five-year period as the savings per day. This estimated savings per day rate for FY 05-06 was then multiplied by the number of anticipated patient days in FY 05-06 (the FY 04-05 estimate of patient days kept constant to be conservative).

This is a rough total estimated savings that might be realized if a consistent level of auditing is undertaken. It is not known what exact findings will occur in the audits or what rates changes there would be with the additional funding, Alternative A assumes that the full savings would be realized (patient days times savings per patient day and the cost to maintain the savings is $1,097,500). Alternative B assumes nine-months (75%) of the savings would be realized if the contract amount is not increased and remains at the FY 99-00 to FY 03-04 contract level. The following table shows the calculation for both Alternative A and Alternative B.

Patient days	3,507,820	FY 03-04 and FY 04-05 Final Request for Medical Services Premiums February 16, 2004 (Page EH-1)
Average savings per patient day	$1.23	Average savings per day for all nursing homes over a five year period per Myers & Stauffer, auditors
2 Years of growth FY 04-05 and FY 05-06 at a growth rate per year based on five years of nursing facility costs equals to 2.42%		
Estimated savings per patient day	$1.29	Average savings per day for all nursing homes multiplied by the growth rate of reimbursement over the most current five-year period available. ($1.23 increased by 2.42% for two years)
Estimated savings	$4,525,088	Patient days multiplied by estimated savings per patient day
Alternative A		
Savings for Alternative A	$4,525,088	Patient days times savings per day
Contract funding Alternative A	$1,097,500	Proposed contract - base FY 05-06 request increased by $233,350
Savings for each dollar spent on the contract under Alternative A	**$4.12**	Estimated reduction divided by contract funding

Alternative B		
Full year of savings from Alternative A	$4,525,088	Full year of savings would be reduced - savings would be for 9 month
Savings for Alternative B	$3,393,816	9 months of savings (estimated by the contractor for HCPF)
Contract Funding Alternative B	$864,150	Base request for FY 05-06
Savings for each dollar spent on the contract under Alternative B	**$3.93**	Estimated reduction divided by contract funding

Alternative A is the preferred alternative as the savings per dollar spent of $4.12 from Alternative A is more than the $3.93 savings per dollar spent from Alternative B.

Quantitative Evaluation of Performance - Compare all Alternatives: Alternative A returns an estimated $0.19 per patient day more than Alternative B and would be the preferred alternative. This is $1,131,272 in estimated avoided costs per year. This amount is roughly estimated and may or may not be accurate, but it is

expected that a reduction in the audit contract would increase the cost per patient day and thus the Medical Services Premiums costs in total.

Statutory and Federal Authority:

26-4-410 (1) (a) (I), C.R.S. (2004) *For the purpose of making payments to private, nonprofit, or proprietary nursing facility providers and intermediate care facilities for the mentally retarded, the state department shall establish a price schedule to be readjusted every twelve months, that shall reimburse, subject to available appropriations, each such provider, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted nursing costs as defined in section 26-4-502.5 (1), and a fair rental allowance for capital-related assets as defined in section 26-4-503 (4). The state department shall adopt rules, including uniform accounting or reporting procedures, in order to determine such actual or reasonable cost of services and case-mix adjusted nursing costs and the reimbursement therefore. The provisions of this subparagraph (I) shall not apply to state-operated intermediate care facilities for the mentally retarded.*

26-4-502 (1), C.R.S. (2004) *"Actual cost" means the allowable audited cost of providing service.*

Department Objectives Met if Approved:

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible.

1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI-9	**OSPB Approval:**		**Date:**	
Program:	Information Technology Contract Monitoring	**Statutory Citation:**	26-4-403.7 (3) (b), C.R.S. (2004)		
Request Title:	Medicaid Management Information System Federally-Mandated Reprocurement				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 03-04	FY 04-05	FY 04-05	FY 04-05	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 06-07
Total of All Line Items	**Total**	0	0	0	0	0	579,600	579,600	0	579,600	327,600
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	56,221	56,221	0	56,221	31,777
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	6,086	6,086	0	6,086	3,440
	FF	0	0	0	0	0	517,293	517,293	0	517,293	292,383
(1) Executive Director's Office, Medicaid Management Information System Reprocurement (New Line Item)	**Total**	0	0	0	0	0	579,600	579,600	0	579,600	327,600
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	56,221	56,221	0	56,221	31,777
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	6,086	6,086	0	6,086	3,440
	FF	0	0	0	0	0	517,293	517,293	0	517,293	292,383

Letter Notation: Cash Funds Exempt of $6,086 are from the Children's Basic Health Plan Trust Fund 11G, §26-19-105, C.R.S.

Cash Fund name/number, Federal Fund Grant name: CFE: Children's Basic Health Plan Trust Fund 11G, FF: Title XIX, Title XXI

IT Request: ☑ **Yes** ☐ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-9
Change Request Title:	Medicaid Management Information System Federally-Mandated Reprocurement
Long Bill Line Item(s)	(1) Executive Director's Office, Medicaid Management Information System Reprocurement (New Line Item)
State and Federal Statutory Authority:	26-4-403.7(3)(b), C.R.S. (2004); SSA §1903(a) [42 U.S.C. 1396b]; 42 C.F.R. §433.112(a); 42 C.F.R. §433.119(c)

Summary of Request (Alternative A): This request is for funding in FY 05-06 and FY 06-07 for the consultant's contract related to the reprocurement processes of the Medicaid Management Information System. This is a follow-up to the emergency supplemental request that was submitted in June 2004. Total funds of $579,600 will be needed with $56,221 in General Fund for FY 05-06.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The last year of the contract under the prior Request for Proposal will end November 30, 2006. The Department's fiscal agent has been ACS (Affiliated Computer Services, or Affiliated Computer Services, Inc. dba Affiliated Computer Services State Healthcare) since December 1, 1998. The Department had worked with the federal Centers for Medicare and Medicaid Services since the summer of 2001 to secure an extension of the renewal date to December 2008. The extension was requested because of competing priorities of Colorado Benefits Management System, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the many budget reduction Medicaid Management Information System changes. On March 29, 2004, the Centers for Medicare

and Medicaid Services officially denied Colorado's request for an extension. The Centers for Medicare and Medicaid Services is requiring the Medicaid Management Information System fiscal agent contract be reprocured and operational by December 1, 2006.

A Supplemental Request was submitted on June 7, 2004, to the Joint Budget Committee of the General Assembly for emergency funding in FY 04-05 to hire a contractor to write the complex Request for Proposal document to which potential fiscal agent bidders will respond. The Joint Budget Committee did not approve the request, but, in a letter to the State Controller dated June 21, 2004, authorized the Department to charge reprocurement expenditures to the Medicaid Management Information System Contract line item until a regular Supplemental appropriation is made. The FY 04-05 reprocurement funding request was for $642,600. The consultant services, which started in FY 04-05, will need to continue into FY 05-06 and FY 06-07, with the transition and enhancement phases still needed to complete the processes.

Successfully continuing the reprocurement process is vital to the Department of Health Care Policy and Financing because the Department will rely on the selected fiscal agent to operate the Medicaid Management Information System over the next three to eight years. Important functions to be overseen by the fiscal agent include the following:

- Processing fee-for-service claims
- Processing encounter claims
- Processing capitations
- Checking eligibility before adjudication of claims
- Conducting prior authorization reviews for specific health care services
- Supporting a Decision Support Subsystem
- Enabling provider enrollment
- Verifying provider credentialing
- Giving provider customer service
- Ensuring compliance with HIPAA regulations
- Publishing provider notifications

General Description of Alternative:

This Alternative requests funding to continue the contracted consultant hired in FY 04-05 into FY 05-06 and FY 06-07 (through December 2006). The contract with the consultant was written with optional additional years to allow the same consultant to continue the processes for reprocurement. The Department would renew for an additional year and continue with processes started in the previous year of FY 04-05.

The Department is not able to absorb this activity within current resources. For these implementation resources, the Department is expected to receive 90% federal financial participation. In order to do so, the Department must submit an Advance Planning Document to the Centers for Medicare and Medicaid Services for approval and has done so. Federal financial participation is contingent on the federal determination.

The contractor selected by the Department, and funded with the approval of the emergency request mentioned above, will assist the Department in the procurement of the next fiscal agent. The federal government requires the Department to have procured and implemented the new system by December 1, 2006. Due to the shortened time to perform the reprocurement, the Department is forgoing major system development and plans to use the current system with minimal enhancements. The goal will be to increase efficiencies while minimizing cost increases. This reprocurement effort has a number of objectives targeted for achievement through system enhancements, by changes to fiscal agent responsibilities, and in future contracting relationships. These objectives will add mission-critical capabilities and offer opportunities for open system flexibility to the current Medicaid Management Information System. The Department, in recognition of the future effort, is seeking assistance and technical advisement from a nationally recognized consultant company.

During FY 05-06, the consultant would perform several functions:

1. The consultant would assist the Department in conducting a bidders' conference, if necessary, to allow bidders to ask questions regarding the scope of work and to clarify the requirements in the Request for Proposal if deemed necessary.
2. The consultant will assist with evaluations of the bidders' submitted proposals and

prepare an evaluation to send to the Centers for Medicare and Medicaid Services.
3. The consultant will develop the contract monitoring and performance plan.
4. The consultant will assist the Department in tracking development progress and in keeping the projects on schedule.
5. The consult will perform project tracking functions.

Proposals from potential fiscal agents will be evaluated in FY 05-06. The results of the evaluations will be forwarded to the Centers for Medicare and Medicaid Services along with a Contract Selection Report explaining the selection of the fiscal agent and a draft of the contract to be used with the selected fiscal agent. As long as the Centers for Medicare and Medicaid Services approve the evaluation, the processes may move forward.

Depending on the selected fiscal agent, the Department may need the contracted consultant's services for at least part of the optional year of FY 06-07. If the selected fiscal agent is the same as the current agent, the system transition and enhancement are expected to be complete by December 1, 2006. If a different fiscal agent is selected, the transition and enhancement will be complete by June 30, 2007. During the transition and enhancements phase, the consultant would continue to track the project to assure that the project is on schedule and that the transition and enhancements exhibit high quality. If the enhancement phase does continue past December 2006, additional funding may be requested through a supplemental request during FY 06-07. Funding at this time is requested to December 2006.

Implementation Schedule:

Task	Month/Year
Proposals from potential fiscal agent due	July 1, 2005
Executive Director approval of new fiscal agent contract	December 1, 2005
If incumbent fiscal agent is selected	
System transition and enhancement begins	January 1, 2006
Transition and enhancement are complete	December 1, 2006

Task	Month/Year
If procurement results in a different fiscal agent	
Transition phase begins	January 1, 2006
Parallel processing/acceptance testing of transition	November 1 – December 31, 2006
Transition complete, start of MMIS operations by new fiscal agent	December 1, 2006
Enhancements complete	June 30, 2007

Calculations for Alternative's Funding:

Summary of Request FY 05-06 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Medicaid Management Information System Reprocurement [See Column 6]	$579,600	$56,221	$6,086	$517,293

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Medicaid Management Information System Reprocurement [See Column 10]	$327,600	$31,777	$3,440	$292,383

Table A: Calculations for Consultants						
Fiscal Year	**Number of Months Consultant Needed**	**Type of Consultant**	**Number of Consultants**	**Hours Needed**	**Hourly Rate**	**Totals**
FY 05-06	4	Consultant	1.0	672	$125	$84,000
	4	Senior Consultant	0.5	672	$175	$58,800
	8	Senior Consultant	1.0	1,344	$175	$235,200
	8	Junior Consultant	2.0	1,344	$75	$201,600
					Grand Total	**$579,600**
FY 06-07	6	Senior Consultant	1.0	1,008	$175	$176,400
(July - December)	6	Junior Consultant	2.0	1,008	$75	$151,200
					Grand Total	**$327,600**

Table B: Preliminary Funding Split Estimates Between Medicaid and Children's Basic Health Plan						
Fiscal Year	**Program Splits**	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
FY 05-06	Total Costs	100%	**$579,600**	**$56,221**	**$6,086**	**$517,293**
	Medicaid Costs	97%		10% of 97%	0% of 97%	90% of 97%
			$562,212	$56,221	$0	$505,991
	Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
			$17,388	$0	$6,086	$11,302
FY 06-07	Total Costs	100%	**$327,600**	**$31,777**	**$3,440**	**$292,383**
	Medicaid Costs	97%		10% of 97%	0% of 97%	90% of 97%
			$317,772	$31,777	$0	$285,995
	Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
			$9,828	$0	$3,440	$6,388

Impact on Other Areas of Government: There are no impacts to other agencies within state government.

Assumptions for Calculations: This request assumes that the Medicaid program will pay 97% of the total funding needed. Of this amount, this request assumes 90% federal match for Title XIX, Medicaid. However, the federal determination on federal financial participation in not known at the time of this writing. Reprocurement projects in the past have been approved by the Centers for Medicare and Medicaid Services for 90% federal funding from the Medicaid program. 42 Code of Federal Regulations, in §433.112(a), states that "[Federal Financial Participation] is available at the 90 percent rate in State expenditures for the design, development, installation, or enhancement of a mechanized claims processing and information retrieval system."

For the purpose of this request, the Children's Basic Health Plan contribution to the total costs is 3%. Using the same percentage as other line items in the Department that also have a contribution from the Children's Basic Health Plan, this percentage is determined by the percentage of capitations paid for the Children's Basic Health Plan in the Medicaid

Management Information System compared to the total forecasted claims and capitations paid. This methodology is still being examined to ensure that it is the best method to accurately account for the appropriate mix of funds.

Federal financial participation for Title XXI, the Children's Basic Health Plan, is 65%. This is the usual percentage for Title XXI.

Table A that calculates the costs for consultants assumes 21 workdays per month.

The Department assumes that a consultant would use varying levels of expertise, depending on the specific work activity in progress. It is estimated that a senior consultant would cost approximately $175 per hour, a general consultant approximately $125 per hour, and a junior consultant approximately $75 per hour. The estimates per hour and the number of hours were estimated by the Information Technology staff based on prior experience with consultants.

Concerns or Uncertainties of Alternative: The Department has estimated the potential costs for the years of the consultant contract. If the actual costs are different than the estimated costs, the Department will manage to the funding authorized by the General Assembly. If a lower percentage than 90% federal financial participation were to be approved by the Centers for Medicare and Medicaid Services, the Department would submit a Supplemental request in the future to adjust to the approved percentage.

If a different fiscal agent is selected, the start of operations by the new fiscal agent will occur by December 1, 2006, but the enhancement phase may be delayed until the last half of FY 06-07, starting January 1, 2007 and to be completed by June 30, 2007. That situation might require additional funding to keep the consultant in place until the enhancement phase could be fully accomplished.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would not fund the additional years in the consultant's contract for assisting the Department with the reprocurement processes.

Calculations for Alternative's Funding: No funding with this alternative.

Concerns or Uncertainties of Alternative: The Department does not have dollars in the Medicaid Management Information System Contract line item to absorb these duties. If this request is not approved, the Department would have to stop the consultant's work started in FY 04-05. Without the consultant's duties being completed, the reprocurement date is likely to be missed. Many of the services performed in the Medicaid Management Information System receive 75% federal funds participation if the system is certified by the Centers for Medicare and Medicaid Services. If the required date is not achieved, the Centers for Medicare and Medicaid Services could decertify the Medicaid Management Information System and lower the federal match rate to 50%. Lowering the federal match rate would result in the need for General Fund.

Supporting Documentation

Analytical Technique: Further analysis by considering return on investment can reveal the profitable alternative for the State. The results of the investment can be expressed in proportion to the investment or as a percentage.

Fiscal Year	Investment: Alternative A	Cost Avoidance (Potential Loss to State): Alternative B
FY 05-06	Total funds of $579,600 with State funds of $56,221 in General Fund and $6,086 in Cash Funds Exempt	State could lose approximately $517,293 in federal funds participation for reprocurement processes if State funding not approved.
FY 06-07	Total funds of $327,600 with State funds of $31,777 in General Fund and $3,440 in Cash Funds Exempt	State could lose approximately $292,383 in federal funds participation for reprocurement processes if State funding not approved.
		State could lose approximately $5,060,237 in federal funds participation for current Medicaid Management Information System continuing operations if system decertified due to missing reprocurement date of December 1,2006.
Total Cost to State	**$97,524 in State funds appropriations**	**Estimated $5,869,913 lost in federal financial participation**

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A would result in a qualified fiscal agent procured under the federal and state required competitive bidding process by December 1, 2006. Alternative B would likely result in loss of roughly $5 million in federal funds, which would need to be supplanted by General Fund [$20,262,998 total funds per HB 04-1422 * 50% = $10,131,499 approximately approved federal funds without a certified Medicaid Management Information System. $15,191,736 appropriated federal funds - $10,131,499 = $5,060,237.]

Alternative A is the preferred alternative.

Statutory and Federal Authority:

26-4-403.7 (3) (b), C.R.S. (2004) *(3) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that: (b) Adequate financing is available to facilitate the implementation and maintenance of the system. Financing may include, but is not limited*

to, federal funds, appropriations, from the general fund, provider transactions fees, or any other financing mechanism which the state department may impose, and grants or contributions from public or private entities.

§1903 (a) of the Social Security Act [42 U.S.C. 1396b] *From the sums appropriated therefore, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—(3) an amount equal to – (B) 75 per centum f so much of sums expended during such quarter as attributable to the operation of system (whether such system are operated directly by the State or by another person under a contract with the State (of the type described in subparagraph (A)(i) (whether or not designed with assistance under such subparagraph) which are approved by the Secretary…*

42 C.F.R. §433.112(a) *[Federal Funds Participation] is available at the 90 percent rate in State expenditures for the design, development, installation, or enhancement of a mechanized claims processing and information retrieval system…*

42 C.F.R. §433.119(c) *[Centers for Medicare and Medicaid Services] will issue to each Medicaid agency, by the end of the first quarter after the review period, a written notice informing the agency whether its system is reapproved or disapproved. If the system is disapproved, the notice will also include –(1) [Centers for Medicare and Medicaid services'] decision to reduce [Federal Funds Participation] for system operations, and the percentage to which it is reduce, beginning with the next quarter.*

Department Objectives Met if Approved: 1.3 To assure payments in support of the programs are accurate and timely.

2.2 To improve management of the Department's information systems technology.

2.3 To hold accountable the Department's administrative contractor, including state and local agencies, by more outcome-based contracting and more sophisticated contract management.

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI-10	**OSPB Approval:**		**Date:**	
Program:	Information Technology Contract Monitoring	**Statutory Citation:**	26-4-106, C.R.S. (2004)		
Request Title:	Fund Colorado Benefits Management System Maintenance				

	Fund	1 Prior-Year Actual FY 03-04	2 Appropriation FY 04-05	3 Supplemental Request FY 04-05	4 Total Revised Request FY 04-05	5 Base Request FY 05-06	6 Decision/ Base Reduction FY 05-06	7 November 1 Request FY 05-06	8 Budget Amendment FY 05-06	9 Total Revised Request FY 05-06	10 Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	4,995,048	5,299,435	0	5,299,435	5,309,975	103,888	5,413,863	0	5,413,863	103,888
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,985,740	2,772,241	0	2,772,241	2,777,754	35,709	2,813,463	0	2,813,463	35,709
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	27,406	27,406	0	27,406	27,406	16,235	43,641	0	43,641	16,235
	FF	2,981,902	2,499,788	0	2,499,788	2,504,815	51,944	2,556,759	0	2,556,759	51,944
(6) DHS Medicaid Funded Programs, Office of Information Technology Services - Medicaid Services - Medicaid Funding, Colorado Benefits Management System	**Total**	4,995,048	5,299,435	0	5,299,435	5,309,975	103,888	5,413,863	0	5,413,863	103,888
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,985,740	2,772,241	0	2,772,241	2,777,754	35,709	2,813,463	0	2,813,463	35,709
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	27,406	27,406	0	27,406	27,406	16,235	43,641	0	43,641	16,235
	FF	2,981,902	2,499,788	0	2,499,788	2,504,815	51,944	2,556,759	0	2,556,759	51,944

Letter Notation: The Cash Funds Exempt amount of $16,235 shall be from the Old Age Pension Fund, appropriated in the Department of Human Services, pursuant to Article 24 of the Constitution of Colorado.

Cash Fund name/number, Federal Fund Grant name: CFE: Old Age Pension Fund, FF: Title XIX

IT Request: ☑ **Yes** ☐ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☑ **Yes** ☐ **No** (If Yes, List Other Departments Here: Department of Human Services)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI –10
Change Request Title:	Fund Colorado Benefits Management System Maintenance
Long Bill Line Item(s)	(6) Medicaid Funded Programs, Office of Information Technology Services – Colorado Benefits Management System
State and Federal Statutory Authority:	(1) 26-4-106, C.R.S. (2004); 42 C.F.R. §433.15(7)

Summary of Request (Alternative A): This request is to increase the portion of the Colorado Benefits Management System paid by the Department of Health Care Policy and Financing to include additional system change costs for programs managed by the Department. The increase in funding would be $103,888 total funds.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: Colorado Benefits Management System is a state-of-the-art computer system that tracks client data, determines eligibility, and calculates benefits for medical, food, and financial assistance programs. This system was implemented September 1, 2004. Continuing operations are a joint effort between the Department of Human Services and the Department of Health Care Policy and Financing. Colorado Benefits Management System replaced six legacy systems: Client Oriented Information Network, Colorado Automated Food Stamps System, Colorado Automated Client Tracking System, Colorado Adult Protection System, Children's Basic Health Plan eligibility determination services, and Colorado Employment First. The Department of Health Care Policy and Financing's

share of the operation expenditures allows a match by federal funds participation from Medicaid.

System changes may be needed in the application, decision tables, valid values, provisions for correspondences to clients, online help, or training materials that are outside the scope of the currently approved design. The changes may be initiated due to rule revisions within the sponsoring departments (Department of Human Services and Department of Health Care Policy and Financing), mandatory federal or state legislation, or by system users such as the counties or medical assistance sites. A change may also be necessary due to a discovered problem. A detailed design assessment may be required. A priority level then is assigned to each system change request. At the same time, the risk of not completing the requested change is also assessed.

The base contract with the outside vendor, Electronic Data Systems, includes 560 hours per month of work for system changes. One or two medium sized requests could easily use the full 560 hours. Since Colorado Benefits Management System covers client programs that previously required six legacy systems to manage, the likelihood of having numerous system changes in any year goes beyond only one or two medium sized requests. The Department anticipates that additional funding for system changes will be an ongoing need.

General Description of Alternative:

Total funds of $103,888 would be utilized for the Colorado Benefits Management System for: 1) enhancements for the Department of Health Care Policy and Financing's eligibility systems and its programs; 2) additional Electronic Data Systems assistance to implement the Department's Prioritized Systems Change Requests; and 3) assistance with maintaining the Decision Support Tables through which the Colorado Benefits Management System makes the eligibility decisions via its computer determination systems. Each of these is described below.

Enhancements for the Department of Health Care Policy and Financing Eligibility Systems and its Programs

The Department anticipates that enhancements to the system will be necessary as the system evolves and new requirements arise. Future changes in federal and state legislation also will generate needs for changes and enhancements. Any change in needs or requirements for tracking client data, modifying eligibility qualifications, restructuring benefits calculations, or reforming financial assistance in any manner would necessitate system changes and enhancements.

Additional Electronic Data Systems Assistance to Implement the Department's Prioritized System Change Requests

Due to the capacity and complexities of the Colorado Benefits Management System, the system changes for the various programs will compete for a high enough priority number to get worked into the computer programming and implementation schedule without long delays. Additional funding would allow more of the requests to be considered for immediate work. Faster scheduling and implementation would reduce the otherwise needed manual work around that would be required for State, county, or eligibility personnel to make legal or policy updates for the change requests not yet mechanized. The additional funding would make it possible for Electronic Data Systems to respond quickly to newly emerging needs.

Assistance with Maintaining the Decision Support Tables

All eligibility policy rules are encoded in Decision Support Tables. Additional funding will be required to maintain the rules in the Decision Support Tables, and it is the responsibility of the Department to do so. To change and implement the Decision Support Tables with the Department's limited staff could exceed staff capabilities. The Department could need help from outside contractors if the workload level exceeds capacity. Therefore, additional funding would be used to alter the Decision Support Tables in a timely manner so that errors in qualifying a client would be avoided.

Calculations for Alternative's Funding:

Summary of Request FY 05-06 and FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**	**Cash Funds Exempt**
Total Request (Column 6 of Schedule 6)	$103,888	$35,709	$51,944	$16,235
(6) DHS Medicaid Funded Programs, Office of IT Services – Colorado Benefits Management System	$103,888	$35,709	$51,944	$16,235

Task	**Costs Per Hour**	**Number of Hours**	**Total Costs**
Enhancements for the Department's Eligibility System	$151	350	$52,850
Move Prioritized Systems Change Requests to Higher Levels (and Get These Requests Implemented)	$151	238	$35,938
Maintain Decision Support Tables	$151	100	$15,100
Total of All Items	**$151**	**688**	**$103,888**

Impact on Other Areas of Government: The request affects the Department of Human Services appropriations. The Cash Funds Exempt of $16,235 in this request would be transferred from the Old Age Pension Fund originally appropriated to the Department of Human Services. This is the same amount previously provided by the Old Age Pension Fund under the legacy system of Client Oriented Information System (COIN). An Interagency Agreement would stipulate how the Health Care Policy and Financing Colorado Benefits Management System funding would be spent and by whom.

Assumptions for Calculations: The Department's Information Technology staff analyzed six types of system change requests, similar to those in this request, along with their total costs and number of hours of labor. For each of the six items, an average hourly rate was calculated. The hourly rate on these different labor functions ranged from $135 an hour to $161 an hour, with an average of $151 an hour.

Information Technology staff then estimated that it would take 688 hours of labor to complete the three tasks described on page 4 (350 hours to fund enhancements for the

Department's Eligibility System, 238 hours to move additional System Change Requests to a higher priority level, and 100 hours to maintain of the Decision Support Tables). These estimates are based on experience acquired during the development phase that occurred prior to the implementation of the Colorado Benefits Management System.

Historically, when the Client Oriented Information Network System (COIN) was used to maintain eligibility listings (after manual determination was made), Cash Funds Exempt of $16,235 from the Old Age Pension Fund appropriated to the Department of Human Services were used as partial payment for system changes. Because Old Age Pension clients continue to be served by the current Colorado Benefits Management System, the Department considers that it is reasonable to continue to transfer from the Old Age Pension Fund at the same funding level.

Concerns or Uncertainties of Alternative: The Department does now know the magnitude or the number of changes at this time. These numbers are best estimates, and the Department will attempt to negotiate and manage these functions within the dollars appropriated.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: Under Alternative B, no additional funding for system changes and Decision Support Table maintenance would be appropriated.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: When the 560 base hours per month for system changes are used up, further system changes and table maintenance could not be performed. Long delays would result in waiting for the next fiscal year to begin when a new allotment of 560 hours would be available. Manual work arounds would be necessary during the delays. A large amount of manual work arounds negates the advantages of using a mechanized system and increases the potential for errors.

Supporting Documentation

Analytical Technique: A cost/benefit analysis has been completed, and the results of the analysis are shown in the chart below. This analysis demonstrates which alternative produces an advantageous result.

Costs/ Benefits	Alternative A	Alternative B
Costs	$103,888	$0
Benefit	Allows funding for necessary changes to be mechanized sooner.	No benefits. Instead a risk that manual work arounds will be necessary, increasing possibility of more errors.
Benefit	Increases likelihood that client expectations will be met by assistance to maintain the decision tables timely and accurately.	No benefits. Instead a risk that qualified clients will be denied benefits, causing an increase in appeals, and adding to costs for Administrative Law Judges.
Benefit	Moves System Change Requests to higher priority so they can be implemented more timely.	No benefits. Instead a risk of delays in implementing changes, corrections, and enhancements.

Quantitative Evaluation of Performance - Compare all Alternatives: Alternative A is clearly the preferred alternative, since it provides numerous benefits while avoiding the risks associated with Alternative B. The Department can increase efficiency in system access, ensure high prioritization of issues in the systems change process, and ensure effective reporting and timeliness in the Decision Support System.

Statutory and Federal Authority: 42 C.F.R. §433.15(7) *All other activities the Secretary finds necessary for proper and efficient administration of the State Plan: 50 percent.*

26-4-106, C.R.S. (2004) – Application – verification of eligibility. *(1) Any person who is determined to be eligible pursuant to the requirements of this article shall be eligible for benefits until such person is determined to be ineligible.*

Department Objectives Met if Approved: 1.2 To support timely and accurate client eligibility determination.

1.5 To accurately project, report and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for program managed by the Department so there may accurate financial reporting at all times.

Schedule 6

Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI - 11	**OSPB Approval:**		**Date:**	
Program:	Rates Section	**Statutory Citation:**	26-4-404 (1) (a), C.R.S. (2004); 26-4-405, C.R.S. (2004); and 26-4-119 (1) (d), C.R.S. (2004)		
Request Title:	Funding for Hospital and Federally Qualified Health Clinic Audits to Increase Recoveries				

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 03-04	Appropriation FY 04-05	Supplemental Request FY 04-05	Total Revised Request FY 04-05	Base Request FY 05-06	Decision/ Base Reduction FY 05-06	November 1 Request FY 05-06	Budget Amendment FY 05-06	Total Revised Request FY 05-06	Change from Base in Out Year FY 06-07
Total of All Line Items	**Total**	1,868,908,515	1,934,894,559	0	1,934,894,559	1,934,584,218	0	1,934,584,218	0	1,934,584,218	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,127,797	936,766,159	0	936,766,159	936,297,614	0	936,297,614	0	936,297,614	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	0	72,180	0	72,180	0
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	0	30,495,113	0	30,495,113	0
	FF	985,928,486	967,874,482	0	967,874,482	967,719,311	0	967,719,311	0	967,719,311	0
(1) Executive Director's Office	**Total**	250,000	250,000	0	250,000	250,000	100,000	350,000	0	350,000	100,000
Hospital and Federally	**FTE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Qualified Health Clinic	**GF**	125,000	125,000	0	125,000	125,000	50,000	175,000	0	175,000	50,000
Audits	**GFE**	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	125,000	125,000	0	125,000	125,000	50,000	175,000	0	175,000	50,000
(2) Medical Services Premiums	**Total**	1,868,658,515	1,934,644,559	0	1,934,644,559	1,934,334,218	(100,000)	1,934,234,218	0	1,934,234,218	(100,000)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	936,641,159	0	936,641,159	936,172,614	(50,000)	936,122,614	0	936,122,614	(50,000)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	0	72,180	0	72,180	0
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	0	30,495,113	0	30,495,113	0
	FF	985,803,486	967,749,482	0	967,749,482	967,594,311	(50,000)	967,544,311	0	967,544,311	(50,000)

Letter Notation:

Cash Fund name/number: ☐ **Federal Fund Grant name:** FF: Title XIX

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE:
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 11
Change Request Title:	Funding for Hospital and Federally Qualified Health Clinic Audits to Increase Recoveries
Long Bill Line Item(s)	(1) Executive Director's Office, Hospital and Federally Qualified Health Clinic Audits
State and Federal Statutory Authority:	26-4-404 (1) (a), C.R.S. (2004); 26-4-505, C.R.S. (2004); and 26-4-119 (1) (d), C.R.S. (2004)

Summary of Request (Alternative A): This request is to increase the contract for auditing services by $100,000 in order to identify overpayments to hospitals and health centers due to cost report adjustments and rate setting. While this independent auditing has been successful in controlling costs, the current level of auditing could be expanded and an increase in recoveries to Medicaid is expected. While the amount that could be returned to both Colorado and the federal government cannot be projected exactly, savings in the Medical Services Premiums are assumed to be at least $100,000 to offset the audit services costs. The request is therefore budget neutral.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department contracts with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers, and rural health centers that participate in Medicaid to establish reimbursement rates for services. Auditing of these facilities is federally mandated. The hospital audits are completed from the

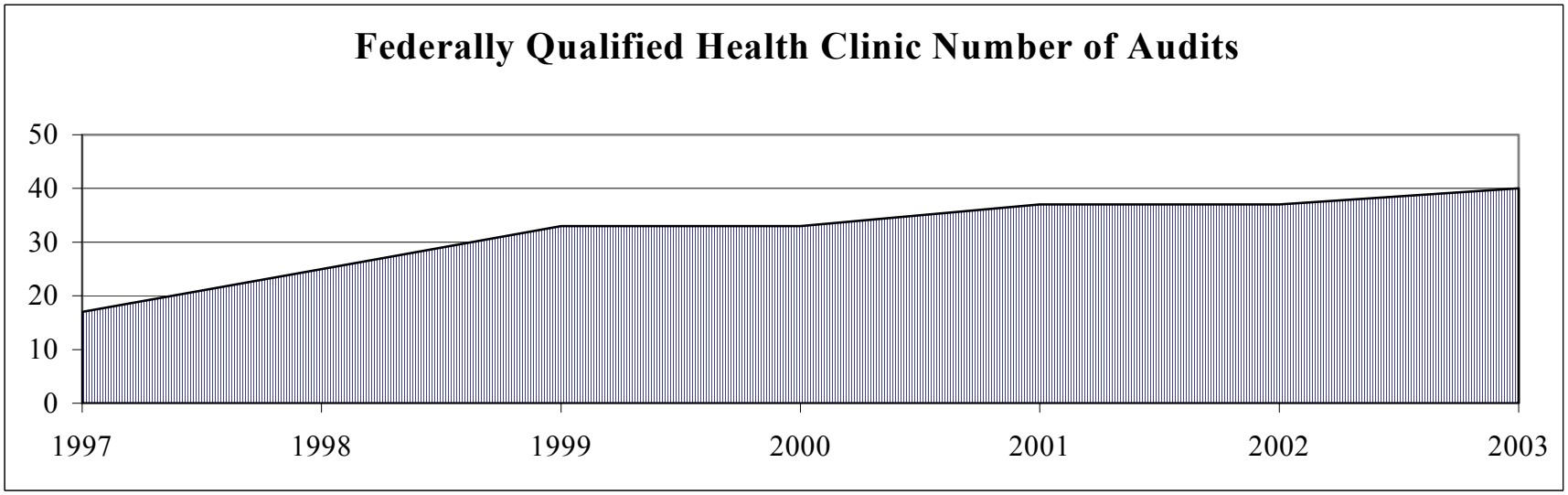
Medicare/Medicaid cost report and tailored to the Medicaid requirements. The accounting firm provides the following services: final settlements, rebasing calculations, consultation, assistance on cost report interpretation, and meetings with providers to resolve problems. The annual rates of reimbursement for hospitals, federally qualified health centers, and rural health centers are computed from the results of these audits. Annual rates are set to cover the reasonable and necessary costs of an efficiently run facility per federal and State law. When this contract expired June 30, 2001, the contractor for these audit services was TrailBlazers Health Enterprises, LLC.

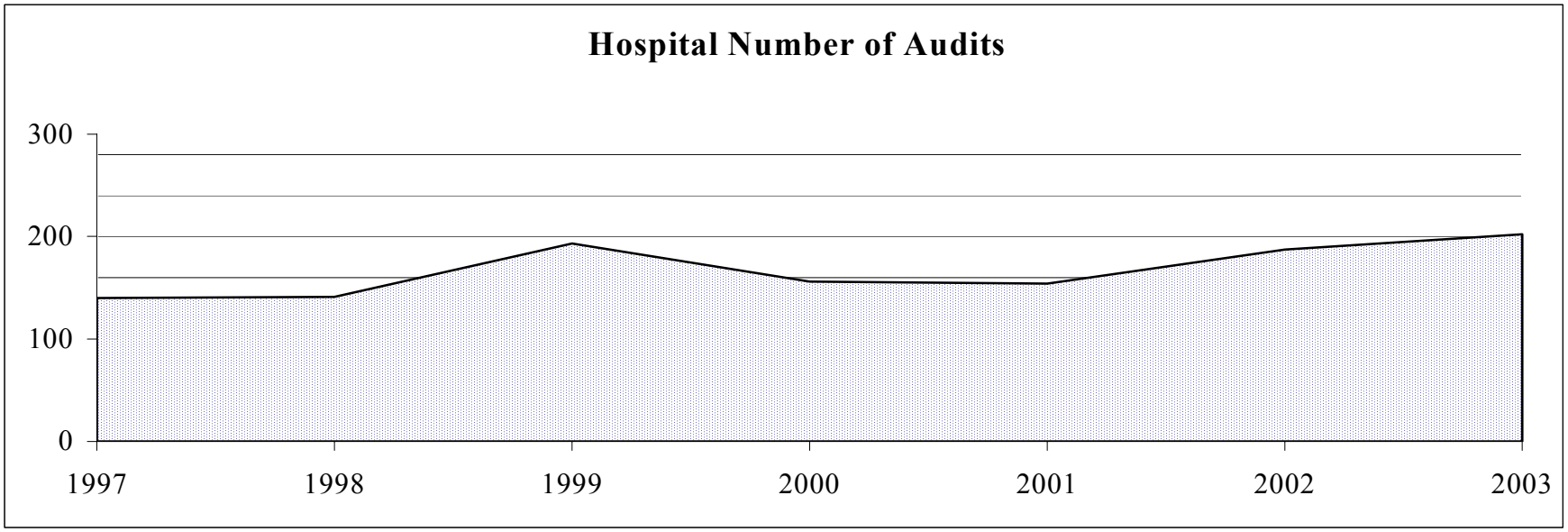
The Department issued a Request for Proposal, but due to higher than appropriated proposal amounts, the Request for Proposal failed. A supplemental increase was approved for FY 01-02 to address the reasons the Request for Proposal failed and the Department was able to extend its contract with TrailBlazers Health Enterprises, LLC for FY 01-02. To accommodate needed increases, a Decision Item was approved for FY 02-03 increasing the contract to $250,000 per year, more than double the earlier contract.

In FY 02-03, the full appropriation was expended as the new contractor (Parrish, Moody and Fikes) completed multiple audits, including hospitals, federally qualified health centers, and rural health centers. Many prior years had gone unaudited due to the lapsed contract for this service, the lower contract amount and difficulty in gathering the necessary data. The expanded audits of hospitals resulted in additional reclaimed funds.

In FY 03-04, to evaluate the time needed and the possible return in savings to the State, the Department's contractor conducted a partial site audit, in addition to current desk audits in the base budget. A site audit is more expensive to conduct, as both more time and additional expenses for travel to each site are needed. These costs are offset by disallowed additional costs, which potentially decrease the rate of each facility audited. Lower rates for facilities translate into savings. The one site audit was very successful and the return on investment was $9 in expenses disallowed for $1 of audit expenses.

The following two graphs depict review volumes for recent history.


Federally Qualified Health Clinic Number of Audits
50
40
30
20
10
0
1997
1998
1999
2000
2001
2002
2003


Hospital Number of Audits
300
200
100
0
1997
1998
1999
2000
2001
2002
2003

General Description of Alternative:

The Department rate setting for health centers will be conducted in FY 05-06. By increasing funding for site audits in addition to the desk audits done annually, the Department would have more accurate and, in all likelihood, lower costs on which to base that rate setting. Although the amount of savings to the program could not be quantified and all savings would not be realized in the year the audits were conducted because the audits and subsequent rate setting are staggered during the fiscal year, the Department concludes that real savings would be obtained.

Hospital audits return savings to the Department as the audits are finished. The savings on those audits would be realized in the year the audit was completed.

It is anticipated that at least the cost of hospital and health center audits, $100,000, would be recovered in FY 05-06. The Medical Services Premiums request is reduced by $100,000 to reflect these savings.

The Department is committed to reclaiming the maximum amounts allowed by increasing both the number and complexity of the audits of hospitals and health centers. Each year, although the Department spends the entire allocation appropriated for this purpose, there are recoveries that are not made. Adding site audits and increasing the complexity of the current desk audit program each year can obtain a better picture of the true costs of these facilities to Medicaid.

Implementation Schedule:

Task	Month/Year
Contract Amendment Written	April 2005
Contract Amendment Signed	July 2005
Start-Up Date	July 2005
Complete Audits	June 30, 2006

Calculations for Alternative's Funding:

Summary of Request FY 05-06 and FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request	$0	$0	$0
(1) Executive Director's Office – Nursing Facility Audits	$100,000	$50,000	$50,000
(2) Medical Services Premiums	($100,000)	($50,000)	($50,000)

	Hours	**Rate**	**Cost**
Auditors	60.00	$60.00	$3,600
Clerical	6.67	$60.00	$400
Total Per Audit	66.67	$60.00	$4,000
		Number of Audits	25
			$100,000

Impact on Other Areas of Government: None

Assumptions for Calculations: The cost per site audit is based on a standard rate that would be charged by the auditor regardless of what levels of employees are working on the audit. That rate is $60 per hour. The number of hours for each site audit was estimated, by the current auditor.

Travel expenses are included in the hourly rate. The Department estimates the number of additional audits in a year to be 7 hospitals and 18 federally qualified health centers, a total of 25 audits at an estimated $4,000 per audit. Total cost of the audits is $4,000 times 25, which equals $100,000.

It is assumed that at least the cost of the audits, $100,000, would be saved in Medical Services Premiums, when more complex and detailed site audits are performed.

Concerns or Uncertainties of Alternative: The exact number of audits and the exact amount of increased recoveries is not known at this time.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: With the same appropriation as in previous years, no additional audits or site visits would be completed.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: As costs per audit increase over time, the number of audits and thus the savings from these audits for these facilities, would decline. The Department has been successful in identifying costs that can be disallowed at the current level of funding, however, the current level of funding does not provide for all of the audits that could be completed given adequate funding. There is concern that only the surface layer of savings has been achieved. Mistakes and identification of costs that are not appropriate have been discovered without utilizing site audit techniques. Maintaining level funding would not produce the maximum cost avoidance possible.

Supporting Documentation

Analytical Technique: Return on Investment

Return on Investment Analysis – Rough Estimate	
Investment in site audits and more complex audits for hospitals and federally qualified health centers	Return would be cost avoidance by disallowing additional costs and reducing payments to hospitals and by disallowing costs and reducing rates in the subsequent year for federally qualified health centers.
$28,000 hospital site audits = 7 audits	For hospitals, the current program disallows $3 to $5 per dollar of audit costs. Site audits would be identified as those with lower disallowed costs. Audits that are disallowing $3 would now return $5 due to a more intense scrutiny of cost information. This would return an additional $2 for each dollar spent.

$72,000 federally qualified health center site audits = 18 audits	For federally qualified health centers, the current program disallows $3 to $5 per dollar of audit costs. The estimated return would be a $5 to $9 return based on the trial site review. This more intense scrutiny of cost information would return an additional $2 to $4 for each dollar spent. For the purpose of this analysis the midpoint was chosen, $3 per dollar invested.
$100,000 total FY 05-06 requested funds	28,000 times $2 = $56,000 72,000 times $3 = $216,000 Total = $272,000
Return on Investment is the ratio of the investment to the return	2.72

A return on investment that is greater than 1 is considered favorable.

Quantitative Evaluation of Performance - Compare all Alternatives: See Return on Investment analysis above.

Statutory and Federal Authority: 26-4-404 (1) (a), C.R.S. (2004). Providers - payments – rules . . . *but no provider shall, by this section or any other provision of this article, be deemed to have any vested right to act as a provider under this article or to receive any payment in addition to or different from that which is currently payable on behalf of a recipient at the time the medical benefits are provided by said provider.*

26-4-405, C.R.S. (2004). Providers - hospital reimbursement. *On or after July 1, 1987, the state department shall pay all licensed or certified hospitals under this article, except those hospitals operated by the department of human services, pursuant to a system of prospective payment, generally based on the elements of the medicare system of diagnosis-related groups . . . The state department shall develop and administer a system for assuring appropriate utilization and quality of care provided by those providers who are reimbursed pursuant to the system of prospective payment developed under this section.*

26-4-119 (1) (d), C.R.S. (2004). Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. *A federally qualified health center, as defined in the federal "Social Security Act", shall be reimbursed by the state department for the total reasonable costs incurred by the center in providing health care services to all recipients of medical assistance.*

Department Objectives Met if Approved:

1.1 To maximize the opportunity to maintain health care services through the purchase of services in the most cost-effective manner possible

1.5 To accurately project, report, and manage budgetary requirements to effect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	DI - 12	**OSPB Approval:**		**Date:**	
Program:	Community Based Long Term Care	**Statutory Citation:**	26-4-674, 26-4-302, 26-4-522, C.R.S. (2004)		
Request Title:	Move Case Management from Mental Health Community Programs to Medical Services Premiums				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual		Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 03-04	Appropriation FY 04-05	FY 04-05	FY 04-05	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 06-07
Total of All Line Items	**Total**	1,868,658,515	1,937,471,939	0	1,937,471,939	1,937,300,619	0	1,937,300,619	0	1,937,300,619	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	938,054,849	0	938,054,849	937,655,815	0	937,655,815	0	937,655,815	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	0	72,180	0	72,180	0
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	0	30,495,113	0	30,495,113	0
	FF	985,803,486	969,163,172	0	969,163,172	969,077,511	0	969,077,511	0	969,077,511	0
(2) Medical Services Premiums	**Total**	1,868,658,515	1,934,644,559	0	1,934,644,559	1,934,334,218	1,780,300	1,936,114,518	0	1,936,114,518	1,780,300
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	855,002,797	936,641,159	0	936,641,159	936,172,614	890,150	937,062,764	0	937,062,764	890,150
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	72,180	0	72,180	72,180	0	72,180	0	72,180	0
	CFE	27,852,232	30,181,738	0	30,181,738	30,495,113	0	30,495,113	0	30,495,113	0
	FF	985,803,486	967,749,482	0	967,749,482	967,594,311	890,150	968,484,461	0	968,484,461	890,150
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, Medicaid Mental Health Fee for Service Payments	**Total**	0	2,827,380	0	2,827,380	2,966,401	(1,780,300)	1,186,101	0	1,186,101	(1,780,300)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	1,413,690	0	1,413,690	1,483,201	(890,150)	593,051	0	593,051	(890,150)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	1,413,690	0	1,413,690	1,483,200	(890,150)	593,050	0	593,050	(890,150)

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 12
Change Request Title:	Move Case Management from Mental Health Community Programs to Medical Services Premiums
Long Bill Line Item(s)	(2) Medical Services Premiums; (3) Medicaid Mental Health Community Programs (B) Mental Health Programs, Medicaid Mental Health Fee for Service Payments
State and Federal Statutory Authority:	26-4-674, 26-4-302, 26-4-522, C.R.S. (2004)

Summary of Request (Alternative A): This Change Request is to move $1,780,300 from the Medicaid Mental Health Community Programs Long Bill group to the Medical Services Premiums Long Bill group. Formerly paid to mental health centers for case management of clients in the Home and Community Based Services for Mental Illness waiver, this funding is now paid to Single Entry Point agencies for the same purpose. Because the service costs for these clients are paid from the Medical Services Premiums Long Bill group, along with other Single Entry Point case management costs, this change will place the funding in the most appropriate budget location.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: Prior to FY 01-02, the Department of Human Services administered the Home and Community Based Services for the Mentally Ill program. On December 26, 2002, under agreement of both agencies, the Department of Human Services notified the Department of Health Care Policy and Financing via letter that it would no longer be responsible for

the program. At that time, Health Care Policy and Financing contracted with community mental health centers to provide case management services to the Home and Community Based Services for the Mentally Ill clients. The funding was in the Long Bill group "Department of Human Services Medicaid Funded Programs," under the line item "Mental Health Community Programs, Medicaid Mental Health Fee for Service Payments." However, the Department of Health Care Policy and Financing contracted directly with and directly paid the community mental health centers for these services.

Beginning July 1, 2003, the Department of Health Care Policy and Financing began to contract with Single Entry Point agencies for these services instead of mental health centers. On March 9, 2004, the Department informed the Joint Budget Committee via letter that although the funding for these Single Entry Point case management services was in the budget line items that are transferred to the Department of Human Services, Health Care Policy and Financing was going to continue to pay the Single Entry Points from this line item in FY 03-04. The Department expressed the plan to submit a Decision Item for FY 05-06 and a Supplemental Request for FY 04-05.

Currently all home and community based waiver services for clients with mental illness and their Medicaid State Plan services are funded through the Medical Services Premiums Long Bill group. In addition, all other Single Entry Point agency case management services for Medicaid clients are funded through the Medical Services Premiums Long Bill group.

General Description of Alternative: The Department requests this technical correction to move appropriated dollars from an inapplicable Long Bill group (Medicaid Mental Health Community Programs) to the more appropriate Long Bill group (Medical Services Premiums). This amount is $1,780,300 total funds at 50% federal financial participation.

There are several advantages to this change. The "Medicaid Mental Health Fee for Service Payments" line item currently houses two primary types of costs: 1) Single Entry Point case management services, and 2) fee-for-service or non-capitation payments made on behalf of Medicaid clients. While the vast majority of Medicaid clients are in mental

health managed care organizations, some clients do receive exceptions to receive their care under fee-for-service. To remove Single Entry Point case management services from this line item would make the line item name completely relevant to the type of expenditures charged to it.

Since all other Single Entry Point agency case management services for Medicaid clients are funded through the Medical Services Premiums Long Bill group, moving these services from the Medicaid Mental Health Fee for Service Payments line item to the Medical Services Premiums places like costs together. This makes projecting expenditures more complete and accurate, and improves understanding and tracking of the like expenditures since they are in the same budget location. All medical costs for the same clients are then in the same location in the budget.

Finally, moving Single Entry Point agency case management services to the Medical Services Premiums Long Bill group improves contract management and procurement tracking, since the dollars for the case management services are in one appropriation instead of two. Over time, this will improve administrative efficiency.

This change is cost neutral. It does not change current administrative operations. This change does not affect Medicaid clients.

Implementation Schedule:

Task	Month/Year
Do not transfer funds to the Department of Human Services, charge Single Entry Point agency case management services to the Medicaid Mental Health Fee for Service Payments line item.	FY 03-04
Line item now in Health Care Policy and Financing and charge Single Entry Point agency case management services to the Medicaid Mental Health Fee for Service Payments line item.	FY 04-05, July 1 to passage of pending Supplemental Request
Charge entire year Single Entry Point agency case management services to the Medical Services Premiums	FY 04-05, after passage of Supplemental Request
Charge Single Entry Point agency case management services to the Medical Services Premiums	FY 05-06

Calculations for Alternative's Funding:

Summary of Request FY 05-06 and FY 06-07 Matches Schedule 6 Incremental Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request	$0	$0	$0
(2) Medical Services Premiums	$1,780,300	$890,150	$890,150
(3) Medicaid Mental Health Community Programs (B) Mental Health Programs, Medicaid Mental Health Fee for Service Payments	($1,780,300)	($890,150)	($890,150)

Impact on Other Areas of Government: Due to HB 04-1265, the Medicaid community mental health appropriations are now in Health Care Policy and Financing, so there are no other State departments affected.

Assumptions for Calculations: The amount of $1,780,300 is the historical amount spent on case management services in the Home and Community Based Services for the Mentally Ill program. Below are these expenditures for the past three fiscal years:

- FY 03-04 $1,780,300
- FY 02-03 $1,908,801 ($1,780,300 + $127,781 overexpenditure from FY 01-02)
- FY 01-02 $1,636,839

Please see the Medicaid Mental Health Community Programs in this November 1, 2004 Budget Request for the assumptions related to the balance of the Medicaid Mental Health Fee for Service Payments line item.

These costs are authorized for 50% federal financial participation.

Concerns or Uncertainties of Alternative: This is a technical improvement and does not result in any concerns.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would retain the funding for the Single Entry Point agency case management services within Medicaid Mental Health Fee for Service Payment line item.

This alternative would also be cost neutral. It does not change current administrative operations. This change would not affect Medicaid clients.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: This alternative would continue to fund the Single Entry Point agency case management services in a line item that is not the best fit for these types of services. It would reduce budget transparency and increase administrative confusion.

Supporting Documentation

Analytical Technique: Because the costs are fixed in both scenarios, the Cost-Effectiveness Analysis is used. Alternative A is more effective because, for the same cost, it:

- Is less administrative burden;
- Improves projection information; and
- Creates budget clarity for mental health fee-for-service payments.

Alternative B provides none of this effectiveness.

Quantitative Evaluation of Performance - Compare all Alternatives: There are no quantifiable outcomes with Alternative A. They are all qualitative benefits as described in the Analytical Technical and the General Description of Alternative.

Statutory and Federal Authority: 26-4-674, C.R.S. (2004). Relationship to single entry point for long-term care.
The home- and community-based services program for persons with major mental illnesses shall not be considered a publicly funded long-term care program for the purposes of sections 26-4-521 to 26-4-525, concerning the single entry point system, unless and until the departments of health care policy and financing and human services provide in the memorandum of understanding between the departments for the inclusion of the program in the single entry point system.

26-4-302, C.R.S. (2004). Basic services for the categorically needy - optional services.
(1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program: (c) Home- and community-based services, as specified in part 6 of this article, which include: (IV) Home- and community-based services for persons with major mental illnesses, as specified in subpart 5 of part 6 of this article; (l) Case management . . .

26-4-522, C.R.S. (2004). Single entry point system - authorization - phases for implementation - services provided.
(1) Authorization. The medical services board is hereby authorized to adopt rules providing for the establishment of a single entry point system that consists of single entry point agencies throughout the state for the purpose of enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.
(3) Single entry point agencies - service programs - functions. (a) A single entry point agency shall be an agency in a local community through which any person eighteen years of age or older who is in need of long-term care can access needed long-term care services. A single entry point agency may be a private, nonprofit organization, a county agency, including a county department of social services, a county nursing service, an area agency on aging, or a multicounty agency. Persons in need of specialized assistance such as services for developmental disabilities or mental illness may be referred by a single entry point agency to programs under the department of human services.
(c) The major functions of a single entry point shall include, but need not be limited to, the following: (I) Providing information; (II) Screening and referral services; (III) Assessing clients' needs in accordance with section 26-4-507; (IV) Developing plans of care for clients; (V) Determining payment sources available to clients for long-term care services; (VI) Authorizing the provision of certain long-term care services, as designated by the state department; (VII) Determining eligibility for certain long-term care programs, as designated by the state department; (VIII) Delivering case management services as an administrative function; (IX) Targeting outreach efforts to those most at risk of institutionalization; (X) Identifying resource gaps and coordinating resource

development; (XI) Recovering overpayment of benefits in accordance with rules adopted by the medical services board; (XII) Maintaining fiscal accountability; and (XIII) Rendering state certified services, as provided by medical services board rules, as a qualified and state certified agency.

Department Objectives Met if Approved: 1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6

Change Request for FY 05-06

Department:	Health Care Policy and Financing	**Dept. Approval by:**	Lisa Esgar	**Date:**	November 1, 2004
Priority Number:	BRI - 1	**OSPB Approval:**		**Date:**	
Program:	Quality Improvement/Behavioral Health Benefits	**Statutory Citation:**	26-4-123, 26-4-119, C.R.S. (2004)		
Request Title:	Balance Mental Health FTE to Department Need				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision Item/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 03-04	FY 04-05	FY 04-05	FY 04-05	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 05-06	FY 06-07
Total of All Line Items	**Total**	13,311,090	14,659,011	0	14,659,011	15,040,412	0	15,040,412	0	15,040,412	0
	FTE	177.57	204.50	0.00	204.50	205.60	(2.00)	203.60	0.00	203.60	(2.00)
	GF	5,374,431	6,563,571	0	6,563,571	6,595,805	0	6,595,805	0	6,595,805	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	82,224	199,337	0	199,337	278,932	0	278,932	0	278,932	0
	FF	7,854,435	7,896,103	0	7,896,103	8,165,675	0	8,165,675	0	8,165,675	0
(1) Executive Director's Office	**Total**	12,398,885	12,692,267	0	12,692,267	13,060,371	687,706	13,748,077	0	13,748,077	687,706
Personal Services	**FTE**	177.57	195.50	0.00	195.50	196.60	7.00	203.60	0.00	203.60	7.00
	GF	4,922,102	5,673,951	0	5,673,951	5,701,905	343,853	6,045,758	0	6,045,758	343,853
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	81,482	198,505	0	198,505	275,730	0	275,730	0	275,730	0
	FF	7,395,301	6,819,811	0	6,819,811	7,082,736	343,853	7,426,589	0	7,426,589	343,853
(1) Executive Director's Office											0
	Total	912,205	929,648	0	929,648	933,438	6,090	939,528	0	939,528	6,090
Operating Expenses	**FTE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	452,329	459,274	0	459,274	458,800	3,045	461,845	0	461,845	3,045
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	742	832	0	832	3,202	0	3,202	0	3,202	0
	FF	459,134	469,542	0	469,542	471,436	3,045	474,481	0	474,481	3,045
(3) Medicaid Mental Health Community Programs											0
	Total	0	1,037,096	0	1,037,096	1,046,603	(1,046,603)	0	0	0	(1,046,603)
	FTE	0.00	9.00	0.00	9.00	9.00	(9.00)	0.00	0.00	0.00	(9.00)
(A) Program Administration	**GF**	0	430,346	0	430,346	435,100	(435,100)	0	0	0	(435,100)
	GFE	0	0	0	0	0	0	0	0	0	0
[eliminate line item]	**CF**	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	606,750	0	606,750	611,503	(611,503)	0	0	0	(611,503)
(3) Medicaid Mental Health Community Programs											
	Total	0	0	0	0	0	352,807	352,807	0	352,807	352,807
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(A) External Quality Review Organization	**GF**	0	0	0	0	0	88,202	88,202	0	88,202	88,202
	GFE	0	0	0	0	0	0	0	0	0	0
[new line item]	**CF**	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	264,605	264,605	0	264,605	264,605

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: **FF:** Title XIX and Title XXI **CFE:** Breast and Cervical Cancer Prevention and Treatment Fund and Children's Basic Health Plan

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** (If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 05-06
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☐ Decision Item
☑ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	BRI-1
Change Request Title:	Balance Mental Health FTE to Department Need
Long Bill Line Item(s)	(1) Executive Director's Office, Personal Services; (1) Executive Director's Office, Operating Expenses (3) Medicaid Mental Health Community Programs, (A) Program Administration, (A) External Quality Review Organization
State and Federal Statutory Authority:	26-4-123, 26-4-119, C.R.S. (2004); 42 C.F.R. 438.310, 42 C.F.R. 438.6

Summary of Request (Alternative A): At the time HB 04-1265 was passed, with the corresponding adjustment for FY 04-05 occurring via the Long Bill, HB 04-1422, it was understood that the Department would move Personal Services related costs from the Program Administration line item in the Medicaid Mental Health Community Programs Long Bill group to the Department's Personal Services and Operating Expenses line items in the Executive Director's Office Long Bill group. This would collect all personal services and operating costs in the Executive Director's Office. This request is to accomplish this move, and to reduce the FTE count by 2.00 to balance to the Department's hiring decisions. There is no change to net General Fund, total funds, or fund splits.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: HB 04-1265 transferred the administration of Medicaid mental health community programs from the Department of Human Services to the Department of Health Care Policy and Financing. As the Single State Agency authorized by the federal Centers for

Medicare and Medicaid Services, and as authorized in State statute, Health Care Policy and Financing has always been responsible for the oversight of the program and contracting with the managed care organizations. However, until April 2004, the Department of Human Services was responsible for the day-to-day administration of the program. Under the authority of HB 04-1265, and the appropriations in the Long Bill, Health Care Policy and Financing was appropriated 9.0 FTE and $1,037,096 for Medicaid mental health administration. The Department of Human Services retained a portion of the funding and FTE for ongoing activity related to Medicaid mental health administration.

There was discussion with the Joint Budget Committee during the HB 04-1265 fiscal note process and Long Bill reconciliation process that the Department of Health Care Policy and Financing would need to assess the administrative needs with this change in responsibility. It was expected that the Department would submit a budget request to move any dollars appropriated to the mental health Program Administration line for staffing costs to the Executive Director's Office Long Bill group. In fact, the Joint Budget Committee was supportive of a consolidation of personal services appropriation for the FY 03-04 budget. This request continues that intent by reconciling personal services and other administrative costs.

General Description of Alternative: This request is fourfold:

- To move FTE and personal services dollars from the mental health Program Administration line item to the Personal Services line item in the Executive Director's Office Long Bill group (7.0 FTE and $687,706 total funds);
- To move operating dollars ($6,090) associated with the FTE from the mental health Program Administration line to the Operating Expenses line item in the Executive Director's Office Long Bill group;
- To retain the External Quality Review Organization contract costs in the mental health Long Bill group; and
- To reduce the overall count of FTE for the Department based on the number of staff needed for the program.

Move FTE and Personal Services Dollars

Although 9.0 FTE were appropriated in the Long Bill for administration of Medicaid mental health community programs, the Department does not require this many full time staff to administer the program. Health Care Policy and Financing typically contracts with private and public entities for much of its administration of programs. This will continue for the mental health community programs. Although the Department does not require the full FTE count as appropriated, the full amount of funding is needed in order to pay both the necessary staff and to fund contracts for the administration of the program.

The Department has 7.0 State FTE dedicated to the administration of this program. See "Description of Positions" for more information about each FTE. These FTE include:

- Two Behavioral Health Specialists (Health Professional VI)
- One General Professional V
- One General Professional IV
- One General Professional II
- One Budget Analyst III
- One Statistical Analyst II

The Personal Services cost associated with these seven positions is approximately $440,878 (see Table B). 7.0 FTE are requested to be moved to Executive Director's Office, Personal Services.

The Department's request also transfers an additional $246,828 from the mental health Program Administration line to the Personal Services line item in the Executive Director's Office Long Bill group. This funding, previously used by the Department of Human Services for personnel costs, is needed by Health Care Policy and Financing for other contracts for the administration of the program. This funding is needed for actuarial services and Ombudsman services. See Table A for calculations of the $246,828.

Actuarial certification is required by State statute and federal regulations. Depending on whether the current rates are being updated, or whether rates are being recalibrated, this cost can range from $50,000 to $150,000 per year. The Department's other actuarial services (that is, for health maintenance organizations and the Program of All Inclusive Care for the Elderly) are also paid from the Personal Services line item. Therefore, it would be most practical to transfer these funds to the Personal Services line item so that all actuary-related funds are in the same appropriation location. This would facilitate budgeting, accounting, contracting, and procurement efficiencies.

Funding is also needed for the Ombudsman contract. The Department currently contracts with a managed care ombudsman for the medical services side of Medicaid. Health Care Policy and Financing has expanded the current contract so that it can address the needs of Medicaid clients seeking mental health services. A portion of this funding would be used by the Department for these services. The Department's other Ombudsman services for managed care organization are also paid from the Personal Services line item. Again, it would be most practical to transfer these funds to the Personal Services line item so that all funds are in the same appropriation location. This action also creates efficiencies for budgeting, accounting, contracting, and procurement.

Move "Operating Expenses" Dollars

The same FTE require ongoing operating costs for supplies and routine telephone charges. These costs are delineated in Table B. Initial operating costs such as computers, software, and large equipment are not affected in FY 04-05 or FY 05-06 as they were not appropriated by the General Assembly. HB 04-1265 specified that "*all . . . computers and software . . . of the Department of Human Services pertaining to . . . administering all Medicaid Community Mental Health Services for medical assistance recipients are transferred to the State Department and shall become the property thereof."* Therefore, total funds of $6,090 based on the Common Policies for maintenance costs are requested to be moved to Executive Director's Office, Operating Expenses.

Retain External Quality Review Organization

The Department's request is for $352,807 to remain in the Program Administration line item in the Medicaid Mental Health Community Programs Long Bill group. The request is also to rename the line item to External Quality Review Organization. This funding is for federally-required external quality review activities that receive a 75% federal financial participation. This is the amount traditionally allocated for this service.

Reduce Overall FTE

Since 7.0 FTE are needed to administer the program internally, 7.0 FTE are requested to be transferred to Personal Services, and 2.0 FTE are reduced. However, there is no reduction in base dollars requested as the full amount of funding is needed in order to pay both the necessary staff and to fund contracts for the administration of the program.

Description of Positions

The seven positions in the Department administering the Medicaid Mental Health Programs are described below:

1. Health Professional VI. This position is responsible for drafting, negotiating, and processing contracts. This position is the Plan Manager for four MHASAs and is the main liaison with these Plans. Responsibilities include processing grievances referred to the Department, review of health plan information, and working with the Compliance Quality Strategy Team to make sure the Plan is compliant with the contract as well as State and federal regulations and laws.

2. Health Professional VI. This position helps define policies and operations of the program and utilized for clinical expertise. This position is the Plan Manager for four MHASAs and is the main liaison with these Plans. Responsibilities include processing grievances referred to the Department, review of health plan information,

and working with the Compliance Quality Strategy Team to make sure the Plan is compliant with the contract as well as State and federal regulations and laws.

3. General Professional IV. This position is the Behavioral Health and Compliance Specialist and serves as part of the Behavioral Health Team. This position is responsible for leading clinical quality activities and integrating clinical findings into the State Quality Strategy. As the team's quality expert, the position oversees the activities of the External Quality Review Organization and is responsible for related contract management responsibilities, including developing and issuing Requests for Proposal, contract development, negotiations and routing, and all contract related documents. The position displays expertise in the area of client satisfaction, clinical outcome measurement, and quality of care reviews. The position helps select and direct these external review activities, lead internal quality interventions and ensure that clinical findings are integrated into the planning of future activities.

4. General Professional V. This position is the Supervisor of the Health Benefits Unit. The purpose of this position is to initiate priorities within the behavioral health managed care program. Department management delegates senior authority in establishing and maintaining primary working relationships with the behavioral health organizations and stakeholders for the mental health program. This position is responsible for ensuring that the Unit effectively develops and implements managed care contracts and monitors the quality and access to care. This position develops and maintains the managed behavioral health care program.

5. General Professional II. This position assists with policy and contractual issues. Conducts preliminary research on regulatory and contract issues. This position works to resolve grievances that are referred to the Department and utilizes eligibility and claims systems to clarify any eligibility issues. This position is responsible for supporting communication with consumers and the contractors.

6. Statistical Analyst II. This position is responsible for the data analysis of mental health costs and encounters and analyzes drug and health status case mix data.

7. Budget Analyst III. This position performs the mental health external quality review and services projections and prepares all budget document for the new Long Bill group, including the base budget, Change Requests, Supplementals, and fiscal notes. This position monitors and tracks expenditures for all costs in this Long Bill group.

Implementation Schedule:

Task	Month/Year
3 staff transferred from Department of Human Services to Health Care Policy and Financing	April 2004
All 7.0 positions filled for FY 04-05	Approximately September 2004
Ombudsman Contract revised	May 2004
Actuary services procured	Annually as needed to meet State and federal requirements

Calculations for Alternative's Funding:

Summary of Request FY 05-06 for (3) Medicaid Mental Health Community Programs, (A) Program Administration	Total Funds	General Fund	Federal Funds	FTE
FY 05-06 Base Request	$1,046,603	$435,100	$611,503	9.0
Incremental Adjustment	($1,046,603)	($435,100)	($611,503)	(9.0)
Remaining Funds *[eliminate line item]*	$0	$0	$0	0.0

Summary of Request FY 05-06 for (3) Medicaid Mental Health Community Programs, (A) External Quality Review Organization	Total Funds	General Fund	Federal Funds	FTE
FY 05-06 Base Request	$0	$0	$0	0.0
Incremental Adjustment	$352,807	$88,202	$264,605	0.0
New Total *[new line item]*	$352,807	$88,202	$264,605	0.0

Summary of Request FY 05-06 for (1) Executive Director's Office	**Total Funds**	**General Fund**	**Federal Funds**	**FTE**
Personal Services, Incremental Increase	$687,706	$343,853	$343,853	7.0
Operating Expenses, Incremental Increase	$6,090	$3,045	$3,045	0.0
Total Net Incremental Increase for Executive Director's Office	$693,796	$346,898	$346,898	7.0

FY 06-07 out year impact is the same as for FY 05-06.

Table A – Other Personal Services Costs			
	Total Funds	**General Fund**	**Federal Funds**
(3) Medicaid Mental Health Community Programs, (A) Program Administration	$1,046,603	$435,100	$611,503
Subtract estimated Personal Services and Operating Costs delineated in Table B	($446,968)	($223,484)	($223,484)
External Quality Review Organization	($352,807)	($88,202)	($264,605)
Net to transfer to Personal Services for Actuary and Ombudsman Services	$246,828	$123,414	$123,414

Table B - FTE and Operating Costs to Move to "Personal Services" and "Operating Expenses"

Fiscal Year(s) of Request		**FY 05-06**	**FY 06-07**	**FY 05-06**	**FY 06-07**	**FY 05-06**	**FY 06-07**	**FY 05-06**	**FY 06-07**
PERSONAL SERVICES	Title:	Behavioral Health Specialist (Health Professional VI) filled via transfer		Behavioral Health Specialist (Health Professional VI) filled via transfer		General Professional IV filled via transfer		One Budget Analyst III - filled via open competitive announcement	
Number of PERSONS / class title		**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Calculated FTE per classification		**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Annual base salary (monthly * 12)		**65,088**		**77,580**		**60,492**		**56,796**	
Number months working in FY 04-05 and FY 05-06		**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
Salary		$65,088	$65,088	$77,580	$77,580	$60,492	$60,492	$56,796	$56,796
PERA	**10.15%**	$6,606	$6,606	$7,874	$7,874	$6,140	$6,140	$5,765	$5,765
FICA	**1.45%**	$944	$944	$1,125	$1,125	$877	$877	$824	$824
Subtotal Personal Services		$72,638	$72,638	$86,579	$86,579	$67,509	$67,509	$63,385	$63,385
OPERATING									
Supplies @ $500/$500	**$500**	$500	$500	$500	$500	$500	$500	$500	$500
Computer @ $959/$0	**$959**	$0	$0	$0	$0	$0	$0	$0	$0
Office Suite Software @ $300/$0	**$300**	$0	$0	$0	$0	$0	$0	$0	$0
Office Equipment @ $2,021 /$0	**$2,021**	$0	$0	$0	$0	$0	$0	$0	$0
Telephone Base (Annual)	**$369.6**	$370	$370	$370	$370	$370	$370	$370	$370
Subtotal Operating		$870	$870	$870	$870	$870	$870	$870	$870
GRAND TOTAL ALL COSTS		**$73,508**	**$73,508**	**$87,449**	**$87,449**	**$68,379**	**$68,379**	**$64,255**	**$64,255**

Fiscal Year(s) of Request		**FY 05-06**	**FY 06-07**	**FY 05-06**	**FY 06-07**	**FY 05-06**	**FY 06-07**	**FY 05-06**	**FY 06-07**
PERSONAL SERVICES	Title:	General Professional V		Statistical Analyst II		General Professional II		**TOTAL**	
Number of PERSONS / class title		**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**		
Calculated FTE per classification		**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	7.00	7.00
Annual base salary (monthly * 12)		**54,996**		**46,320**		**33,780**			
Number months working in FY 03-04 and FY 04-05		**12**	**12**	**12**	**12**	**12**	**12**		
Salary		$54,996	$54,996	$46,320	$46,320	$33,780	$33,780	$395,052	$395,052
PERA	**10.15%**	$5,582	$5,582	$4,701	$4,701	$3,429	$3,429	$40,097	$40,097
FICA	**1.45%**	$797	$797	$672	$672	$490	$490	$5,729	$5,729
Subtotal Personal Services		$61,375	$61,375	$51,693	$51,693	$37,699	$37,699	**$440,878**	**$440,878**
OPERATING									
Supplies @ $500/$500	**$500**	$500	$500	$500	$500	$500	$500	$3,500	$3,500
Computer @ $959/$0	**$959**	$0	$0	$0	$0	$0	$0	$0	$0
Office Suite Software @ $300/$0	**$300**	$0	$0	$0	$0	$0	$0	$0	$0
Office Equipment @ $2,021 /$0	**$2,021**	$0	$0	$0	$0	$0	$0	$0	$0
Telephone Base (Annual)	**$369.6**	$370	$370	$370	$370	$370	$370	$2,590	$2,590
Subtotal Operating		$870	$870	$870	$870	$870	$870	**$6,090**	**$6,090**
GRAND TOTAL ALL COSTS		**$62,245**	**$62,245**	**$52,563**	**$52,563**	**$38,569**	**$38,569**	$446,968	$446,968

Impact on Other Areas of Government: There is no budgetary impact to any other State agency due to this line item change.

Assumptions for Calculations: There is no annualization to Operating Expenses because no dollars were appropriated or allocated for any one time costs such as computers or office furniture. The base operating amounts per person per Common Policy instructions was used.

POTS are not addressed in this request because they were specifically appropriated to the applicable line items in the FY 04-05 Long Bill (HB 04-1422). POTS for these 7.0 FTE in FY 05-06 have been requested in the applicable POTS lines in the Base Budget Request.

Calculations assume that all positions are filled in FY 05-06 and FY 06-07.

Salaries for filled positions assume the current salary. Salaries for positions vacant at the time of this writing assume minimum salary according to the Department of Personnel and Administration Compensation Plan for FY 04-05. Discrepancies with actual salaries will be accommodated through funding in the Personal Services line item, which is typical protocol.

Funding for External Quality Review Organization activities is calculated at 75% federal financial participation. All other funding is subject to 50% federal financial participation.

The estimates of actuarial services are based on the Department's recent experience with these types of contractors.

The amounts used for Personal Services, Ombudsman, and actuary services are estimates for the purpose of describing the request.

Concerns or Uncertainties of Alternative: There are no concerns with this alternative.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative maintains all administrative costs, including FTE, salaries, operating costs, and other administrative funding, in the (3) Medicaid Mental Health Community Programs, (A) Program Administration line item. There is no change to net FTE, General Fund, total funds, or fund splits.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: This alternative adds administrative burden and confusion by placing a small number of FTE and their related costs in a line item separate from all other personnel in the Department. In addition, it assigns the Department 2.0 FTE more than it needs to administer its assigned programs.

Supporting Documentation

Analytical Technique: Cost Effectiveness Analysis
Both alternatives have the same benefits and program impacts, but Alternative A has a reduced FTE count.

Alternative	Personal Services Funding Net Impact	Operating Expenses Funding Net Impact	FTE Count Net Impact
Alternative A – Transfer Funding	$0	$0	-2.0
Alternative B – Reject Transfer	$0	$0	0.0

Alternative A is the preferred alternative because it has the same benefits as Alternative B but reduces the Department's FTE count.

Quantitative Evaluation of Performance - Compare all Alternatives:

The only quantifiable difference between alternatives is the change in FTE. All other benefits are qualitative, consisting primarily of budget reconciliation administrative efficiencies.

Statutory and Federal Authority:

26-4-123, C.R.S. (2004) - Medicaid Community Mental Health Services - Administration - Rules. *(1) Except as provided for in Subsection (3) of this Section, the State Department shall administer all Medicaid Community Mental Health Services for medical assistance recipients including but not limited to the prepaid capitated single entry point system for mental health services, the fee-for-service mental health services, and alternatives to institutionalization. The administration of Medicaid Community Mental Health Services shall include but shall not be limited to program approval, program monitoring, and data collection. (4) On and after the effective date of this Subsection (4), all positions of employment in the Department of Human Services concerning the powers, duties, and functions of administering all Medicaid Community Mental Health Services for medical assistance recipients transferred to the State Department pursuant to this Section and determined to be necessary to carry out the purposes of this Section by the Executive Director of the State Department shall be transferred to the State Department and shall become employment positions therein. (5) On and after the effective date of this Subsection (5), all items of property, real and personal, including office furniture and fixtures, computers and software, books, documents, and records of the Department of Human Services pertaining to the duties and functions of administering all Medicaid Community Mental Health Services for medical assistance recipients are transferred to the State Department and shall become the property thereof.*

42 C.F.R. 438.310 *(a) Statutory basis. This subpart is based on sections 1932(c)(2), 1903(a)(3)(C)(ii), and 1902(a)(4) of the Act. (b) Scope. This subpart sets forth requirements for annual external quality reviews of each contracting managed care organization (MCO) and prepaid inpatient health plan (PIHP), including-- (1) Criteria that States must use in selecting entities to perform the reviews; (2) Specifications for the activities related to external quality review; (3) Circumstances under which external quality review may use the results of Medicare quality reviews or private accreditation*

reviews; and (4) Standards for making available the results of the reviews. (c) Applicability. The provisions of this subpart apply to MCOs, PIHPs, and to health insuring organizations (HIOs) that began on or after January 1, 1986 that the statute does not explicitly exempt from requirements in section 1903(m) of the Act.

42 C.F.R. 438.6 Contract requirements. *(a) Regional office review. The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in Sec. 438.806 . . . (2) Basic requirements. (i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.*

26-4-119, C.R.S. (2004). Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. *(1) (a) The state department shall make prepaid capitation payment to managed care organizations based upon a defined scope of services. (b) Except as otherwise provided in paragraph (d) of this subsection (1), under no circumstances, including competitive bidding as set forth in paragraph (c) of this subsection (1), shall the state department pay a capitation payment to an MCO that exceeds ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 26-4-118. A certification by a qualified actuary retained by the state department shall be conclusive evidence that the state department has correctly calculated the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 26-4-118.*

Department Objectives Met if Approved: 1.5 To accurately project, report, and manage budgetary requirements to effect executive and legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.