Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 15, 2005
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. (2005)		
Request Title:	Request for FY 06-07 Medical Services Premiums				

	Fund	1 Prior-Year Actual FY 04-05	2 Appropriation FY 05-06	3 Supplemental Request FY 05-06	4 Total Revised Request FY 05-06	5 Base Request FY 06-07	6 Decision/ Base Reduction FY 06-07	7 November 15 Request FY 06-07	8 Budget Amendment FY 06-07	9 Total Revised Request FY 06-07	10 Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	$1,920,474,771	$2,178,221,370	$0	$2,178,221,370	$2,177,202,148	$69,348,101	$2,246,550,249	$0	$2,246,550,249	$69,348,101
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	$935,078,890	$1,042,362,634	$0	$1,042,362,634	$1,038,134,760	$35,346,629	$1,073,481,389	$0	$1,073,481,389	$35,346,629
	GFE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	CF	$0	$76,512	$0	$76,512	$76,512	$0	$76,512	$0	$76,512	$0
	CFE	$30,699,080	$66,834,649	$0	$66,834,649	$85,146,310	($1,527,603)	$83,618,707	$0	$83,618,707	($1,527,603)
	FF	$954,696,801	$1,089,373,641	$0	$1,089,373,641	$1,053,844,566	$35,529,075	$1,089,373,641	$0	$1,089,373,641	$35,529,075
(2) Medical Services Premiums	**Total**	$1,920,474,771	$2,178,221,370	$0	$2,178,221,370	$2,177,202,148	$69,348,101	$2,246,550,249	$0	$2,246,550,249	$69,348,101
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	$935,078,890	$1,042,362,634	$0	$1,042,362,634	$1,038,134,760	$35,346,629	$1,073,481,389	$0	$1,073,481,389	$35,346,629
	GFE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	CF	$0	$76,512	$0	$76,512	$76,512	$0	$76,512	$0	$76,512	$0
	CFE	$30,699,080	$66,834,649	$0	$66,834,649	$85,146,310	($1,527,603)	$83,618,707	$0	$83,618,707	($1,527,603)
	FF	$954,696,801	$1,089,373,641	$0	$1,089,373,641	$1,053,844,566	$35,529,075	$1,089,373,641	$0	$1,089,373,641	$35,529,075

*Column 2, 4, and 5 include Clawback payment.

Letter Notation:

Cash Fund name/Number, Federal Fund Grant Name: CF: Provider Fees and Service Fees CFE: Certified Public Expenditures, Breast and Cervical Cancer Prevention and Treatment Fund, Health Expansion Fund, and Prevention, Early Detection, and Treatment Fund (Transferred from the Department of Public Health and Environment). FF: Title XIX

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

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

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 15, 2005
Priority Number:	DI-2	**OSPB Approval:**		**Date:**	
Program:	Behavioral Health Benefits	**Statutory Citation:**	26-4-119, C.R.S. (2005); 26-4-123, C.R.S. (2005);		
Request Title:	Request for FY 06-07 Medicaid Community Mental Health Services		26-4-532 (7), C.R.S. (2005); 24-22-117, C.R.S. (2005).		

	Fund	1 Prior-Year Actual FY 04-05	2 Appropriation FY 05-06	3 Supplemental Request FY 05-06	4 Total Revised Request FY 05-06	5 Base Request FY 06-07	6 Decision/ Base Reduction FY 06-07	7 November 15 Request FY 06-07	8 Budget Amendment FY 06-07	9 Total Revised Request FY 06-07	10 Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	199,117,604	213,710,216	0	213,710,216	206,653,096	20,616,227	227,269,323	0	227,269,323	20,616,227
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	75,363,053	83,119,904	0	83,119,904	83,121,915	4,099,680	87,221,595	0	87,221,595	4,099,680
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	45,522,078	0	45,522,078	37,231,173	12,056,627	49,287,800	0	49,287,800	12,056,627
	FF	75,363,053	85,068,234	0	85,068,234	86,300,008	4,459,920	90,759,928	0	90,759,928	4,459,920
(3) Medicaid Mental Health Community Programs, (A) Medicaid Mental Health Capitation Base Payments	**Total**	149,346,526	168,915,966	0	168,915,966	171,378,473	8,492,764	179,871,237	0	179,871,237	8,492,764
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	74,673,263	82,514,992	0	82,514,992	82,517,003	3,888,305	86,405,308	0	86,405,308	3,888,305
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	1,937,651	0	1,937,651	3,166,373	355,916	3,522,289	0	3,522,289	355,916
	FF	74,673,263	84,463,323	0	84,463,323	85,695,097	4,248,543	89,943,640	0	89,943,640	4,248,543
(3) Medicaid Mental Health Community Programs, (B) Other Medicaid Mental Health Payments, Medicaid Mental Health Fee for Service Payments	**Total**	1,379,580	1,209,823	0	1,209,823	1,209,823	422,753	1,632,576	0	1,632,576	422,753
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	689,790	604,912	0	604,912	604,912	211,376	816,288	0	816,288	211,376
	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	689,790	604,911	0	604,911	604,911	211,377	816,288	0	816,288	211,377
(3) Medicaid Mental Health Community Programs, (B) Other Medicaid Mental Health Payments, Medicaid Mental Health Child Placement Agency	**Total**	2,436,950	6,149,084	0	6,149,084	6,149,084	0	6,149,084	0	6,149,084	0
	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	2,436,950	6,149,084	0	6,149,084	6,149,084	0	6,149,084	0	6,149,084	0
	FF	0	0	0	0	0	0	0	0	0	0

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 15, 2005
Priority Number:	DI-2	**OSPB Approval:**		**Date:**	
Program:	Behavioral Health Benefits	**Statutory Citation:**	26-4-119, C.R.S. (2005); 26-4-123, C.R.S. (2005);		
Request Title:	Request for FY 06-07 Medicaid Community Mental Health Services		26-4-532 (7), C.R.S. (2005); 24-22-117, C.R.S. (2005).		

	Fund	1 Prior-Year Actual FY 04-05	2 Appropriation FY 05-06	3 Supplemental Request FY 05-06	4 Total Revised Request FY 05-06	5 Base Request FY 06-07	6 Decision/ Base Reduction FY 06-07	7 November 15 Request FY 06-07	8 Budget Amendment FY 06-07	9 Total Revised Request FY 06-07	10 Change from Base in Out Year FY 07-08
(3) Medicaid Mental Health Community Programs, (B) Other Medicaid Mental Health Payments, Medicaid Anti-Psychotic Pharmaceuticals	**Total**	45,954,548	37,435,343	0	37,435,343	27,915,716	11,700,711	39,616,427	0	39,616,427	11,700,711
	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	45,954,548	37,435,343	0	37,435,343	27,915,716	11,700,711	39,616,427	0	39,616,427	11,700,711
	FF	0	0	0	0	0	0	0	0	0	0

The Department requests the release of funding restrictions for FY 04-05 overexpenditures of $2,382,301 in the Medicaid Mental Health Capitation Payments line and $158,007 in Medicaid Mental Health Fee for Service Payments.

Letter Notation:

Cash Fund name/number, Federal Fund Grant name:

CFE: Breast and Cervical Cancer Prevention and Treatment Fund - Fund 15D FF: Title XIX

CFE: Health Care Expansion Fund - Fund 18K FF: Title XIX

CFE: Cessation, Prevention, and Detection Fund - 18N 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:)

Schedule 6											
Change Request for FY 06-07											
Department:	Health Care Policy and Financing			**Dept. Approval by:**	John Bartholomew		**Date:**	November 15, 2005			
Priority Number:	DI - 4			**OSPB Approval:**			**Date:**				
Program:	Information Technology Contract Monitoring			**Statutory Citation:**	24-4-403.7 (3) (b), C.R.S. (2005) and 24-75-102, C.R.S. (2005)						
Request Title:	Medicaid Management Information System Federally Mandated Reprocurement										
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	9,450	579,600	0	579,600	327,600	412,500	740,100	0	740,100	55,200
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,363	132,120	0	132,120	74,677	81,106	155,783	0	155,783	5,898
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	6,086	0	6,086	3,440	4,331	7,771	0	7,771	579
	FF	7,087	441,394	0	441,394	249,483	327,063	576,546	0	576,546	48,723
(1) Executive Director's Office, Medicaid Management Information System Reprocurement							See also "(M)" Headnote				
	Total	9,450	579,600	0	579,600	327,600	412,500	740,100	0	740,100	55,200
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,363	132,120	0	132,120	74,677	81,106	155,783	0	155,783	5,898
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	6,086	0	6,086	3,440	4,331	7,771	0	7,771	579
	FF	7,087	441,394	0	441,394	249,483	327,063	576,546	0	576,546	48,723
Letter Notation:	$90,000 shall be transferred to the Governor's Office of Innovation and Technology and shall be comprised of $18,942 General Fund, $945 Children's Basic Health Plan Cash Funds Exempt, and $70,113 federal funds from the line item Medicaid Management Information System Reprocurement. The Department also requests an "(M)" Headnote exception in the FY 06-07 Long Bill.										
Cash Fund name/number, Federal Fund Grant name:				FF: Title XIX, Title XXI; CFE: Children's Basic Health Plan Trust Fund							
IT Request:	**X Yes**	**No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)								
Request Affects Other Departments:	**X Yes**	**No**	Governor's Office of Innovation and Technology								

CHANGE REQUEST for FY 06-07
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:	Medicaid Management Information System Federally-Mandated Reprocurement
Long Bill Line Item(s)	(1) Executive Director's Office, Medicaid Management Information System Reprocurement
State and Federal Statutory Authority:	26-4-403.7 (3) (b), C.R.S. (2005); 24-75-102, C.R.S. (2005); State of Colorado Fiscal Rules, Rule 7.3 (2005); 42 C.F.R. §433.119 (c); 42 C.F.R.§443.120 (a) and (b)

Summary of Request (Alternative A): This request is for additional funding for 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 on June 7, 2004, Decision Item #9 submitted November 1, 2004, and Supplemental Item #5 and Budget Amendment #2 submitted January 3, 2005. This request is for $90,000 to be transferred to the Governor's Office of Innovation and Technology for independent verification and validation assistance, plus $322,500 in additional funds for enhancement work activities at 90% federal funds participation, and regular reprocurement activities at 75% federal funds participation for Medicaid, and 65% federal funds participation for the Children's Basic Health Plan. An "(M)" Headnote exception is also requested.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Medicaid Management Information System is a complex system for processing claims, paying capitations, and conducting prior authorization reviews for certain medical

services and pharmacy prescriptions. The fiscal agent for the Medicaid Management Information System is a private contractor that administers the system. The Department's fiscal agent has been ACS (Affiliated Computer Services, or Affiliated Computer Services State Healthcare, LLC., dba Consultec, LLC) since December 1, 1998. The last year of the current contract ends November 30, 2006. 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. Verbal approval had been given by the Centers for Medicare and Medicaid Services. The extension was requested because of competing priorities of Colorado Benefits Management System and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 to be reprocured and operational by December 1, 2006. On October 11, 2005, the Department requested a reconsideration of its request for an extension to complete reprocurement or to defer penalties. The Department can not be certain when a response to reconsideration may be received from the Centers for Medicare and Medicaid Services, or if it will be favorable.

Due to pressing needs of the Colorado Benefits Management System, only a limited amount of progress had been possible on the Medicaid Management Information System reprocurement during the spring and summer of 2005. The Department acknowledges that the federal December 1, 2006 deadline for reprocurement will be missed. The limited progress caused $633,150 of FY 04-05 funding to revert. Since no contract was in place for the consultant, it was not possible to request a roll forward as would have been allowed by the State of Colorado Fiscal Rules, Rule 7-3 if a consultant's contract had been already in place.

Successfully continuing the reprocurement process is vital to the Department of Health Care Policy and Financing because the Department does rely on the selected fiscal agent to operate the Medicaid Management Information System over the three to eight years that the new contract with the fiscal agent will be in effect. 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, including training
- Ensuring compliance with HIPAA regulations
- Publishing provider notifications and manuals
- Maintaining operability of the Medicaid Management System according to Health Care Policy and Financing requirements

In prior requests over the past two years for the reprocurement process, the Department planned to hire a consultant to prepare the Request for Proposal for a new fiscal agent in accordance with the regulations of the federal Centers for Medicare and Medicaid Services. The Department would encourage potential fiscal agent bidders to increase competition. The Department has planned a bidders' conference to answer questions about the scope of work and to clarify fiscal agent requirements expected of potential bidders. The consultant will assist with the evaluation of bids. After the fiscal agent is selected from the bids, the consultant will develop a contract monitoring and performance plan to track development and scheduled progress. Although the consultant was not in place in FY 04-05, the consultant did start in FY 05-06.

General Description of Alternative: This Alternative requests funding to continue the contracted consultant beyond the already funded time ending in December 2006 to the close of FY 06-07 ending in June 2007. In addition, this request would increase the consultant costs in FY 06-07 from what was requested on January 3, 2005. Lastly, this request asks for temporary "(M)" Headnote flexibility in case of loss of federal financial participation for the consultant due

to not having a "certified" system by the time that the federal Centers for Medicare and Medicaid Services requested.

Since there was a need to concentrate on the Colorado Benefits Management System, little progress was achieved on reprocurement for the Medicaid Management Information System during FY 04-05. Consequently, much of the work needed to be accomplished in FY 04-05 has been shifted to FY 05-06, and work scheduled for FY 05-06 has slipped to FY 06-07. However, the Department expects the consultant to work in an expeditious manner, so that some "catching up" can be accomplished, if possible. Furthermore, the process was expected to be completed by December 2006, but now will continue through at least June 2007 and possibly longer. If a different fiscal agent is selected during reprocurement, enhancement work may even continue into FY 07-08. The consultant will need to continue working until the new fiscal agent is operating the Medicaid Management Information System and until the different fiscal agent, if so selected, can complete necessary enhancements for the Medicaid Management Information System to function efficiently.

More funding is needed so that the consultant can continue the agreed functions beyond December 1, 2006, the date that was originally expected to be the completion date of the consultant's contract and the completion of the reprocurement processes. The consultant would be spending more hours of work during FY 06-07, and hours of work might still be occurring in FY 07-08.

The Governor's Office of Innovation and Technology would assist reprocurement by managing the independent verification and validation, by using the Program Management Office services, by submitting monthly status reports to the Information Management Committee, and by managing the risk associated with completing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identifier rule implementation (see DI #7) at the same time as reprocurement continues.

The Department did receive November 2, 2004 approval from the Centers for Medicare and Medicaid Services for 90% federal funds participation for enhancement only

activities during reprocurement, and 65% and 75% federal funds participation for regular reprocurement activities for the Children's Basic Health Plan and Medicaid, respectively. On September 12, 2005 the Department received another updated letter from the federal Centers for Medicare and Medicaid Services that reconfirms availability of 90% federal funds participation for as much as 22% of the funded activities to be enhancements. Therefore, the Department has allocated the funding request accordingly.

The Department realizes that the delay in reprocurement is likely to result in decreased federal funds participation, so the Department may need additional General Fund in order to support the consultant's continued work. During FY 06-07, the Medicaid portion of the funding may receive reduced federal financial participation if the federal Centers for Medicare and Medicaid Services decide to decertify Colorado's Medicaid Management Information System due to unfinished reprocurement by November 30, 2006. When a Medicaid Management Information System misses its deadline for reprocurement, the Centers for Medicare and Medicaid Services may reduce the federal funds participation rate for both the current operating system and for lagging reprocurement. 42 Code of Federal Regulations, §433.120(a) states that after "the system no longer meets the conditions of reapproval in §433.119, [the Centers for Medicare and Medicaid Services] will reduce [federal financial participation] for system operations for at least four quarters." §433.120(b) further states that "[the Centers for Medicare and Medicaid Services] will not reduce [federal financial participation] by more than 10 percentage points in any four quarter period." The reduction begins during the next calendar quarter after decertification. It is likely that decertification will be determined in December 2006 after the reprocurement due date is missed on December 1, 2006. The Centers for Medicare and Medicaid Services use certain criteria to determine the percentage reduction, but the Department can not be certain what the particular reduction will be. The reduction could be the maximum allowable of 10 percentage points.

If decertification and reduction in federal funds participation occurs, the Department would need an exception to the "(M)" Headnote to temporarily allow for more General Fund to offset the decrease in federal funds participation because the Department still would need the full amount of the requested funding in order to complete the

reprocurement within the time frame. Any further delays due to inadequate funding would risk additional loss of federal funds participation. If decreased federal funding is received, the Department will submit a Supplemental Request for General Fund to address the reduced federal match. Until the Supplemental Request is approved, the Department would need to continue to work, and would temporarily utilize the granted "(M)" Headnote flexibility. The following paragraph quotes, in part, the "(M)" Headnote in the FY 05-06 Long Bill, SB 05-209, with wording added for the exception that the Department would request in **boldface type**:

> *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 proportionally,* ***except for the Department of Health Care Policy and Financing's Medicaid Management Information System Contract line item and Medicaid Management Information System Reprocurement line item for the purpose of compliance with federally required reprocurement of the Medicaid Management Information System.***

The Department assumes that reprocurement processes will go forward according to the revised schedule. However, if unforeseen circumstances cause a delay resulting in not totally using the full appropriation for any fiscal year, the Department would plan to use the roll forward process permitted in the State of Colorado Fiscal Rules, Rule 7-3 because there is a contract in place for the consultant. Therefore, a large reversion of funds, as occurred at the end of FY 04-05, is not likely to recur.

The Department can not be certain who will be selected as the ongoing fiscal agent, so the Implementation Schedule reflects that uncertainty.

Implementation Schedule:

Task	Month/Year
If incumbent fiscal agent is selected again	
Executed contract with fiscal agent	July 1, 2006
System transition begins (with enhancements automatically included)	August 1, 2006
Transition complete	June 30, 2007
If reprocurement results in a different fiscal agent	
Executed contract and System transition begins immediately	July 1, 2006
Parallel processing/acceptance testing of transition	May 1, 2007 to June 30, 2007
Transition complete, start of MMIS operations by new fiscal agent	July 1, 2007
Enhancements that new fiscal agent may need to make	February 1, 2008
For either incumbent or different fiscal agent	
Independent Verification and Validation Assistance by the Governor's Office of Innovation and Technology	During FY 06-07

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Request [Items below total to this]	$740,100	$155,783	$7,771	$576,546
Base Funding for Medicaid Management Information System Federally-Mandated Reprocurement [matches column 5 on Schedule 6]	$327,600	$74,677	$3,440	$249,483
Incremental Funding for Medicaid Management Information System Federally Mandated Reprocurement [column 6 on Schedule 6]	$412,500	$81,106	$4,331	$327,063

Note: The $90,000 to transfer to the Governor's Office of Innovation and Technology is also included in the $740,100 total funding for the Medicaid Management Information System Reprocurement line item in this request.

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Request [Items below total to this]	$55,200	$5,898	$579	$48,723
Incremental Funding for Medicaid Management Information System Federally Mandated Reprocurement [column 10 on Schedule 6]	$55,200	$5,898	$579	$48,723

Table A: Calculations for Consultants for Past Years and Future Years						
Fiscal Year	**Number of Months Consultant Needed**	**Type of Consultant**	**Number of Consultants**	**Hours Needed**	**Hourly Rate**	**Totals**
FY 04-05 Appropriated*	9	Senior Consultant	1	1,512	$175	$264,600
	9	Consultant	2	1,512	$125	$378,000
					Grand Total	**$642,600**
FY 05-06 Appropriated	4	Senior Consultant	0.5	672	$175	$58,800
	8	Senior Consultant	1	1,344	$175	$232,200
	4	Consultant	1	672	$125	$84,000
	8	Junior Consultant	2	1,344	$75	$201,600
					Grand Total	**$579,600**
FY 06-07 Requested	12	Senior Consultant	1.0	1,980	$175	$346,500
	12	Junior Consultant	2.0	2,024	$75	$303,600
					Grand Total	**$650,100**
FY 07-08 Requested	7	Senior Consultant	1.0	1,176	$175	$205,800
	7	Junior Consultant	2.0	1,180	$75	$177,000
					Grand Total	**$382,800**

* Of the FY 04-05 appropriation totaling $642,600, only $9,450 was actually spent due to delays in starting the reprocurement project.

Table B: Independent Verification and Validation Costs		
Fiscal Year	**Work Activities**	**Costs**
FY 06-07	Independent Verification and Validation Assistance by the Governor's Office of Innovation and Technology	$90,000
FY 07-08	No Independent Verification and Validation Assistance Requested at This Time	$0

Table C1: Funding Splits Between Medicaid and Children's Basic Health Plan for FY 06-07						
FY 06-07			**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
	Total Need		$740,100	$155,783	$7,771	$576,546
	Base Request		$327,600	$74,677	$3,440	$249,483
	Additional Funding Needed		$412,500	$81,106	$4,331	$327,063
	Program Splits	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
	Total Costs	100%	$740,100	$155,783	$7,771	$576,546
	Medicaid Costs	97%	$717,897	$155,783	$0	$562,114
	Enhancement Costs	22% of 97%		10% of 22%	0% of 22%	90% of 22%
			$157,937	$15,793	$0	$142,144
	Reprocurement Costs	78% of 97%		25% of 78%	0% of 78%	75% of 78%
			$559,960	$139,990	$0	$419,970
	Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
			$22,203	$0	$7,771	$14,432

Table C2: Funding Splits Between Medicaid and Children's Basic Health Plan for FY 07-08						
FY 07-08			**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
	Total Need		$382,800	$80,575	$4,019	$298,206
	Base Request from FY 06-07		$327,600	$74,677	$3,440	$249,483
	Incremental Funding for FY 07-08		$55,200	$5,898	$579	$48,723
	Program Splits	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
	Total Costs	100%	$382,800	$80,575	$4,019	$298,206
	Medicaid Costs	97%	$371,316	$80,575	$0	$290,741
	Enhancement Costs	22% of 97%		10% of 22%	0% of 22%	90% of 22%
			$81,690	$8,169	$0	$73,521
	Reprocurement Costs	78% of 97%		25% of 78%	0% of 78%	75% of 78%
			$289,626	$72,406	$0	$217,220
	Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
			$11,484	$0	$4,019	$7,465

Impact on Other Areas of Government: The Governor's Office of Innovation and Technology will assist with independent verification and validation.

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(5) Office of Innovation and Technology, Medicaid Management Information System Reprocurement Transfer (new line)	$90,100	$0	$90,000	$0

Assumptions for Calculations: If reprocurement results in a different fiscal agent, the new fiscal agent will still be completing enhancements to the system until February 1, 2008.

Medicaid funding for reprocurement is assumed to be 97% of the total. Within the 97% total, 22% is assumed to be related to enhancements to the system, and 78% is assumed to be for regular reprocurement activities. Enhancements can be funded at 90% federal financial participation, while regular reprocurement is approved at 75% federal financial participation. If the percentages of federal financial participation change for any reason in the future, such as decertification, the Department would submit a Supplemental Request.

For this request, the Children's Basic Health Plan contribution to the total costs is assumed to be 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. Federal financial participation for Title XXI, the Children's Basic Health Plan, is 65%, the usual percentage for Title XXI administrative costs.

Table A calculates the costs for consultants and 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, and a junior consultant approximately $75 per hour. The per hour costs and the number of hours needed were estimated by the Department based on prior experience with Information Technology projects that involve establishing requirements for the contractor, fiscal agent testing of transitioned systems, user acceptance testing, and implementation of a system. The consultant would oversee all of these mentioned tasks. The Department gained recent experience to gage the time frames necessary for the mentioned tasks by observing the time frames used by consultants and contractors when implementing the Health Insurance Portability and Accountability Act regulations required over the past few years. Supplemental Item #5 and Budget Amendment #2 submitted on January 3, 2005 estimated the consulting hours for FY 06-07 at 3,024 for July through December. The

requested consultant hours for FY 06-07 in Table A are approximately double (6,028)[1] to extend the services to at least June 2007. If the current contractor is not selected during the reprocurement process, an additional 7 months of consulting will be necessary in FY 07-08 for an additional 3,536 hours.

The Governor's Office of Innovation and Technology estimated the cost for independent verification and validation. This requested funding would be appropriated to the Department of Health care Policy and Financing, to draw a federal match, but then transferred to the Governor's Office of Innovation and Technology as Cash Funds Exempt.

In FY 06-07, the combination of funding needed for the consultants of $650,100 and the funding needed for independent verification and validation of $90,000 results in the total need.

Concerns or Uncertainties of Alternative: The Department has assumed that the reprocurement processes will be completed in FY 06-07, but it is difficult to be entirely certain. If a different fiscal agent is selected, the start of operations by the new fiscal agent probably will occur by July 1, 2007, but any needed enhancements could take until February 2008. That situation would require additional funding to keep the consultant in place until the enhancements 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 months in FY 06-07 after December 2006 for the consultant's contract to assist the Department with completing the reprocurement processes and would not allow for flexibility in the application of the "(M)" Headnote.

Calculations for Alternative's Funding: No change in funding with this alternative and no flexibility for the "(M)" Headnote.

[1] 6,028 equals 1 senior consultant at 1,980 hours plus 2 junior consultants at 2,024 hours each (see table A).

Concerns or Uncertainties of Alternative: The Department does not have the staff or the expertise in the Medicaid Management Information System monitoring work group to perform the duties that the consultant performs. The Department would have to stop the consultant's work after December 2006. Without the consultant's duties being completed, the completion of reprocurement would be further delayed. If reprocurement were further delayed, the Department risks reductions in federal financial participation to as low as 50%, the minimum level, for the time frame that reprocurement is still not completed. Reductions to the federal financial participation rate would increase the need for General Fund. The Department would need to submit a Supplemental Request for additional General Fund for the Medicaid Management Information System Contract line item if federal funds are reduced due to extended reprocurement.

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.

Fiscal Year	Investment: Alternative A	Cost Avoidance (Potential Loss to State): Alternative B
FY 06-07	Total funds of $740,100 with State funds of $155,783 General Fund and $7,771 in Cash Funds Exempt	Without consultant during FY 06-07 and FY 07-08, reprocurement may continue up to three more fiscal years through FY 10-11. Loss of federal funds participation for three more years is estimated at $5,339,976[2] per year minimally and likely would be higher due to continued increasing claims volume causing higher operating costs for the Medicaid Management Information System.
FY 07-08	Total funds of $382,800 with State funds of $80,575 General Fund and $4,019 Cash Funds Exempt	
FY 08-09 through FY 10-11	No funds requested for reprocurement	
Total Cost to State	**$248,148 in State funds appropriation**	**At least $5,339,976 per year lost in federal financial participation for three more years (FY 08-09 through FY 10-11) = $16,019,928 lost.**

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A would result in a qualified fiscal agent procured under federal and state required competitive bidding processes and a transition phase with enhancements so that the Medicaid Management Information System can continue operating without interruption. Alternative B would extend the time frame that federal financial participation is at risk and could cause the State to lose $16 million more in federal funds ($5,339,976 times 3 more years = $16,019,928).

Alternative A is the preferred alternative.

Statutory and Federal Authority:

26-4-403.7 (3) (b), C.R.S. (2005) (3*) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payment and eligibility determinations or other related transactions may be*

[2] The Medicaid Management Information System Contract has a Base Request in FY 06-07 of $23,047,082 in total funds and $16,863,517 in federal funds. If reprocurement is not successful by FY 08-09, federal funds participation could drop to 50% of $23,047,082, or $11,523,541. This would be a loss of $5,339,976 ($16,863,517 - $11,523,541) in federal funds participation.

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

24-75-102(1), C.R.S. (2005) *Except as otherwise provided by law, all moneys appropriated by the general assembly may be expended or encumbered, if authorized by the controller, only in the fiscal year for which appropriated. Except as otherwise provided by law, any moneys unexpended or not encumbered from the appropriation to each department for any fiscal year shall revert to the general fund or, if made to a special fund, to such special fund. Determination of such expenditures or encumbrances shall be made no later than thirty-five days after the close of the fiscal year and pursuant to the provisions of section 24-30-202 (11).*

State of Colorado Fiscal Rules, Rule 7.3 (2005) EXCEPTIONS TO RULE: The State Controller may approve the carry over of the unexpended appropriations to a subsequent fiscal year under one or more of the following: .01 The appropriated funds have been legally committed by purchase order or contract and there are extenuating circumstances that warrant carry over of the remaining appropriation.

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 reduced, beginning with the next quarter.*

42 C.F.R. §433.120 *(a) If [Centers for Medicare and Medicaid Services] determines after the reapproval review that the system mo longer meets the conditions of reapproval in §433.119, [Centers for Medicare and Medicaid Services] will reduce FFP for system operations for at least four quarters…(b) however, [Centers for Medicare and Medicaid] will not reduce FFP by more than 10 percentage points in any four-quarter period.*

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 contractors, including other State and local agencies, by more outcome-based contracting and more sophisticated contract management.

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	DI-5	**OSPB Approval:**		**Date:**
Program:	Community Based Long Term Care	**Statutory Citation:**	26-4-522 (4) (b), C.R.S. (2005)	
Request Title:	Increased Funding for Single Entry Point Audits			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	1,920,474,771	2,178,256,710	0	2,178,256,710	2,177,237,488	0	2,177,237,488	0	2,177,237,488	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,380,304	0	1,042,380,304	1,038,152,430	0	1,038,152,430	0	1,038,152,430	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	0	85,146,310	0	85,146,310	0
	FF	954,696,801	1,069,734,291	0	1,069,734,291	1,053,862,236	0	1,053,862,236	0	1,053,862,236	0
(1) Executive Director's Office, Single Entry Point Audits	**Total**	0	35,340	0	35,340	35,340	76,660	112,000	0	112,000	76,660
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	17,670	0	17,670	17,670	38,330	56,000	0	56,000	38,330
	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	17,670	0	17,670	17,670	38,330	56,000	0	56,000	38,330
(2) Medical Services Premiums	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	(76,660)	2,177,125,488	0	2,177,125,488	(76,660)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	(38,330)	1,038,096,430	0	1,038,096,430	(38,330)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	0	85,146,310	0	85,146,310	0
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	(38,330)	1,053,806,236	0	1,053,806,236	(38,330)

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX, CFE: Breast and Cervical Cancer Prevention Fund, Colorado Autism Treatment Fund, Health Care Expansion Fund, Transfers from Department of Public Health and Environment, and Certification of Public Expenditures

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 06-07
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:	Increased Funding for Single Entry Point Audits
Long Bill Line Item(s)	(1) Executive Director's Office, Single Entry Point Audits; (2) Medical Services Premiums
State and Federal Statutory Authority:	26-4-522 (4) (b), C.R.S. (2005); CFR Title 45, Part 74.53 (4) (e)

Summary of Request (Alternative A): This Change Request increases funding for Single Entry Point Audits by $76,660, to hire an outside contractor to perform the federally required annual audits of Single Entry Point providers. Typically, these audits result in identified overpayments. While the amount that could be returned to both the State and the federal government cannot be projected exactly, it is assumed that savings in the Medical Services Premiums appropriation will be at least enough to offset the audit services costs.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: There is a federal requirement to perform audits as part of the annual certification process for Single Entry Point agencies. Prior to FY 04-05, the Department of Human Services' field audit staff, through an interagency agreement, performed these audits for $35,340. Resources devoted to performing these audits were minimal and the Department of Human Services reviewed three of the 25 Single Entry Point agencies, on average, each year. These audits, while identifying inappropriate charges, were unable to recoup all overpayments due to the delay in conducting the reviews. For FY 04-05, the Department

of Human Services' field audit staff was reduced by 4.0 FTE. Because of this reduction, the Department of Human Services lacked sufficient resources to enter into an interagency agreement for performing these Single Entry Point audits. Therefore, at the end of FY 04-05, the Department retained an outside contractor to review cost reports provided by the 25 Single Entry Point providers.

Due to limited time and funding, the contractor reviewed each cost report and determined which agencies posed the highest risk. On site audits are then performed on any agency measuring at the highest risk level to the extent that funds allow. State auditors have determined that the Single Entry Point audit program has been out of federal compliance for the past three years due to not conducting the required annual audits of the 25 Single Entry Point Agencies, not conducting them in a timely manner, and not recouping improper payments.

General Description of Alternative:

In order to bring the audits into compliance with State auditor findings, to increase the accuracy of Single Entry Point Agency bills, and to potentially recoup greater amounts of improper payments, the Department requests an increase to the appropriation to hire an outside auditor. With additional resources the outside contractor will develop cost category definitions and give them to providers to insure consistent procedures among all Single Entry Point entities.

The contracted auditor will perform annual audits of all 25 providers located throughout the state to identify discrepancies, write reports, and assist in the recovery of overpayments. Single Entry Point agencies receive $17,030,016 annually in funding. If the audits are able to identify 0.66% (implying 99.34% billing accuracy) in inappropriate payments, the cost of performing these audits would pay for themselves. With this funding, the contracted auditor will develop risk factors and definitions of risk levels. They will determine if cost representations are accurate and report on results of the review. The contractor will travel to facilities around the state to determine compliance with generally accepted accounting principles, contract provisions, legislative intent and regulatory provisions in relation to the Single Entry Point Agency's cost reports. Additionally, they will maintain files of the audit work papers, and coordinate with State

agencies to defend the Department's position in litigation proceedings that arise due to recoveries identified in the audits.

Implementation Schedule:

Task	Month/Year
Request for Proposal for Single Entry Point Agency Contract Auditor Issued	February 2006
Contract Written	March 2006
Contract Awarded/Signed	June 2006
Start-Up Date of New Contract with Auditor	July 2006

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request FY 06-07 (Column 6)	$0	$0	$0
(1) Executive Director's Office- Single Entry Point Audits	$76,660	$38,330	$38,330
(2) Medical Services Premiums	($76,660)	($38,330)	($38,330)

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request FY 07-08 (Column 10)	$0	$0	$0
(1) Executive Director's Office- Single Entry Point Audits	$76,660	$38,330	$38,330
(2) Medical Services Premiums	($76,660)	($38,330)	($38,330)

Table 1	
Estimated Contractor Costs	
Number of Single Entry Point Agencies	25
Cost per Audit	$4,480
Total need for FY 06-07 and FY 07-08	$112,000
FY 06-07 Base Funding	$35,340
Requested Increase for Contracted Auditor	$76,660

Impact on Other Areas of Government: None

Assumptions for Calculations: Table 1 is a calculation of the anticipated costs to perform the audits. The Department assumes that the cost per audit would be approximately $4,480. This is based on comparable audit costs for programs with similarly sized entities that require review, such as nursing facilities[1], or hospitals and federally qualified health clinics[2]. The Auditors would review, on an annual basis, all 25 Single Entry Point Agencies' operations and reports. ($4,480 per facility * 25 facilities = $112,000).

Concerns or Uncertainties of Alternative: The Department is basing the potential audit costs of the Single Entry Point agencies on the cost of performing audits on similarly sized entities in other program areas, however the winning contractor's bid amount is unknown and the appropriation request may not be sufficient. Additionally, the amount of errors and inappropriate payments actually identified and recouped during the audits is not known.

[1] In FY 04-05 there were 198 nursing facilities, with a total audit appropriation of $1,097,500 this equals $5,542 per entity.
[2] In FY 04-05 the appropriation for hospitals and federally qualified health clinics was increased by $100,000 to perform 25 field audits which equals $4,000 per entity.

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

General Description of Alternative: Maintain current funding level for Single Entry Point Audits.

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

Concerns or Uncertainties of Alternative: At the current funding level, the request for proposal will either fail or the successful bidder would not perform as many audits of Single Entry Point providers as required to adhere to federal requirements and comply with State auditor findings. There would be fewer recoveries of improperly disbursed funds. Therefore, the program would continue to be out of compliance with both the State auditors and federal requirements.

Alternative C:

General Description of Alternative: In order to bring the program into compliance with federal regulations, to increase the accuracy of Single Entry Point agency bills and to recoup greater amounts of improper payments, this alternative is to increase the appropriation for this program to hire 1.0 FTE to perform the audits. With this additional resource, the Department will develop cost category definitions and provide them to providers to insure consistent procedures among all Single Entry Point Agencies. The employee would conduct annual audits of all 25 providers located throughout the state to identify discrepancies, write reports and assist in recovery of overpayments. By having an FTE dedicated to this function, the Department may be able to insure greater consistency year over year in the annual evaluations of the Single Entry Point entities. While the cost of this alternative is less than Alternative A, this option will not provide the same level of resources to perform and support the findings as alternative A. The amount of recoveries under this alternative is assumed to be less. Therefore this option is also considered to be budget neutral in year one.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period Completed	February 2006
FTE Hired	July 2006
Audit Plan Written	August 2006
Start-Up Date	September 2006
Reports Issued	Ongoing FY 06-07

Calculations for Alternative's Funding:

Summary of Alternative FY 06-07	FTE	Total Funds	General Fund	Federal Funds
Total Request	1.0	$0	$0	$0
(1) Executive Director's Office, Personal Services	1.0	$56,715	$28,358	$28,357
(1) Executive Director's Office, Operating Expenses		$18,405	$9,202	$9,203
(1) Executive Director's Office, Single Entry Point Audits		($35,340)	($17,670)	($17,670)
(2) Medical Services Premiums		($39,780)	($19,890)	($19,890)

Summary of Alternative FY 07-08	FTE	Total Funds	General Fund	Federal Funds
Total Request	1.0	($3,815)	($1,907)	($1,908)
(1) Executive Director's Office, Personal Services	1.0	$56,715	$28,358	$28,357
(1) Executive Director's Office, Operating Expenses		$14,590	$7,295	$7,295
(1) Executive Director's Office, Single Entry Point Audits		($35,340)	($17,670)	($17,670)
(2) Medical Services Premiums		($39,780)	($19,890)	($19,890)

Table 2 - FTE and Operating Costs				***GRAND TOTAL***	
Fiscal Year(s) of Request		**FY 06-07**	**FY 07-08**	**FY 06-07**	**FY 07-08**
PERSONAL SERVICES	Title:	**Auditor III**		To two decimal	
Number of PERSONS / class title		**1**	**1**		
Calculated FTE per classification		**1.00**	**1.00**	1.00	1.00
Annual base salary (monthly * 12)	**$**	**50,820**			
Number months working in FY 06-07 and FY 07-08		**12**	**12**		
Salary		$ 50,820	$ 50,820	$ 50,820	$ 50,820
PERA	**10.15%**	$ 5,158	$ 5,158	$ 5,158	$ 5,158
FICA	**1.45%**	$ 737	$ 737	$ 737	$ 737
Subtotal Personal Services		$ 56,715	$ 56,715	$ 56,715	$ 56,715
OPERATING					
Supplies @ $500/$500	**$ 500**	$ 500	$ 500	$ 500	$ 500
Computer @ $1,500/$0**	**$ 1,500**	$ 1,500	$ -	$ 1,500	$ -
Office Suite Software @ $294/$0	**$ 294**	$ 294	$ -	$ 294	$ -
Office Equipment @ $2,021 /$0	**$ 2,021**	$ 2,021	$ -	$ 2,021	$ -
Telephone Base (Annual)	**$ 369.6**	$ 370	$ 370	$ 370	$ 370
Travel (9,000 Miles at $0.28 Per Mile)		$ 2,520	$ 2,520	$ 2,520	$ 2,520
Lodging ($100 * 5 Days *16 Audits)		$ 8,000	$ 8,000	$ 8,000	$ 8,000
Meals ($40 * 5 Days * 16 Audits)		$ 3,200	$ 3,200	$ 3,200	$ 3,200
Subtotal Operating		$ 18,405	$ 14,590	$ 18,405	$ 14,590
GRAND TOTAL ALL COSTS		**$ 75,120**	**$ 71,305**	**$ 75,120**	**$ 71,305**
Less: Current Appropriation		($35,340)	($35,340)	($35,340)	($35,340)
NET TOTAL ALL COSTS		**$39,780**	**$35,965**	**$39,780**	**$35,965**

** Auditor would require a laptop computer to perform the duties of the position

Impact on Other Areas of Government: None

Assumptions for Calculations: Table 2 calculates the estimated costs of hiring an FTE to perform the function. The costs are based on one FTE Auditor III position and estimated travel expenses to conduct 25 Single Entry Point agency audits throughout the State. The Department believes the Auditor III level is appropriate for the new position because the individual will be responsible for all aspects of designing the audit plan, developing procedures, and will be the subject matter expert. The Department estimates that each agency audit will require travel to one of the 25 agencies, one week to complete on-site field work and one week writing and issuing the report. Therefore, travel costs were projected using the estimated number of miles required to travel to and from the Single Entry Point Agency offices in various locations, with overnight stays required at 16 of the 25 agencies, lodging costs and meals per diem were determined using blended State reimbursement rates for different areas of the State while traveling 16 weeks per year.

Concerns or Uncertainties of Alternative: The amount of errors and inappropriate payments that will be discovered and recouped during the audits is not known. The auditor would require ongoing training to maintain expertise on the program. Employee turnover could severely impact the schedule. Additional state resources may be required to assist the auditor in defending the Department against litigation that may arise due to Single Entry Point Agencies disputing the findings of an audit.

Supporting Documentation

Analytical Technique: Cost Benefit

Alternative	Increase in Costs	Benefits
Alternative A (Recommended Change)	$0	This will bring the Department into compliance with State auditor findings and federal regulations. It potentially increases recoveries of improper payments due to the timely performance of the audits. Over time it would reduce future expenditures due to more accurate submissions of reimbursement reports. This option would also provide the Department more flexibility in managing the program. An outside contractor that specializes in these types of audits would have greater expertise, and conduct the audits in a more thorough manner, potentially increasing recoveries over those that can be attained with Alternative C. Additionally, contract audit staff rotation would provide fresh perspectives when conducting reviews.
Alternative B (No Change)	$0	This alternative would continue the program as is and continue to be out of compliance with State auditor findings and federal regulations. There will be fewer recoveries of improper payments to vendors. And as a result, future expenditures are likely to grow at a faster rate than they are currently.
Alternative C	$0	This alternative would also bring the Department into compliance with State auditor findings and federal regulations, ensuring continued funding for the program. It will also increase recoveries of improper payments due to the timely performance of the audits. Having an in house Auditor will also provide more consistency over time when reviews are performed. Additionally, over time it may reduce future expenditures due to more accurate submissions of reimbursement reports.

Quantitative Evaluation of Performance - By implementing Alternative A or C, the Department will be in compliance with federal regulations and State auditor findings. It is anticipated that a contract auditor arrangement will be able to generate greater recoveries than Alternative C due to their accumulated knowledge and expertise. Additionally, Alternative A will provide the Department more flexibility in managing this program over the long run. By hiring an outside contractor with greater resources and expertise on Single Entry Point agencies, the audits would be conducted in a more thorough manner. By rotating staff, the contract firm would be able to provide a fresh perspective on the Single Entry Point agencies'

activities. Under Alternative C, the Department would be responsible for ongoing employee costs and operating expenses, training will also be required to keep them up to date on changing regulations, and finally, managing employee turnover while adhering to the audit schedule.

Alternative B costs nothing but also does not return any improper payments. The Department will continue to be out of compliance with federal regulations and State auditor findings.

Statutory and Federal Authority:

26-4-522 (4) (b), C.R.S. (2005) Single entry point system - authorization - phases for implementation - services provided. State certification of a single entry point agency - quality assurance standards. *The medical services board shall adopt rules for the establishment of a quality assurance program for the purpose of monitoring the quality of services provided to clients and for recertifying single entry point agencies. The rules shall provide for: Procedures to evaluate the quality of services provided by the agency; an assessment of the agency's compliance with program requirements...and an evaluation concerning financial accountability.*

Title 45-public welfare, part 74 uniform administrative requirements for awards and subawards Sec. 74.53 (4) (e) Retention and access requirements for records...*HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of recipients that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents....*

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 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.

1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	DI - 6	**OSPB Approval:**		**Date:**
Program:	Information Technology Contract Monitoring	**Statutory Citation:**	26-4-403.7 (3) (b), C.R.S. (2005); 26-4-404 (1) (c), C.R.S. (2005);	
Request Title:	Fiscal Agent Reduction in Federal Funds		24-75-109 (3), C.R.S. (2005)	

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	21,076,845	23,261,268	0	23,261,268	23,047,082	0	23,047,082	0	23,047,082	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	5,187,882	5,662,806	0	5,662,806	5,572,025	0	5,572,025	0	5,572,025	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	370,212	568,453	0	568,453	611,540	0	611,540	0	611,540	0
	FF	15,518,751	17,030,009	0	16,987,427	16,863,517	0	16,863,517	0	16,863,517	0
(1) Executive Director's Office, Medicaid Management Information System Contract							See "(M)" Headnote				
	Total	21,076,845	23,261,268	0	23,261,268	23,047,082	0	23,047,082	0	23,047,082	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	5,187,882	5,662,806	0	5,662,806	5,572,025	0	5,572,025	0	5,572,025	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	370,212	568,453	0	568,453	611,540	0	611,540	0	611,540	0
	FF	15,518,751	17,030,009	0	16,987,427	16,863,517	0	16,863,517	0	16,863,517	0

Letter Notation: This request is for an "(M)" Headnote exception in the FY 06-07 Long Bill.

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX, Title XXI, CFE: Children's Basic Health Plan Fund, Old Age Pension Fund, Colorado Autism Treatment Fund, Nurse Home Visitor Fund, Breast and Cervical Cancer Prevention and Treatment Fund, and Health Care Expansion Fund

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

Request Affects Other Departments: Yes X No

CHANGE REQUEST for FY 06-07
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:	Fiscal Agent Reduction in Federal Funds
Long Bill Line Item(s)	(1) Executive Director's Office, Medicaid Management Information System Contract
State and Federal Statutory Authority:	26-4-403.7 (3) (b), C.R.S (2005); 26-4-404 (1) (c), C.R.S. (2005); 24-75-109 (3), C.R.S. (2005); 42 C.F.R. §433.119 (c); 42 C.F.R. §433.120 (a) and (b); 42 C.F.R. §433.131

Summary of Request (Alternative A): This request is for temporary flexibility in funding splits due to delays in reprocurement of the Medicaid Management Information System contract. Flexibility in the Medicaid Management Information System Contract line item is requested, but no specific dollar change is requested at this time. The Department will wait until official notification of a reduction in federal financial participation is received to submit a Supplemental Request.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The last renewable contract year under the prior Request for Proposal will end November 30, 2006. The Department 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. Verbal approval was provided by the Centers for Medicare and Medicaid Services. The extension was requested because of the competing priorities of Colorado Benefits Management System and the implementation of various regulations related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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. On October 11, 2005, the Department requested a reconsideration of its request for an extension to complete reprocurement or a deferral of any penalties. However, the Department can not be certain when a response may be received from the Centers for Medicare and Medicaid Services, or if it will be favorable. However, the Department was able to negotiate a fixed price with the current fiscal agent, Affiliated Computer Services, as a short term plan until the new contract is reprocured.

In March 2004, the Department and the fiscal agent converted the Medicaid Management Information System Contract from a cost per claim basis to a fixed price contract. The fixed price portion of the contract covers all base medical claims, special types of claims paid from cash funds, encounter claims, capitations, non-pharmacy prior authorization reviews, the decision support subsystem called Business Objects America, the prescription drug claims processing subsystem called Prescription Drugs Card System, and mandatory Health Insurance Portability and Accounting Act of 1996 (HIPAA) permanent remediation measures. Cost containment was the main goal for moving toward fixed price.

Recent legislation, HB 05-1262, has increased the need for additional prescription drug claims processing capacity, additional capacity for the decision support system, and additional medical claims processing, all of which become components of the fixed price contract. In addition to the fixed price contract, an increase in pharmacy prior authorization reviews is expected; although pharmacy prior authorization reviews are contracted as a separate function outside the fixed price amount.

General Description of Alternative: Total funding provided for the Medicaid Management Information System Contract line item in FY 06-07 is adequate to cover all contractual needs with the fiscal agent. However, the funding splits may need to be adjusted due to the delays in reprocurement of the Medicaid Management Information System. The last renewable contract year under the prior Request for Proposal will end November 30, 2006. Per federal

regulations, reprocurement should be completed by the end of the current contract, so that system operation can continue forward seamlessly beginning December 1, 2006 with a new contracted fiscal agent in place. However, due to pressing needs of the Colorado Benefits Management System, only a limited amount of work toward the Medicaid Management Information System contract reprocurement was possible during FY 04-05. The limited amount of work done caused the reprocurement processes to be delayed, thus, the Department anticipates that the reprocurement processes will continue through FY 06-07 and perhaps longer. If the federal Centers for Medicare and Medicaid Services choose to decertify the current system because the reprocured contract missed the due date of December 12, 2006, the current operating arrangements for the Medicaid Management Information System Contract will be at risk for a reduction in federal funds participation. Reprocurement might not be completed until as late as February 2008.

The Department anticipates that federal funds participation rates may be reduced in the second half of FY 06-07 and again in the second half of FY 07-08. The federal Centers for Medicare and Medicaid Services expects the Department to have completed the reprocurement processes by December 1, 2006. When this date is missed, the Centers for Medicare and Medicaid Services may decertify Colorado's Medicaid Management Information System. As a result of decertification, at the beginning of the next quarter of the fiscal year, starting in January 2007, the federal funds participation rate may be reduced as much as ten percentage points. The Department assumes that the maximum reduction allowed by the federal regulations will occur. Since many contract functions in the Medicaid Management Information System are at 75% federal financial participation, those contract functions could be lowered to 65% federal financial participation. Any contract functions that are already lower than 75% would not be affected at this time. Some contract functions are funded at 50% federal financial participation. Since 50% is the minimum allowable amount, those items would not suffer a reduction.

Many of the claims functions are currently at 75% federal financial participation. These types of claims include any Medicaid claims not specified as a special type funded by a separate legislative bill or funded by Cash Funds, including Health Care Expansion claims (HB 05-1262), Breast and Cervical Cancer Prevention and Treatment claims,

Nurse Home Visitor claims, Community Transition for the Elderly claims, and Autism claims. Old Age Pension claims are not subject to any reduction because their processing is funded entirely from a State source, the Old Age Pension Fund.

School Based Health claims are often described as 100% federally funded, but that description overlooks a key nuance in how the funding actually occurs. Only the federally funded portion of the claim processing funds is included in the appropriation in the Long Bill for this program, but the match to the federal funds comes from the local school districts rather than from State government. When the local school districts submit billings to the Medicaid Management Information System for claims processing, the payments are calculated with the local school district match removed before the payments are sent back to the school districts. Medical Services Premiums amounts for School Health Services are paid at 50% federal funds and 50% local school district match; however, the local school district match is not included in the total payment as it is Cash Funds Exempt from certified public expenditures. Administrative costs, such as claims processing, are a portion of the local school district match also. From the perspective of the Centers for Medicare and Medicaid Services, the School Health Services program operates totally at 50% federal financial participation. Therefore, no reduction in School Health Services claims processing in the Medicaid Management Information System for federal financial participation is expected.

Non-fixed price functions of pharmacy prior authorization reviews and postage are already at the minimum federal financial participation level of 50% because the Centers for Medicare and Medicaid Services have approved only the minimum level for those two functions. Therefore, those functions are not subject to reduction. Development costs, another function outside of fixed price, historically have been approved by the Centers for Medicare and Medicaid Services at 75% federal funds participation. However, since no development costs have been identified for FY 06-07 at this time, no reduction in federal financial participation would be necessary for this function.

The maximum allowable reduction of ten percentage points would continue for four quarters as stated in federal regulations, unless reprocurement could be completed sooner,

but that does not appear likely. The four quarters would encompass the third and fourth quarters of FY 06-07 and the first and second quarters of FY 07-08. After the four quarters have ended, the Centers for Medicare and Medicaid Services would review Colorado's situation and determine the federal financial participation rate for future quarters while reprocurement is still not completed. A further maximum reduction of another ten percentage points is possible for the following four quarters covering the third and fourth quarters of FY 07-08 and continuing into FY 08-09. However, FY 08-09 is beyond the scope of this Decision Item. When reprocurement is completed, the Centers for Medicare and Medicaid Services will review the results of the reprocurement. If the Centers for Medicare and Medicaid Services approve the results of the reprocurement, the federal financial participation rates will be returned to the pre-reprocurement level by recertification of the system. However, the return to the higher level does not occur automatically without approval from the Centers for Medicare and Medicaid Services, so the Department makes no assumptions about a particular time frame for the return to higher federal financial participation rates.

Fund split adjustments for the Medicaid Management Information System contract may be necessary. The total funding already projected for FY 06-07 will be adequate to cover the needs of the contract, however a federal financial participation reduction is possible for the last two quarters of FY 06-07 and continuing into FY 07-08 due to missing the reprocurement deadline.

If decertification and reduction in federal funds participation occurs, the Department would need an exception to the "(M)" Headnote to temporarily allow for more General Fund to offset the decrease in federal funds participation because the Department still would need the full amount of the total funds appropriated in order to continue operating the Medicaid Management Information System until reprocurement is complete. Lack of sufficient funding would cause operations of the Medicaid Management Information System to stop operating or to have a large General Fund overexpenditure. If decreased federal financial participation is received, the Department will submit a Supplemental Request for General Fund to address the reduced federal match. Until the Supplemental Request is approved, the Department would need to continue work and would temporarily

utilize the granted "(M)" Headnote flexibility. The following paragraph quotes, in part, the "(M)" Headnote in the FY 05-06 Long Bill, SB 05-209, with wording to add for the exception that the Department would request in **boldface type**:

> *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 proportionally,* ***except for the Department of Health Care Policy and Financing's Medicaid Management Information System Contract line item and Medicaid Management Information System Reprocurement line item for the purpose of compliance with federally required reprocurement of the Medicaid Management Information System.***

Calculations for Alternative's Funding:

Summary Request for FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Request FY 06-07 (Column 7)	$23,047,082	$5,572,025	$611,540	$16,863,517
FY 06-07 Incremental Change Request (Column 6)*	$0	$0	$0	$0
FY 06-07 Base Request (Column 5)	$23,047,082	$5,572,025	$611,540	$16,863,517

* This Request is for an "(M)" Headnote exception in the FY 06-07 Long Bill.

Impact on Other Areas of Government: Budgetary flexibility for the Department of Health Care Policy and Financing would not affect other departments.

Assumptions for Calculations: The Department will not be notified of the decision made by the federal Centers for Medicare and Medicaid Services until December 2006. Therefore, at this time, the Department can not be certain of the exact calculations.

Concerns or Uncertainties of Alternative: If claims volume unexpectedly increases or decreases significantly in the future, the fixed price cost may have to be renegotiated. If postal rates increase, Supplemental funding for the postal increase may be necessary. If reprocurement takes even longer than the time

frames currently envisioned, all functions in the Medicaid Management Information System could be reduced to the minimum level of 50% federal financial participation.

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

General Description of Alternative: This alternative does not change funding for the fiscal agent contract under any requirement and allows no flexibility for General Fund. This alternative is not recommended.

Calculations for Alternative's Funding: No change in funding with this alternative, and no "(M)" Headnote flexibility.

Concerns or Uncertainties of Alternative: With a lack of flexibility in the "(M)" Headnote and a reduction of the federal financial participation rate, the Medicaid Management Information System Contract line item would run out of appropriated General Fund. The Department would be obligated to stop the operation of the Medicaid Management Information System. However, 26-4-404 (1) (c), C.R.S. (2005) requires the Department to "exercise its overexpenditure authority" and "not intentionally interrupt the normal provider payment schedule." The statutory citation refers to the Medical Services Premiums line item. When the Department stops processing in the Medicaid Management Information System, the Department would simultaneously cause a violation of the Colorado Statutes because if the Medicaid Management Information System is not operating, claims from medical providers would not be processed and payments to the medical providers, covered by the Medical Services Premiums line item, would not be made.

Supporting Documentation

Analytical Technique: Probability Assessment identifies the likelihood of potential impacts if "(M)" Headnote flexibility is not allowed.

PROBABILITY ASSESSMENT TABLE		
Low	**Medium**	**High**
Highly Unlikely 0% - 40%	Likely 41% - 79%	Highly Likely 80% - 100%
RISK ASSESSMENT		
Risk Description	**Potential Impacts**	**Probability**
If "(M)" Headnote flexibility is not allowed, then there will be impacts to the Medicaid Management Information System	Stopping operations of the Medicaid Management Information System may be necessary.	High
	Medical providers may experience delays in reimbursement because insufficient funds for automated claims processing would slow or stop reimbursements until the funding from the next fiscal year became available.	High

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A offers the most continuous, uninterrupted operation of the Medicaid Management Information System with sufficient funding for stability of services to both medical providers and clients. Alternative B would cause the Medicaid Management Information System processing to stop before the end of the fiscal year (June 30, 2007) since State funding of General Fund and Cash Funds Exempt would not be sufficient to offset the reduced federal funds.

Since the Medicaid Management Information System would not process claims after available funding was exhausted, payments to medical providers covered by the Medical Services Premiums line item would not be processed. Each day of not processing claims could delay payments to medical providers approximately $5,888,586 (or the FY 06-07 Base Request for Medical Services Premiums of $2,149,333,888, less funding for Upper Payment Limit calculations that are not processed through the fiscal agent, divided by 365).

Alternative A with “(M)” Headnote flexibility is the preferred alternative.

Statutory and Federal Authority:

26-4-403.7 (3) (b), C.R.S. (2005) (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.*

26-4-404 (1) (c), C.R.S. (2005) *The state department shall exercise its overexpenditure authority under section 24-75-109, C.R.S., and shall not intentionally 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 provider in writing of its decision to interrupt the normal payment schedule*

24-75-109 (3), C.R.S. (2005) *For any overexpenditure, whether or not allowed by the controller in accordance with subsection (1) of this section, the controller shall restrict, in an amount equal to said overexpenditure, the corresponding item or items of appropriation that are made in the general appropriation act for the fiscal year following the fiscal year for which the overexpenditure that is allowed occurs.*

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 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 the next quarter.

42 C.F.R. §433.120 (a) and (b) *(a) [Centers for Medicare and Medicaid] will reduce [federal financial participation] for system operation for at least four quarters. (b) [Centers for Medicare and Medicaid] will not reduce [federal financial participation] by more than 10 percentage points in any four-quarter period.*

42 C.F.R. §433.131 *If a State is unable to comply with the conditions of approval or of reapproval and the noncompliance will cause a percentum reduction in [federal financial participation], [the Centers for Medicare and Medicaid Services] will waive the [federal funds participation] reduction in the following circumstances:*
(a) Good cause. If [the Centers for Medicare and Medicaid Services] determines that good cause existed, [the Centers for Medicare and Medicaid Services] will waive the [federal funds participation] reduction attributable to those items for which the good cause existed. A waiver of [federal financial participation] consequences of the failure to meet the conditions of approval or reapproval based upon good cause will not extend beyond two quarters.
(b) Circumstances beyond the control of a State. The State must satisfactorily explain the circumstances that are beyond its control. When [the Centers for Medicare and Medicaid Services] grants the waiver, [the Centers for Medicare and Medicaid Services] will also defer all other system deadlines for the same length of time that the waiver applies.

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 requirements to affect 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 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 15, 2005
Priority Number:	DI - 7	**OSPB Approval:**		**Date:**	
Program:	Information Technology Contract Monitoring	**Statutory Citation:**	26-4-105, C.R.S. (2005) and 26-4-403.7, C.R.S. (2005)		
Request Title:	HIPAA National Provider Identifier Assessment and Implementation				

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	0	0	0	0	0	800,062	800,062	0	800,062	0
	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	194,015	194,015	0	194,015	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	0	0	0	0	8,401	8,401	0	8,401	0
	FF	0	0	0	0	0	597,646	597,646	0	597,646	0
(1) Executive Director's Office, Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identifier Assessment and Implementation	**Total**	0	0	0	0	0	800,062	800,062	0	800,062	0
	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	194,015	194,015	0	194,015	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	0	0	0	0	8,401	8,401	0	8,401	0
	FF	0	0	0	0	0	597,646	597,646	0	597,646	0

Letter Notation:	$50,000 shall be transferred to the Governor's Office of Information Technology for independent verification and validation.
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX and Title XXI CFE: Children's Basic Health Plan Trust Fund 11G
IT Request: Yes	(If yes and request includes more than 500 programming hours, attach IT Project Plan) - See attachment at the end of this Request.
Request Affects Other Departments: X Yes No	Governor's Office of Information Technology

CHANGE REQUEST for FY 06-07
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:	HIPAA National Provider Identifier Assessment and Implementation
Long Bill Line Item(s)	(1) Executive Director's Office, Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identifier Assessment and Implementation
State and Federal Statutory Authority:	26-4-105, C.R.S. (2005); 26-4-403.7, C.R.S. (2005); 45 C.F.R. Subpart D, §162.404, §162.406, and §162.408

Summary of Request (Alternative A): This Change Request asks for funding to cover the assessment and implementation of a federal rule released under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Total funds in FY 06-07 of $800,062 will be needed. A new line item would also be created called Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identifier Assessment and Implementation. The Governor's Office of Information Technology would manage independent verification and validation related to this project. This HIPAA rule affects the processing of claims in the Medicaid Management Information System.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created the need for several changes in the way that the Department conducts business. Some of the federal HIPAA regulations, such as the Security Rule, have affected the Department internally. Other HIPAA regulations have affected the Department's fiscal agent

operations and the Medicaid Management Information System. The regulation for the National Provider Identifier will have definite impacts on the Medicaid Management Information System.

Currently, both Medicare and Medicaid, as well as private insurance health plans use various types of medical provider identification codes, including: tax identification numbers, social security numbers, and plan-specific numbers. Research by the federal Department of Health and Human Services deemed that none of the existing code systems were adequate to be expanded into a national system. Therefore, a totally new system was determined to be necessary.

Colorado Medicaid provider identification numbers currently used when processing Medicaid claims are not compatible with the National Provider Identifier standards. Therefore, adjustments will be necessary for Colorado to achieve compliance with the federal requirements.

The National Provider Identifier codes are maintained in a national database called the National Plan and Provider Enumeration System funded by the federal Health and Human Services Department, but contracted to an agent called the "Enumerator." Health care providers were able to begin submitting their applications for a unique identifier beginning May 23, 2005. Providers must have obtained and be ready to use a unique identifier before a specified implementation date, depending on their size. Large health care plans and providers are required to use the National Provider Identifier when submitting claims by May 23, 2007. Small health plan providers have an extra year, until May 23, 2008, to begin using the National Provider Identifier. The Medicaid Management Information System must, therefore, be prepared to process claims with the National Provider Identifier as of May 23, 2007 because many of the Department's contracted providers are classified as large providers.

The National Provider Identifier's sole purpose is to identify uniquely the specific health care provider. A health care provider may be an individual or an organization such as a health plan, a health maintenance organization, or a health care clearing house. For

example, doctors, nurses, and medical therapists would need a National Provider Identifier, as well as hospitals, clinics, and nursing care facilities. However, non-health care providers, such as transportation providers who do not directly supply health care, will continue to use the older Medicaid provider identification number, since federal regulations exclude non-medical providers from the requirement of using the National Provider Identifier.

The National Provider Identifier consists of ten numeric characters that contain no intelligence about race or ethnicity of the provider, medical specialty of the provider, state location where the provider practices, medical school attended, type of educational degree, or certification(s) held. The provider's personal information would remain private. The National Provider Identifier will be used by the health care provider for a lifetime; after the death of the provider, that particular National Provider Identifier will be deactivated and will not be reused.

General Description of Alternative: One time funding is requested for the fiscal agent to assess the Medicaid Management Information System for all system changes, such as system logic, Decision Support System changes, database changes, interfaces changes, and many standardized reports changes, that will be needed to incorporate National Provider Identifier codes. After all changes are identified, the fiscal agent must make all of the changes determined during the assessment to be necessary.

After the required effective date, claims and other transactions that require a National Provider Identifier cannot be processed unless the ten character numeric identifier is included in the data. The fiscal agent will need to determine the specific locations in the computer coding to make the appropriate changes, and follow up by making the changes. For every place within the Medicaid Management Information System where a Medicaid provider identification code is used to identify a health care provider, the provider code will need to be replaced with the new National Provider Identifier or will require mapping to the new National Provider Identifier.

The fiscal agent will be asked to assess the entire database system for effects that the National Provider Identifier will have on processing billed claims, encounters, capitation payments, and prior authorization reviews. This assessment must also look at various reporting functions through the Medicaid Management Information System Decision Support System and review the interface with the Colorado Financial Reporting System. Therefore, the number of changes required in the Department's systems may be considerable.

The fiscal agent is most familiar with the current computer programming and can perform the changes in the most efficient and timely manner. Timeliness is an important consideration because assessment and implementation are required to be completed by May 23, 2007.

The Governor's Office of Information Technology will assist with the project by providing independent verification and validation services. These services include:

- Management of the independent verification and validations services from outside of the Department of Health Care Policy and Financing;
- Insuring that implementation of the National Provider Identifier occurs prior to the completion of the fiscal agent reprocurement;
- Providing a risk management plan to identify the risk factor of the joint activities of reprocurement and National Provider Identifier implementation occurring simultaneously;
- Keeping the utilization of independent verification and validation within the estimated additional cost of $50,000; and
- Utilizing the Governor's Office of Information Technology Program Management Office services.

Implementation Schedule:

Task	Month/Year
Medicaid Management Information System Modifications Assessment Completed	September 30, 2006
Medicaid Management Information System Modifications Implemented	Prior to May 23, 2007
Independent Verification and Validation by Governor's Office of Information Technology	Ongoing throughout the project
Effective Date by which National Provider Identifier Must Be Used (Large Provider)	May 23, 2007
Effective Date by which National Provider Identifier Must Be Used (Small Provider)	May 23, 2008

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(1) Executive Director's Office, Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identifier Assessment and Implementation	$800,062	$194,015	$8,041	$597,646

Note: The $50,000 to transfer to the Governor's Office of Information Technology is also included in the $800,062 total funding for the Department of Health Care Policy and Financing.

Calculations of Funding Need During FY 06-07			
Task	**Hours of Work**	**Rate per Hour**	**Total Cost**
Assessment of Needed System Changes by Fiscal Agent	800	$127	$101,600
Computer Programming Code Changes by Fiscal Agent	5,106	$127	$648,462
Subtotal for Fiscal Agent	5,906		**$750,062**
Independent Verification and Validation			$50,000
Subtotal for Governor's Office of Information Technology			**$50,000**
Grand Total			**$800,062**

Total Funding Splits Between Medicaid and Children's Basic Health Plan					
Progrm Splits	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Costs	100%	$800,062	$194,015	$8,401	$597,646
Medicaid Costs	97%		25% of 97%	0% of 97%	75% of 97%
		$776,060	$194,015	$0	$582,045
Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
		$24,002	$0	$8,401	$15,601

Fiscal Agent Funding Splits Between Medicaid and Children's Basic Health Plan					
Progrm Splits	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Costs	100%	$750,062	$181,890	$7,876	$560,296
Medicaid Costs	97%		25% of 97%	0% of 97%	75% of 97%
		$727,560	$181,890	$0	$545,670
Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
		$22,502	$0	$7,876	$14,626

Independent Verification and Validation Funding Splits Between Medicaid and Children's Basic Health Plan					
Progrm Splits	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Costs	100%	$50,000	$12,125	$525	$37,350
Medicaid Costs	97%		25% of 97%	0% of 97%	75% of 97%
		$48,500	$12,125	$0	$36,375
Children's Basic Health Plan Costs	3%		0% of 3%	35% of 3%	65% of 3%
		$1,500	$0	$525	$975

Impact on Other Areas of Government: The Governor's Office of Information Technology will provide independent verification and validation services for the project.

Independent Verification and Validation Funding to the Governor's Office of Information Technology				
Funding Splits	**Total Costs**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Health Insurance Portability and Accountability Act of 1996 (HIPAA) National Provider Identifier Assessment and Implementation Transfer to the Governor's Office of Information Technology	$50,000	$0	$50,000	$0

Assumptions for Calculations: The total number of hours necessary to complete the assessment and the computer programming changes to implement the National Provider Identifier into the Medicaid Management Information System was estimated by the current fiscal agent, Affiliated Computer Services, Inc.

The rate of $127 per hour is the current rate for FY 05-06 for any system development costs to the Medicaid Management Information System.

The Governor's Office of Information Technology cost for independent verification and validation was estimated by that office. This cost is assumed to be originally appropriated to the Department of Health Care Policy and Financing to draw the federal match but then transferred to the Governor's Office of Information Technology.

The Medicaid program will pay 97% of the total costs. For the purpose of this request, the Children's Basic Health Plan contribution to the total costs is 3%. This percentage was determined as the historical 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. Funding from the Children's Basic Health Plan is comprised of 35% Cash Funds Exempt and 65% federal funds participation.

The Centers for Medicare and Medicaid Services may approve a favorable funding split of 10% General Fund and 90% federal funds participation for a system development project. However, this favorable funding split requires the submission and approval of an Advance Planning Document to the Centers for Medicare and Medicaid Services asking for the higher federal funds participation, although the Centers for Medicare and Medicaid Services does not always approve these requests. An Advance Planning Document will be prepared; however, this request is constructed estimating the federal financial participation conservatively. Therefore, the Department is requesting 25% General Fund and 75% federal funds participation initially. If the Centers for Medicare and Medicaid Services later approves the higher federal funds participation, a subsequent request will ask for a change in the fund split.

No costs related to the National Provider Identifier are estimated for FY 07-08 because the required implementation date occurs in May 2007. It is anticipated that all changes will need to be completed during FY 06-07, so that this particular HIPAA regulation would be operational before FY 07-08 begins.

Concerns or Uncertainties of Alternative: The contract with the current fiscal agent, Affiliated Computer Services, Inc., ends on November 30, 2006. Reprocurement efforts are currently underway by the Department. However, the Department can not be certain at this time who the fiscal agent might be after November 30, 2006. The State owns the Medicaid Management Information System, although the fiscal agent operates the system. Implementing the HIPAA National Provider Identifier in a timely manner is a federal mandate. Therefore, work to meet the May 23, 2007 effective date must be completed, regardless of whom the fiscal agent might be by that date. At this time, the Department is requesting the standard funding split for system changes to the Medicaid Management Information System. Because implementing the National Provider Identifier is a federal mandate, it would not be subject to a reduction in federal financial participation if the Medicaid Management Information System became decertified after the November 30, 2006 end of the current contract with the fiscal agent. (See November 15, 2005 Decision Items #4 and #6.) However, decertification could occur if this federal mandate is not implemented.

Research by the Department's Controller Division indicates that the outcome of the assessment, computer programming changes, and implementation completed under this request should not affect the Colorado Financial Reporting System. This system requires a vendor identification code for all medical providers and non-medical providers to receive payment from the system. It is the understanding of the Department's Controller that the requirement for the National Provider Identifier exists only for medical claims processing systems and not for financial reporting systems. Non–medical providers, such as transportation providers, will still need to have a Medicaid Provider Identification in the existing format. Only health care providers qualify for the new National Provider Identifier. To avoid a mixed system of some providers having Medicaid Identification codes as a vendor code in the Colorado Financial Reporting System and other providers having a National Provider Identifier as a vendor code, the Colorado Financial Reporting System will continue to rely on the currently used Medicaid Provider Identification codes as the vendor code numbers.

The vendor code number is a layout used statewide by all departments in State government to identify vendors who receive payments from Colorado State government. A change to the vendor code layout would affect all State government departments. The cost would be prohibitive to modify the vendor code layout in the Colorado Financial Reporting System for all departments, most of whom do not have health care providers as vendors and have no reason to change identification codes. Therefore, the Medicaid Management Information System will need to provide a mapping of the National Provider Identifier to the existing Medicaid Provider Identification number code, that also functions as the vendor code for payment purposes, to continue the format compliant with the statewide vendor code used in the Colorado Financial Reporting System.

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

General Description of Alternative: Do not complete assessment, computer programming changes or implementation of the National Provider Identifier in the Medicaid Management Information System and do not use the assistance of the Governor's Office of Information Technology.

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

Concerns or Uncertainties of Alternative: The Medicaid Management Information System would not be able to incorporate the National Provider Identifier and would be out of compliance with federal regulations, thus risking federal system decertification and economic sanctions by lowered federal funds participation.

Supporting Documentation

Analytical Technique: A risk/benefit analysis was chosen to assess the relative merits of the two alternatives. The risks and benefits of funding the assessment, computer programming changes, and implementation (Alternative A) were compared to the risks and benefits of not funding the HIPAA National Provider Identifier work (Alternative B). A rating was estimated based on goals, objectives, and priorities of the Department.

Scores were based on the following ranking:
3 = High Benefits – positive benefits are greater than risks.
2 = Neutral – no risks or benefits are realized by the Department.
1 = High Risk – risks more prevalent causing negative implications for the Department.

Description of Risk/Benefits	Alternative A (with funding)	Alternative B (without funding)
Benefit: Needed system changes to the Medicaid Management Information System can be implemented so compliance with federal regulations can occur in a timely manner, and the Medicaid Management Information System can continue to have a favorable rate of 75% federal funds participation for claims processing. **Risk:** Lack of funding could cause risk of missing the deadline for the effective date of National Provider Identifier since the needed changes likely would not be made, and failure to comply with the deadline could result in federal sanctions and a lowered rate of federal funds participation for noncompliance with HIPAA regulations.	3	1
Benefit: System changes would be thorough so the deadline for implementing the National Provider Identifier would be met and claims processing could continue in a timely manner with payments going to medical providers on a timely basis. **Risk:** Lack of funding could cause risk of making system changes in a less thorough manner, if done at all, and might miss important considerations that would delay the implementation date, cause claims going into suspense status, and require manual processing to clear the claims from the suspense status, with payments to medical providers delayed by several days or weeks because manual processing would be slow.	3	1

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A permits the system changes to be identified, programmed, and implemented ahead of the federal deadline for the effective date and avoid the risk of federal sanctions that would result in a funding crisis by lowering the rate of federal funds participation in the ongoing Medicaid Management Information System operations. Alternative B subjects the Department to considerable risk. The financial risk for noncompliance with federal requirements could cause the loss of federal financial participation for the operations of the Medicaid Management Information System. Additionally, medical providers will use the National Provider Identifier whether the Medicaid Management Information System is ready or not, so it is better to be ready to process electronically, than to resort to manual processing for the claims.

Alternative A is the preferred alternative.

Statutory and Federal Authority:

26-4-105, C.R.S. (2005) Federal requirements under Title XIX. *Nothing in this article shall prevent the state department from complying with federal requirements for a program of medical assistance in order for the state of Colorado to qualify for federal funds under Title XIX of the social security act and to main a program within the limits of available appropriations.*

26-4-403.7, C.R.S. (2005) *The General Assembly hereby find and declares that the agency responsible for the administration of the State's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide the following: (a) Electronic claim submittals; (b) On-line eligibility determinations; (c) Electronic remittance statements; (d) Electronic fund transfers; and (e) Automation of other administrative functions associated with the medical assistance program.*

45 C.F.R., Subpart D – Standard Unique Health Identifier for Health Care Providers (Applicable sections following)

§162.404 Compliance dates of the implementation of the standard unique health identifier for health care providers. *(a) A covered health care provider must comply with the implementation specifications in §162.410 no later than May 23, 2007.*

§162.406 Standard unique health identifier for health care providers. *(a) Standard. The standard unique health identifier for health care providers is the National Provider Identifier (NPI). The NPI is a 10-position numeric identifier, with a check digit in the 10th position, and no intelligence about the health care provider in the number.*

§162.408 National Provider System. *The National Provider System (NPS) shall do the following: (a) Assign a single, unique NPI to a health care provider, provided that – (1) The NPS may assign an NPI to a subpart of a health care provider in accordance with*

paragraph (g); and (2) The Secretary has sufficient information to permit the assignment to be made. (b) Collect and maintain information about each health care provider that has been assigned an NPI and perform tasks necessary to update that information. (c) If appropriate, deactivate an NPI upon receipt of appropriate information concerning the dissolution of the health care provider that is an organization, the death of the health care provider who is an individual, or other circumstances justifying deactivating. (d) If appropriate, reactivate a deactivated NPI upon receipt of appropriate information. (3) Not assign a deactivated NPI to any other health care provider. (f) Disseminate NPS information upon approved requests. (g) Assign an NPI to a subpart of a health care provider on request if the identifying data for the subpart are unique.

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 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.

IT Project Plan
NPI HIPAA RULE

FY06-07

This form is intended to provide an overview of an IT-related project with a primary focus on the technology components. This will assist the IMC and OIT in validating the proposed information and technology approach to support their roles in IT planning, project oversight, and procurement review.

1. IDENTIFYING INFORMATION

Project Name:	National Provider Identifier (NPI) HIPAA RULE							
Project Code:	Agency Code (3 alpha characters)			Project Code (5 alphanumeric characters)				
	U	H	A	0	7	0	0	1
Department:	Health Care Policy and Financing							
Primary IT System:	Medical Claims Processing System (MMIS)						new	revised
								x

Project funding: Check all that apply	Base	New – Budget Amendment	New – Change Request	New – Non-appropriated	New – Supplemental Request
		X			

Associated IT Systems:

IT System Name	How impacted?
MMIS, MMIS-DSS, WEB PORTAL	Programming modifications will be implemented through existing resources to update claims processing and the support systems for the New National Provider Identifier. Federal Regulations require compliance with the NPI Rule by 05/23/2007. System changes must be complete in advance of the compliance date.

Project Contacts:

	Name	Job Title	Telephone	E-mail
Business **Sponsor**	Steve Tool	Executive director of HCPF	303 866-2868	Steve.tool@state.co.us
Dept **CIO**	John Wagner	C.I.O.	303 866-4017	John.wagner@state.co.us
Project	Pam Moores	Manager of IT Contracts	303 866-6114	Pam.moores@state.co.us

. BUSINESS OVERVIEW

Problem or Opportunity Definition : SEE the EFFICIENCY AND EFFECTIVENESS ANALYSIS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers NPI FINAL RULE

States that as of May 23, 2005 (effective date) require each health care provider to obtain, by application, a national provider Identifier (NPI) for HIPAA transactions and must be compliant within 2 years of the effective date.

Summary of Proposed Solution : SEE the EFFICIENCY AND EFFECTIVENESS ANALYSIS

Benefits Overview (check all that apply)

Quantified Benefits		Qualified Benefits	
	Cost avoidance	x	Statutory obligations, federal mandates
	Cost reduction		System replacement
x	Productivity benefits		Customer service and satisfaction
	Increased revenues/cash flow		Environmental, health, and other societal benefits
	External Customer Benefit		Aggregation
	Consolidation		Other:

Business Performance Measures

For each benefit identified in this "Business Overview" section and/or other documentation (e.g. E&E), provide a corresponding performance measure.

Prg #1	Program Name	Actual	Actual	Base	Request	Out-years	
		FY01-02	FY02-03	FY03-04	FY04-05	FY05-06	FY06-07
Objective #1	Productivity benefits					X	X
PM # 1	Provide easier mapping of provider data						
Objective #2	Federal Mandates					X	X
PM # 2	Compliance to HIPAA rules and Avoidance of any penalties						

3. TECHNOLOGY OVERVIEW

Proposed Technology
There is no new proposed technology. The following systems require some software modifications:

MMIS	COBOL	on OS390 platform
WEB PORTAL	.NET	on WINTEL
MMIS-DSS	SQL	on UNIX

Alternative Technology Considered (NONE)

Architecture Review Score (as percentage compliance)

Network	Datacenter	Web Access	Email	Identity Mgt	Database	Application	Security	**Overall**
100%	100%	100%	100%	100%	100%	100%	100%	**100%**

4. PROJECT ASSESSMENT

I. Strategic

Evaluate the project alignment with Agency and Statewide goals and the State IT strategic plan

	Yes	No *	N/A*
1. Is the proposed solution in alignment with the objectives of the strategies and initiatives in the State's Strategic Communications and Data Processing Plan (SCDP)?	X		
2. Is the proposed technology already in place within the agency?	X		
3. Has the agency evaluated implementations of similar technology in other agencies?			X
4. If "yes" to question 2 above, can you leverage the existing implementation(s)?	X		
5. Does the plan address total cost of ownership (TCO) over, at a minimum, the next 3-5 years?	X		
* Please provide, in section below, an explanation for all "No" and "N/A" responses:			
3. Not changing the technology, only software modifications.			

II. Management

Assessment of project alignment to core business activities as well as development and project management methodologies

	Yes	No *	N/A*
1. Will this solution support the agency's core business activities?	X		
2. Does this project have an agency sponsor?	X		
3. Has an experienced project management team been formed?	X		
4. Are project planning and project management practices and tools already in place?	X		
5. Have the project risks been identified AND appropriate mitigation strategies established?		X	
6. Is the agency prepared to commit user time necessary for user acceptance testing and training?	X		
7. Will a Validation and Verification (V&V) team be in place prior to vendor selection and through deployment?	X		
* Please provide, in section below, an explanation for all "No" and "N/A" responses:			
	5. Initial risk document pending to OIT, final risks when assessment is complete.		
	7. IV&V is anticipated to be in place.		

III. Operational Infrastructure

Evaluate the proposed implementation and the effects on operations

	Yes	No *	N/A*
1. Will existing technical operations and maintenance support personnel be used for implementing this project while still supporting their existing workload?	X		
2. Will a user acceptance test plan be complete prior to starting this project?		X	
3. Will an impact assessment on current operations be complete prior to starting this project?	X		
4. Does the solution impact only one agency?	X		
5. Will a project contingency plan (in the event of project delay or failure) be completed prior to starting this project?		X	
6. Will a business continuity and disaster recovery plan be completed prior to starting this project?		X	
* Please provide, in section below, an explanation for all "No" and "N/A" responses:			
	2 User acceptance test plan will not be complete prior to start, but as part of the requirements phase.		
	5&6 The project begins with an assessment; these items will be complete prior to the start of implementation.		

IV. Scope & Requirements

Assess the project on clearly defined requirements and deliverables and adequate understanding by key stakeholder.

	Yes	No *	N/A*
1. Have Management and Project Team approved project scope?	X		
2. Have deliverables been clearly defined and appropriately scheduled (e.g. in phases)?		X	
3. Have critical success factors been identified and agreed upon for all stakeholders?	X		
4. Are core business processes documented?	X		
5. Is there a change management process in place?	X		
6. Is there a development methodology in place?	X		
* Please provide, in section below, an explanation for all "No" and “N/A” responses:			
2 .The Assessment request has not been completed			

V. Technology Competency

Assess the project and technical personnel needed to implement the project

	Yes	No *	N/A*
1. Do the project technical personnel possess the required technical skills?	X		
2. Has adequate training been included in timeframes for users and technical personnel?	X		
3. Have technical personnel implemented other solutions using the same proposed technology?	X		
4. Are technical personnel fully versed in core business operations?	X		
5. Has the assigned project team delivered projects, of similar complexity, on time and within budget in the past 2 years?	X		
* Please provide, in section below, an explanation for all "No" and “N/A” responses:			

VI. Infrastructure Dependencies

Evaluate modifications to the existing infrastructure to ensure successful operation

	Yes	No *	N/A*
1. Will this project deliver full functionality without additional investments?	X		
2. Is the proposed solution compatible with all existing technology?	X		
3. If key services will be replaced, has a user impact assessment been done and have users agreed to the proposed solution?			X
* Please provide, in section below, an explanation for all "No" and “N/A” responses:			
	3 Key services will not be changed as it is an identifier and not a service.		

VII. IT Policies & Standards

Evaluate the project alignment with State IT policies and standards

	Yes	No *	N/A*
1. Project compliant with Aggregation Policy?	X		
2. Project compliant with Interoperability Policy?	X		
3. Project compliant with Security Policy?	X		
4. Project compliant with Project Management Policy and Standard?	X		
5. Project compliant with Web Data Collection Policy?	X		
6. Project compliant with ADA Standard?	X		
7. Project compliant with End-user Computing Standard?	X		
8. Has the department completed an Architecture Review Scorecard assessing this solution specifically (not the entire dept)?	X		
* Please provide, in section below, an explanation for all "No" and “N/A” responses:			

5. PLANNED PROJECT PROCUREMENTS

A	B	C	D	E	F	G	H	I	J	K
Stage #	Product/svc description	COFRS code	Type	Amount		Vendor/OEM name	Dates			Aggregation
				Units	$		Need	Solicit	Renew	
2:	SOFTWARE Assessment	1961:	Amendment	800.0	$101,600	ACS	07/01/06			N
4:	SOFTWARE MODIFICATIONS	1961:	Amendment	5106.0	$648,462	ACS	11/01/06			N
				Total	$750,062					

6. ENTERPRISE IT RESOURCES

		DPA / DoIT		Portal Authority	
		Yes	No	Yes	No
Question #1 Has your department presented this IT project proposal to both the Department of Personnel and Administration's Division of Information Technology (DPA/DoIT) and Colorado Statewide Internet Portal Authority for feedback on opportunities to leverage existing and/or near-term planned enterprise IT resources?			X		X
Question #2 What was DPA/DoIT's response? Can they assist your department in implementing and/or maintaining all or part of this proposed technology solution?	Stage 2: Concept Definition		X		X
	Stage 3: Design		X		X
	Stage 4: Build		X		X
	Stage 5: Test		X		X

	Stage 6: Deploy		X		X
	Stage 7: Operations & Maintenance		X		X

Please provide the respective contact information below:

Organization	Name of contact	Job Title	Telephone	E-mail
DPA / DoIT				
Portal Authority				

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	DI-8	**OSPB Approval:**		**Date:**
Program:	Long Term Benefits Division	**Statutory Citation:**	26-4-410 (1) (a) (I), C.R.S. (2005); 26-4-502.5 (1), C.R.S. (2005); and 26-4-503, C.R.S. (2005)	
Request Title:	Periodic Nursing Facilities Appraisals Contract			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	0	0	0	0	0	266,171	266,171	0	266,171	0
	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	133,086	133,086	0	133,086	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	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	133,085	133,085	0	133,085	0
(1) Executive Director's Office Nursing Facilities Appraisals	**Total**	0	0	0	0	0	266,171	266,171	0	266,171	0
	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	133,086	133,086	0	133,086	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	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	133,085	133,085	0	133,085	0

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 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

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

Priority Number:	DI-8
Change Request Title:	Periodic Nursing Facilities Appraisals Contract
Long Bill Line Item(s)	(1) Executive Director's Office, Nursing Facility Appraisals
State and Federal Statutory Authority:	26-4-410 (1) (a) (I), C.R.S. (2005); 26-4-502.5 (1), C.R.S. (2005); and 26-4-503, C.R.S. (2005)

Summary of Request (Alternative A): This is a request for funding in the amount of $266,171 to perform the required quadrennial nursing facilities appraisals per State statute. The funding split is 50% General Fund and 50% federal funds.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: Nursing facilities appraisals occur once every four years. The Department contracts with an independent firm to conduct the appraisals. The underlying result of the contracted appraisal is the determination of "fair rental value". Fair rental value or appraised value means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. The fair rental (property) value determination is used in the process of rate setting, which is governed by 26-4-503, C.R.S. (2005). The per diem rate paid to nursing facilities is based in part on the fair rental value of the facility. The Department is also required to defend the appraisals when litigation occurs. Litigation support is included in the contractor's cost, which includes expert testimony and analysis by the appraisers. The funding ensures all nursing facilities are appraised and the Department

has the litigation support needed for any issues which may arise from the appraisals. This process is appropriated only once every four fiscal years. In order to calculate the reimbursement rate paid to nursing facilities, it is essential the appraisals occur when required. If the appraisals do not occur, as specified in statute, the Department will be out of compliance and at increased risk of litigation from nursing facility owners.

The last time the Department received funding for this purpose was in FY 01-02; however, the work and funding was rolled forward into FY 02-03.

General Description of Alternative: Nursing facility rates are determined according to formulas and increases in State statutes. Part of the per diem rate paid to these facilities is based on fair rental value, or appraised value. Per statute, the Department is required to contract with an independent firm to conduct nursing facility appraisals every four years. This process provides an actual basis for the fair rental values used in rate determinations, and provides litigation support for any issues that many arise from appraisals or rate setting.

This alternative proposes funding for facilities appraisals in FY 06-07 to comply with statutory regulations. This option would ensure that funds are available for the services needed to perform the appraisals of nursing facilities. It would confirm that nursing facilities have a reimbursement rate which reflects current property values. Due to fluctuations in property values, it is essential these appraisals be performed when required by statute.

This request is for same amount of funding as the actual expense incurred in the last facilities appraisals contract performed in FY 02-03. In FY 02-03, there were 194 nursing facilities appraised with actual expenses for these appraisals costing $266,171.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period Completed	February 2006
Contract Written	April 2006
Contract Awarded/Signed	June 1, 2006
Start-Up Date	July 1, 2006
Appraisal Report issued	January 2007

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request FY 06-07 (Column 7)	$266,171	$133,086	$133,085
FY 06-07 Change Request (Column 6)	$266,171	$133,086	$133,085

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request Change from Base in out Year (Column 10)	$0	$0	$0

Impact on Other Areas of Government: None

Assumptions for Calculations: The funding would be 50% General Fund, and 50% federal funds. The total appropriation amount is based on actual expenses incurred for the nursing facilities appraisals that were performed in FY 02-03. The estimated number of nursing facilities requiring appraisals is 205; therefore, the amount allocated to each facility appraisal would be $1,298.40.

Concerns or Uncertainties of Alternative: The Department is basing the potential costs of the facilities appraisal contract on the actual expenses incurred in the last facility appraisal contract; however the winning contractor's bid amount is unknown and the appropriation may not be sufficient to accommodate bids received.

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

General Description of Alternative: This alternative would not fund the request to perform the statutorily mandated facilities appraisals.

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

Concerns or Uncertainties of Alternative: If this request is not funded, there would be insufficient funds to perform facility appraisals and the Department would be out of compliance with State statute. Appraisals not being completed would result in facilities being reimbursed using rates based on outdated property value information. There would be less certainty that rates accurately reflect current property data, which increases the Department's risk for litigation from the nursing facility owners because of inaccurate rental value information.

Supporting Documentation

Analytical Technique: Cost Benefit Analysis

Quantitative Evaluation of Performance -

Alternative	Costs	Benefits
A	$266,171	Compliance with State statutory requirements resulting in less potential for litigation with facility owners. Greater cost accuracy on bills including "fair rental value" costs. This price includes litigation services to defend the appraisals and associated reimbursements.
B	$0	Out of compliance with State statutes. Greater potential for disputes requiring litigation from nursing facility owners due to lack of updated cost reports. No services would be provided to defend against litigation from nursing facility owners.

Statutory and Federal Authority: 26-4-410 (1) (a) (I) C.R.S. (2005) Providers - reimbursement - fees - nursing facility - nursing facility patient program improvement fund - intermediate care facility for the

mentally retarded - reimbursement - maximum allowable - nonmonetary incentive program - legislative declaration. *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. 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 therefor. The provisions of this subparagraph (I) shall not apply to state-operated intermediate care facilities for the mentally retarded.*

26-4-502.5 (1) C.R.S. (2005) Definitions relating to reimbursement of case-mix adjusted nursing costs...*"Case-mix adjusted nursing costs" means those costs comprising the compensation, salaries, bonuses, worker's compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurse's aides.*

26-4-503. Definitions relating to reimbursement of rental allowance for capital-related assets...*"Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boechk Commercial Underwriter's Valuation System for Nursing Homes", December 1985 edition. The depreciated cost of replacement appraisal shall be re-determined every four years by new appraisals of the nursing facilities. Such new appraisals shall be based upon rules and regulations promulgated by the medical services board in the department of health care policy and financing... "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility..."Fair rental allowance" means the product obtained by*

multiplying the base value of a capital-related asset by the rental rate.... "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

Department Objectives Met if Approved:

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

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

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 15, 2005
Priority Number:	DI - 9	**OSPB Approval:**		**Date:**	
Program:	Acute Care Benefits Section	**Statutory Citation:**	26-4-302, C.R.S. (2005)		
Request Title:	Move Non-Emergency Medical Transportation Administrative Costs from County Administration				

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	19,117,137	13,253,365	0	13,253,365	13,253,365	0	13,253,365	0	13,253,365	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	7,654,430	5,527,011	0	5,527,011	5,527,011	0	5,527,011	0	5,527,011	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	0	0	0	0	0	0	0	0	0
	FF	11,462,707	7,726,354	0	7,726,354	7,726,354	0	7,726,354	0	7,726,354	0
(1) Executive Director's Office, Non-Emergency Transportation Services	**Total**	3,450,394	4,455,988	0	4,455,988	4,455,988	485,732	4,941,720	0	4,941,720	485,732
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,725,197	2,227,994	0	2,227,994	2,227,994	242,866	2,470,860	0	2,470,860	242,866
	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	1,725,197	2,227,994	0	2,227,994	2,227,994	242,866	2,470,860	0	2,470,860	242,866
(6) Department of Human Services Medicaid-Funded Programs (D) County Administration-Medicaid Funding	**Total**	15,666,743	8,797,377	0	8,797,377	8,797,377	(485,732)	8,311,645	0	8,311,645	(485,732)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	5,929,233	3,299,017	0	3,299,017	3,299,017	(242,866)	3,056,151	0	3,056,151	(242,866)
	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	9,737,510	5,498,360	0	5,498,360	5,498,360	(242,866)	5,255,494	0	5,255,494	(242,866)

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:)	Department of Human Services	

CHANGE REQUEST for FY 06-07
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:	Move Non-Emergency Medical Transportation Administrative Costs from County Administration
Long Bill Line Item(s)	(1) Executive Director's Office, Non-Emergency Transportation Services; (6) Department of Human Services Medicaid-Funded Programs (D) County Administration-Medicaid Funding
State and Federal Statutory Authority:	26-4-302 (1.5) C.R.S. (2005)

Summary of Request (Alternative A): This Change Request is to move $485,732 from the Department of Human Services Medicaid-Funded Programs Long Bill group to the Executive Director's Office Long Bill group. Formerly paid to eight Front Range counties (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, and Larimer) for administrative costs of intake of client calls, determining eligibility, and authorizing and arranging transportation to provide clients with non-emergency transportation, this funding is now paid to a transportation broker for these same purposes. Because the majority of the non-emergency transportation costs are paid from a specific line item of the Executive Director's Office Long Bill group, this change will place the funding there.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department of Health Care Policy and Financing assures non-emergency transportation to and from medically necessary services covered by the Colorado Medical

Assistance Program for clients who have no other means of transportation throughout all sixty-four counties in Colorado. The type of transportation authorized is determined by the distance to be traveled, transportation and treatment facilities available, and the physical condition and welfare of the client. Non-emergency medical transportation services include transportation between the client's home and Medicaid covered benefits. There are also administrative costs related to non-emergency medical transportation including, but not limited to, the intake of client calls, determining eligibility, and authorizing and arranging transportation. State designated entities (counties) have been responsible for operating non-emergency medical transportation within allocated funding.

Prior to FY 04-05, the administrative costs were funded through the Department Human Services Medicaid-Funded, County Administration-Medicaid Funding Long Bill group. The costs for providing the non-emergency medical transportation were funded through the Medical Services Premiums Long Bill group.

HB 04-1220 authorized the Department of Health Care Policy and Financing to provide non-emergency medical transportation services as an administrative cost, compared to a medical service, allowing the State more flexibility in how it provides non-emergency medical transportation. Effective July 1, 2004, the medical services funding was transferred from the Medical Services Premiums Long Bill group to the Executive Director's Office Long Bill group, in the Non-Emergency Transportation Services line item. The funding for administrative costs, however, remained in the Department of Human Services Medicaid-Funded Programs, County Administration-Medicaid Funding Long Bill group. Effective August 1, 2004, the Department of Health Care Policy and Financing required non-emergency medical transportation providers to become Medicaid providers. This resulted in the transportation providers billing directly for most transportation, eliminating that responsibility from the counties. Counties continued to authorize and arrange non-emergency medical transportation.

Beginning July 1, 2005, the Department of Health Care Policy and Financing entered into an emergency contract for transportation brokerage services to provide non-emergency medical transportation and administrative services to Medicaid clients residing in the

eight front-range counties (Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, and Larimer). The funding allocated to the Department of Human Services-Medicaid Funded Programs, County Administration-Medicaid Funding for the administrative services for these eight counties has been restricted, therefore is not being transferred to the Department of Human Services. Rather, the eight front-range counties are submitting claims to the Department of Health Care Policy and Financing and are paid with these restricted funds directly from the Department. The remaining fifty-six Colorado counties administer the non-emergency medical transportation program. These counties continue to receive funding from Department of Human Services-Medicaid Funded Programs, County Administration-Medicaid Funding.

General Description of Alternative:

The Department requests this technical correction to move appropriated dollars for the administrative costs for the eight Front Range counties served by the transportation broker from the Department of Human Services Medicaid-Funded Programs, County Administration-Medicaid Funding appropriation to the Executive Director's Office, Non-Emergency Transportation Services line item. This amount is $485,732 total funds at 50% federal financial participation.

The advantage to this change is it would improve understanding and tracking of the transportation brokerage contract, since it would place all expenditures associated with the transportation broker in the same budget location. Currently, the administrative cost budget for all Colorado counties is in the Department of Human Services Medicaid-Funded Programs, County Administration line item. Because this funding is not being transferred to the Department of Human Services, it would be more accurate to move the budget for the administration costs for the eight Front Range counties from the Department of Human Services Medicaid-Funded Programs, County Administration line to the appropriate Non-Emergency Medical Transportation line item in the Department's Executive Director's Office section.

This change has a net zero impact to the Department's Budget.

Calculations for Alternative's Funding:

Summary of Request FY 06-07 and FY 07-08 Matches Schedule 6 Incremental Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request	$0	$0	$0
(1) Executive Director's Office, Non-Emergency Medical Transportation	$485,732	$242,866	$242,866
(6) Department of Human Services Medicaid-Funded Programs (D) County Administration-Medicaid Funding	($485,732)	($242,866)	($242,866)

Summary of Request FY 06-07 and FY 07-08 (1) Executive Director's Office Non-Emergency Medical Transportation	**Total Funds**	**General Fund**	**Federal Funds**
FY 06-07 Base Amount	$4,455,988	$2,227,994	$2,227,994
Requested Increase (matches Schedule 6)	$485,732	$242,866	$242,866
FY 06-07 Request	$4,941,720	$2,470,860	$2,470,860

Summary of Request FY 06-07 and FY 07-08 (6) Department of Human Services Medicaid-Funded Programs (D) County Administration-Medicaid Funding	**Total Funds**	**General Fund**	**Federal Funds**
FY 06-07 Base Amount	$8,797,377	$3,299,017	$5,498,360
Requested Reduction (matches Schedule 6)	($485,732)	($242,866)	($242,866)
FY 06-07 Request	$8,311,645	$3,056,151	$5,255,494

Impact on Other Areas of Government: This request reduces the amount of Cash Funds Exempt transferred to the Department of Human Services by $485,272 in their Long Bill group (4) County Administration, in the line item "County Administration."

DHS Long Bill Group (4) County Administration, County Administration				
	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 06-07 Base Amount	$43,683,325	$13,163,290	$17,587,080	$12,932,955
Requested Reduction	($485,732)	$0	($485,732)	$0
FY 06-07 Request	$43,197,593	$13,163,290	$17,101,348	$12,932,955

Assumptions for Calculations: The amount of $485,732 is based on the annualized monthly average of administrative costs for each of the eight Front Range counties. The actual administrative expenditures the contractor billed to each of the eight Front Range counties were received by each county for the period of March 2003 through February 2004, and are shown in the table below. This data was utilized to project FY 04-05 and FY 05-06 withholding amounts from the Department of Human Services-Medicaid Funded Programs, County Administration-Medicaid Funding line item. The following table is how the FY 06-07 estimated amount was calculated:

County	Actual Costs (March 2003-February 2004)	Monthly Average	Annual Estimate based on Monthly Average
Adams	$58,755	$4,896	$58,755
Arapahoe	$126,689	$10,557	$126,689
Boulder	$33,040	$2,753	$33,040
Broomfield	$2,082	$174	$2,082
Denver	$204,864	$17,072	$204,864
Douglas*	$2,288	$254	$3,051
Jefferson	$37,632	$3,136	$37,632
Larimer	$19,619	$1,635	$19,619
Total	**$484,969**	**$40,478**	**$485,732**

* Actual costs for Douglas represent only nine months of data. Monthly average has been annualized.

These costs are authorized for 50% federal financial participation.

Concerns or Uncertainties of Alternative: The Department has estimated the potential contractor costs for the eight Front Range counties. If the actual costs are different than the estimated costs, the Department will manage to the funding authorized by the General Assembly.

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

General Description of Alternative: This alternative would retain the funding for the administrative costs for non-emergency medical transportation for the eight Front Range counties within Department of Human Services Medicaid-Funded Programs, County Administration-Medicaid Funding line item.

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

Concerns or Uncertainties of Alternative: This alternative would continue to fund the administrative costs for non-emergency transportation services in the Department of Human Services transfer line, resulting in the line to be overstated given that the transfer to Department of Human Services for Non-emergency Medical Transportation will not occur for the eight Front Range counties. It would require the Department to restrict funding in this Department of Human Services transfer appropriation every year, and the budget would not reflect the actual need in either the Department of Human Services transfer appropriation, or the Non-Emergency Medical Transportation appropriation.

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;
- Creates budget clarity for non-emergency transportation payments.
- Prevents the appearance of a transfer that does not occur.

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:

26-4-302, C.R.S. (2005). 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: (t) Repealed: (1.5) In addition to the services described in subsection (1) of this section and subject to continued federal financial participation, Colorado has selected to provide transportation services as an administrative cost.*

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 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	DI - 10	**OSPB Approval:**		**Date:**
Program:	Medical Assistance Office	**Statutory Citation:**	26-4-104, C.R.S. (2005)	
Request Title:	Denver Health Medical Center Medicaid Outstationing Alternative Financing Plan			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	2,339,155	2,179,541,303	0	2,179,541,303	2,538,298
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	0	1,038,134,760	0	1,038,134,760	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	1,169,578	86,315,888	0	86,315,888	1,269,149
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	1,169,577	1,055,014,143	0	1,055,014,143	1,269,149
(2) Medical Services Premiums											
	Total	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	2,339,155	2,179,541,303	0	2,179,541,303	2,538,298
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	0	1,038,134,760	0	1,038,134,760	0
	GFE	0	0	0	0		0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,065,603	0	66,065,603	85,146,310	1,169,578	86,315,888	0	86,315,888	1,269,149
	FF	954,696,801	1,069,716,621	0	1,069,716,621	1,053,844,566	1,169,577	1,055,014,143	0	1,055,014,143	1,269,149

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	CF: Service fees from privately-owned intermediate care facilities; CFE: Breast and Cervical Prevention and Treatment Fund, Colorado Autism Treatment Fund, Health Care Expansion Fund, Transfer from the Department of Public Health and Environment, and Certification of Public Expenditures; 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 06-07
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:	Denver Health Medical Center Medicaid Outstationing Alternative Financing Plan
Long Bill Line Item(s)	(2) Medical Services Premiums
State and Federal Statutory Authority:	26-4-104, C.R.S. (2005), et seq., 1902 (a) (55) of the Social Security Act, 42 CFR 435.904, 42 CFR 433.51.

Summary of Request (Alternative A): This Request is for $2,339,155 total funds for Medical Services Premiums to enhance reimbursement to public hospital-affiliated federally qualified health centers for their costs of providing outstation locations to process applications. This Request would benefit the Denver Health Medical Center federally qualified health centers by reimbursing them for the federal share of their actual expenditures in excess of the current reimbursement methodology. This proposed increase would not require any increase in State General Fund.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: Under 1902 (a) (55) of the Social Security Act, as implemented by regulations at 42 CFR 435.904, state Medicaid agencies must provide an opportunity for certain low-income eligibility groups to apply for Medicaid at “outstation” locations other than the usual “welfare” offices. Outstation locations include Disproportionate Share Hospitals and federally qualified health centers. Currently, all federally qualified health centers,

including the hospital-affiliated clinics administered by Denver Health Medical Center, provide a level of on-site services to inform, educate, assist and enroll qualifying children and their families into the Medicaid program. The federally qualified health centers receive a separate "outstationing payment" as reimbursement for their costs associated with providing these services. Under the Department's current Volume 8 rules (section 8.700.8 – Reimbursement for Outstationing Administration), reimbursement is limited to the lower of actual reasonable costs up to $12.66 per application, or a maximum of $60,000 per clinic per year. The Denver Health Medical Center hospital-affiliated federally qualified health centers currently receive the maximum annual $60,000 reimbursement paid for each clinic. However, based on annual Medicare/Medicaid cost reports, the costs of providing outstationing services for Denver Health's federally qualified health centers significantly exceed the $60,000 per clinic limit. Denver Health Medical Center is a significant public provider of health services for many of the Department's programs.

General Description of Alternative:

This Request is for additional funding to cover fifty percent of the additional costs beyond the current reimbursement maximum of $60,000 per facility for outstationing services. Under this alternative, the Department would claim federal financial participation on the additional costs currently experienced by Denver Health Medical Center federally qualified health clinics that are not being reimbursed by the existing Volume 8 rules. The State share of the costs claimed would be from the certification of public expenditures by Denver Health Medical Center recorded as Cash Funds Exempt, and would not increase the amount of General Fund appropriated to the Medical Services Premiums line item, where these costs are budgeted. This Request provides an opportunity to enhance and increase the reimbursement to Denver Health Medical Center for outstationing activities without an increase in General Fund.

Currently, the only "hospital-affiliated" federally qualified health centers are those operated by Denver Health Medical Center. During calendar years 2000 through 2002, Denver Health Medical Center operated 24 facilities. However, beginning in calendar year 2003, Denver Health Medical Center reduced the number of facilities in operation down to 19.

To determine reimbursement for their outstationing activities, Denver Health affiliated federally qualified health centers report their costs associated with providing outstationing services on an extra line on the Denver Health Medical Center annual Medicare/Medicaid cost report. After these Medicare/Medicaid cost reports are audited, the Department reimburses Denver Health Medical Center with a single lump sum retroactive payment. The lag time between the reporting year of the Medicare/Medicaid cost report and completion of the Medicaid audit for that report is currently about five years. Thus, for FY 06-07, Denver Health Medical Center will be reimbursed based on its 2002 Medicare/Medicaid cost report. Correspondence with the Centers for Medicare and Medicaid Services indicate that this proposal is accepted. No change in our Medicaid State Plan is necessary. A change in Department rules regarding reimbursement for outstationing activities would need to be approved by the Medical Services Board. The language of the recommended rule change will ensure that interpretation will limit additional reimbursement to the amount of certified public expenditures available. It is likely such a change would be approved.

Calculations for Alternative's Funding:

FY 06-07 Summary of Request Medical Services Premiums Matches Schedule 6	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 06-07 Base Funding	$2,177,202,148	$1,038,134,760	$76,512	$85,146,310	$1,053,844,566
Additional Outstationing Funding	$2,339,155	$0	$0	$1,169,578	$1,169,577
FY 06-07 November 15 Request	$2,179,541,303	$1,038,134,760	$76,512	$86,315,888	$1,055,014,143

Current Reimbursement Calculation:

Fiscal Year	**Cost Report for Year Ending**	**Number of Clinics**	**Reimbursement per Clinic (current maximum)**	**Total Reimbursement for all Clinics (50% federal funds, 50% General Fund)**
FY 06-07	2002	24	$60,000	$1,440,000
FY 07-08	2003	19	$60,000	$1,140,000

Proposed Reimbursement Calculation:

Fiscal Year	Cost Report for Year Ending	Actual Outstationing Costs	Current Reimbursement	Excess Costs over Current Reimbursement	Additional Provider Payment (Federal Share of Excess Costs Over Current Reimbursement – 50% of Excess Costs)
06-07	2002	$3,779,155	$1,440,000	$2,339,155	$1,169,577
07-08	2003	$3,678,298	$1,140,000	$2,538,298	$1,269,149

Fiscal Year	Alternative Request Total Funds	Alternative Request Cash Funds Exempt	Alternative Request Federal Funds
06-07	$2,339,155	$1,169,578	$1,169,577
07-08	$2,538,298	$1,269,149	$1,269,149

Impact on Other Areas of Government: This alternative does not impact other areas of State government.

Assumptions for Calculations: Denver Health Medical Center costs of providing outstationing services (to be used in the reimbursement calculation for FY 06-07) are estimated to equal $3,779,155[1]. These costs represent outstationing costs for 24 facilities, or an average of $157,465 per facility ($3,779,155 / 24 = $157,465). As $157,465 is greater than the current maximum reimbursement amount of $60,000, current Volume 8 rules will not reimburse Denver Health Medical Center for outstationing costs beyond $1,440,000 (or $60,000 * 24 facilities). However, the federal government would authorize this through a State Plan Amendment and Volume 8 rules could be changed to reflect the change in methodology to the extent that this is possible through the certification of public expenditures.

This Request is for funding equal to $2,339,155, the difference of the estimated outstationing facilities costs and the maximum amount that Volume 8 rules will currently

[1] Calendar Year 2002 and 2003 Medicare/Medicaid cost reports are actual reported amounts, but are not yet audited.

allow. Using certification of public expenditures, the Department can draw federal matching funds for 50% of the uncompensated costs and pass these funds along to the provider. One half of the $2,339,155 total uncompensated costs, or $1,169,578, would be appropriated as Cash Funds Exempt.

For FY 07-08, the estimated outstationing reimbursement is assumed to decrease, as the number of facilities drops from 24 to 19. Assuming the $60,000 per facility, Denver Health Medical Center could receive a maximum of $1,140,000 for outstationing services. However, as costs are estimated to be $3,678,298, the net of $2,538,298 in uncompensated costs can be again split 50% Cash Funds Exempt, and 50% matching federal funds. This annualization would occur in the Base Budget Request.

Concerns or Uncertainties of Alternative: FY 06-07 and FY 07-08 amounts are estimated using Medicare/Medicaid cost reports that have not yet been finalized. However, the Department's auditor indicates that the handling of the cost centers and reported overhead costs used to determine the total costs looks consistent with the calculations on previous years' audited cost reports.

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

General Description of Alternative: Reimbursement to Denver Health Medical Center for federally required outstationing activities to assist low-income children and families in applying for Medicaid benefits at their federally qualified health centers would be based on the existing methodology and remain at the current capped amount of $60,000 per clinic under current Department rules.

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

Concerns or Uncertainties of Alternative: This alternative does not maximize the federal funds participation and continues to expect Denver Health Medical Center to absorb a significant portion of the costs associated with performing outpatient activities. Denver Health Medical Center's ability to provide quality health care services to clients of the Medicaid and Children's Basic Health Plan

programs and to uninsured and underinsured residents may be compromised due to the provider's financial stability.

Supporting Documentation

Analytical Technique: Cost/Benefit Analysis

	Alternative A	Alternative B
Cost	FY 06-07 $2,339,155 FY 07-08 $2,538,298	FY 06-07 $0 FY 07-08 $0
Benefit	Denver Health Medical Center receives an additional $1,169,577 in reimbursement from federal matching funds	No benefits. Denver Health Medical Center does not receive any additional reimbursement for incurred costs for providing outstationing services.
Benefit	No additional General Fund is required to reimburse providers for these uncompensated costs	No General Fund is needed.

Quantitative Evaluation of Performance - Compare all Alternatives:

The preferred alternative will allow Denver Health Medical Services to receive $1,169,577 in additional reimbursement for a portion of their costs to provide outstationing services.

Statutory and Federal Authority:

26-4-104 (1), C.R.S. (2005), et seq. Program of medical assistance – single state agency. *The state department, by rules and regulations, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article.*

1902(a) (55) of the Social Security Act, 42 CFR 435.904. Establishment of outstation locations to process applications for certain low income eligibility groups. (*a) State plan requirements. The Medicaid State plan must specify that the requirements of this section*

are met. (b) Opportunity to apply. The agency must provide an opportunity for the following groups of low-income pregnant women, infants, and children under age 19 to apply for Medicaid at outstation locations other than AFDC offices:
(1) The groups of pregnant women or infants with incomes up to 133 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(i)(IV) of the Act;
(2) The group of children age 1 up to age 6 with incomes at 133 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(i)(VI) of the Act;
(3) The group of children age 6 up to age 19 born after September 30, 1983, with incomes up to 100 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(i)(VII) of the Act; and
(4) The groups of pregnant women or infants, children age 1 up to age 6, and children age 6 up to age 19, who are not eligible as a mandatory group, with incomes up to 185 percent of the Federal poverty level as specified under section 1902(a)(10)(A)(ii)(IX) of the Act.

42 CFR 433.51.
Public funds as the State share of financial participation.
(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
(b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

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.

1.6 To work towards systemic improvement in the Department's operations to expand efficiencies, minimize waste, ensure coordination, and eliminate discrepancies.

Schedule 6
Change Request for FY 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	DI-11	**OSPB Approval:**		**Date:**
Program:	Rates Section	**Statutory Citation:**	26-4-404 (1) (a), C.R.S. (2005); 26-4-405, C.R.S. (2005); and 26-4-119 (1) (d), C.R.S. (2005)	
Request Title:	Hospital and Federally Qualified Health Center Audits - Increase for COLA Provision in Contract			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	250,000	350,000	0	350,000	350,000	17,850	367,850	0	367,850	17,850
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	125,000	175,000	0	175,000	175,000	8,925	183,925	0	183,925	8,925
	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	175,000	0	175,000	175,000	8,925	183,925	0	183,925	8,925
(1) Executive Director's Office, Hospital and Federally Qualified Health Clinic Audits											
	Total	250,000	350,000	0	350,000	350,000	17,850	367,850	0	367,850	17,850
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	125,000	175,000	0	175,000	175,000	8,925	183,925	0	183,925	8,925
	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	175,000	0	175,000	175,000	8,925	183,925	0	183,925	8,925

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 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

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

Priority Number:	DI-11
Change Request Title:	Hospital and Federally Qualified Health Center Audits - Increase for COLA Provision in Contract
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. (2005); 26-4-405, C.R.S. (2005); and 26-4-119 (1) (d), C.R.S. (2005)

Summary of Request (Alternative A): This request increases funding of hospital and federally qualified health clinic audits by 5.1%, or $17,850 total funds to comply with the cost of living adjustment contained in the terms of the contract with Parrish Moody and Fikes, the certified public accounting firm performing the audits.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department contracts with a certified public accounting firm to perform federally mandated cost and rate data audits for hospitals, federally qualified health clinics and rural health centers that participate in Medicaid. The hospital and clinic audits are completed from Medicare/Medicaid cost reports and are tailored to the Medicaid requirements; commonly referred to as desk audits. The certified public accounting firm provides the following services: establish reimbursement rates, review contracts, calculate final cost settlements, rebase calculations, consult and assist on cost report interpretations, and meet with providers to resolve discrepancies. The annual rates of

reimbursement for hospitals, federally qualified health clinics and rural health centers are computed from and based on 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.

Audits have produced savings in Medical Services Premiums of over $5 million in each of the past years with the base appropriation of $250,000. Although the Department spent the entire appropriation each year for this purpose, additional recovery opportunities existed which the Department was not able to recover. By including site audits, the Department believed it could increase recoveries beyond existing levels. Therefore, Change Request DI-11, "Funding for Hospital and Federally Qualified Health Clinic Audits to Increase Recoveries", submitted November 1, 2004, was approved to fund this program for an additional $100,000 to sanction the performance of 25 site audits with the intent of providing additional Medical Services Premiums savings. DI-11, referenced above, states that for every additional dollar spent on hospital and federally qualified health clinic audits, the Department recoups $2.72 in improper payments.

The Department's rate setting for health centers is being conducted in FY 05-06. By increasing funding for desk and site audits each year, the Department obtains more accurate, and in all probability, lower costs on which to base ongoing audits.

General Description of Alternative: This Request increases funding by 5.1%, or $17,850 total funds, to provide for the cost of living adjustment contained in the contract with Parrish Moody and Fikes.

The contract with the certified public accounting firm is a two year agreement with the option to renew for three successive one year terms. Due to the length of the agreement, a cost of living increase was included in the contract for the three optional years, and is based on the Consumer Price Index for Urban Wage Earners and Clerical Workers, for the twelve months preceding the option year, but is subject to approval by the General Assembly. FY 06-07 is the second option year, no increase was provided for in the first option year of the contract. Specifically, Section II.3.d of the contract states:

"Negotiated contract price increases in the years subsequent to the contract period shall be limited to the Consumer Price Index - W (CPI-W) inflationary increase for the twelve months preceding the option year being negotiated, but are subject to the General Assembly's approval."

It is anticipated that by providing the contractually stipulated cost of living adjustment, the Department will be able to maintain the historic level of recoveries, thereby continuing previously realized savings in the Medical Services Premiums budget line item expenses.

The Department is committed to reclaiming the maximum amounts allowed by increasing both the number and complexity of audits of hospitals and health clinics. Adding or maintaining the number of 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.

Calculations for Alternative's Funding:

Summary of Request FY 06-07 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request FY 06-07 (Column 7)	$367,850	$183,925	$183,925
FY 06-07 Change Request (Column 6)	$17,850	$8,925	$8,925
FY 06-07 Base Request (Column 5)	$350,000	$175,000	$175,000

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request Change From Base in Out Year (Column 10)	$17,850	$8,925	$8,925

Impact on Other Areas of Government: None

Assumptions for Calculations: This cost of living increase is based on program management's analysis of the Consumer Price Index - W, increases for two years as no increase was provided during the first option year of the contract.

Concerns or Uncertainties of Alternative: This is a cost of living increase and will not necessarily increase recoveries nor result in any additional Medical Services Premiums savings. Rather, the intent of this Change Request is to provide the certified public accounting firm with the resources necessary to maintain current efforts in identifying overpayments to providers. Therefore, no additional recoveries are guaranteed.

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

General Description of Alternative: Maintain current funding level for hospital and federally qualified health clinics audits.

Calculations for Alternative's Funding: There is no change in funding with this alternative.

Concerns or Uncertainties of Alternative: If the appropriation is not increased per the contract, the certified public accounting firm may choose to perform fewer audits, perform the same number of audits as they previously conducted, or not agree to renew the contract.

To date, the Department has been successful in identifying costs that can be disallowed at the current level of funding. However, if the contracted cost of living adjustment is not funded, the Department would be violating the intent of the contract with the certified public accounting firm. How the firm would respond is unknown. They could negotiate a reduced audit schedule for the same funding, or they may choose not to renew the contractual relationship entirely. It is assumed that due to increased administrative costs at the accounting firm, and no cost of living adjustment to date, the certified public accounting firm would either scale back their work or possibly even drop out of the contract without the cost of living adjustment.

Supporting Documentation

Analytical Technique: Return on Investment

Site Audits	Amount	Cost per Audit	# of Audits	Net Savings Site Audit	
Alternative A, with cost of living allowance	$105,100	$4,204.00	25.00	Savings per $ Spent*	$2.72
Alternative B, no cost of living allowance	$100,000	$4,000.00	25.00	Total Savings	($13,872)
Assumed Fewer Audits for Same Dollars	$100,000	$4,204.00	23.79	Costs	$5,100
Decrease in number of Site Audits			1.21	Net Savings	($8,772)
Desk Audits	**Amount**	**Cost per Audit**	**# of Audits**	**Net Savings Desk Audit**	
Alternative A, with cost of living allowance	$262,750	$1,094.79	240.00	Savings per $ Spent*	$2.72
Alternative B, no cost of living allowance	$250,000	$1,041.67	240.00	Total Savings	($34,680)
Assumed Fewer Audits for Same Dollars	$250,000	$1,094.79	228.35	Costs	$12,750
Decrease in number of Desk Audits			11.65	Net Savings	($21,930)
Total Blended Net Savings					($30,702)

* This amount has not been updated since the prior year. Since this analysis is a rough estimate of savings versus costs, and is assumed to be in the base, the Department is not recommending removing these savings from the Medical Services Premiums.

Quantitative Evaluation of Performance - Since it is unknown how the certified public accounting firm would respond if they were not provided the cost of living increase, program staff was asked to assign probabilities to each possible alternative. That is, drop out of the contract, reduce the audit schedule with no increase in funding, or continue the full audit schedule with no increase in funding. The probabilities they assigned were 10% probability of dropping out of the contract, 75% probability of reducing the audit schedule, and a 15% probability of agreeing to the full audit schedule with no increase in funding. Using the most likely scenario provided by program management, which is a reduced audit schedule for the same amount of funding, the table above quantifies the net savings that would continue to be realized by funding the cost of living adjustment.

Based on the previously mentioned assumption that for every dollar spent on audits of hospitals and federally qualified health clinics a savings of $2.72 is realized, Alternative

A will result in a continued net savings of $30,702 versus a loss of this ongoing savings under Alternative B.

Statutory and Federal Authority:

26-4-404, (1) (a) C.R.S. (2005) 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. (2005) 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. The state department shall promulgate rules and regulations to provide for the implementation of this section.*

26-4-119, (1) (d) C.R.S. (2005) 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 programs 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 06-07

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 15, 2005
Priority Number:	DI-11.5	**OSPB Approval:**		**Date:**
Program:	Medical Assistance Office	**Statutory Citation:**	26-4-104 (1), C.R.S. (2005) and 26-4-201 (1), C.R.S. (2005)	
Request Title:	3% Provider Rate Increase			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 04-05	Appropriation FY 05-06	Supplemental Request FY 05-06	Total Revised Request FY 05-06	Base Request FY 06-07	Decision/ Base Reduction FY 06-07	November 15 Request FY 06-07	Budget Amendment FY 06-07	Total Revised Request FY 06-07	Change from Base in Out Year FY 07-08
Total of All Line Items	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	33,404,373	2,210,606,521	0	2,210,606,521	33,404,373
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	16,702,187	1,054,836,947	0	1,054,836,947	16,702,187
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,834,649	0	66,834,649	85,146,310	0	85,146,310	0	85,146,310	0
	FF	954,696,801	1,089,373,641	0	1,089,373,641	1,053,844,566	16,702,186	1,070,546,752	0	1,070,546,752	16,702,186
(2) Medical Services Premiums	**Total**	1,920,474,771	2,178,221,370	0	2,178,221,370	2,177,202,148	33,404,373	2,210,606,521	0	2,210,606,521	33,404,373
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	935,078,890	1,042,362,634	0	1,042,362,634	1,038,134,760	16,702,187	1,054,836,947	0	1,054,836,947	16,702,187
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	30,699,080	66,834,649	0	66,834,649	85,146,310	0	85,146,310	0	85,146,310	0
	FF	954,696,801	1,089,373,641	0	1,089,373,641	1,053,844,566	16,702,186	1,070,546,752	0	1,070,546,752	16,702,186

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: CF: Provider Fees and Service Fees CFE: Certified Public Expenditures, Breast and Cervical Cancer Prevention and Treatment Fund, Health Expansion Fund, and Prevention, Early Detection, and Treatment Fund (Transferred from the Department of Public Health and Environment). 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 06-07
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):

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

Priority Number:	DI-11.5
Change Request Title:	3% Provider Rate Increase
Long Bill Line Item(s)	(2) Medical Services Premiums
State and Federal Statutory Authority:	26-4-104 (1), C.R.S. (2005) and 26-4-201 (1), C.R.S. (2005)

Summary of Request (Alternative A): This Request is for a 3% provider reimbursement rate increase to inpatient hospitals, primary care physicians, and home health and home and community-based providers. This Request is for $33,404,373 total funds. Since a full analysis can not be completed at this time, the Department used estimates from its February 25, 2005 responses to Joint Budget Committee Follow-up Questions, updated for caseload growth. An updated impact for this recommended provider rate increase will be included with the February 15, 2006 Medical Services Premiums Budget Request.

General Description of Alternative: Costs associated with each percentage change in reimbursement rate for providers require a corresponding change in health maintenance organization reimbursement rates. The following tables outline the impact to both providers' and health maintenance organizations' reimbursement for a 3% change in reimbursement rate. Increases were determined using actual FY 03-04 specific provider type expenditures for inpatient hospital, home health, or primary care physicians that were used in the Department's responses to the Joint Budget Committee's Follow-up Questions on February 25, 2005. These estimates were then adjusted to account for actual and projected caseload growth from FY 03-04 to FY 06-07.

The corresponding HMO rate increase was determined using the actual weighted FY 03-04 HMO service category specific amount times 3%. The weight associated with the HMO service category amount was the ratio of the rate for the specified provider group over the total HMO rate.

Reported in Follow-up Responses to the Joint Budget Committee on February 25, 2005			
Provider Type	Fee-for-Service	Health Maintenance Organization	Total Impact for 3% Rate Increase
A. Inpatient Hospital	$8,197,421	$1,389,538	$9,586,959
B. Home Health / Home and Community-Based Service Providers	$6,979,616	$25,781	$7,005,397
C. Primary Care Providers	$7,527,309	$1,363,844	$8,891,154
D. Total for All Provider Types [=A+B+C]	**$22,704,346**	**$2,779,163**	**$25,483,509**
Caseload Growth from the November 15, 2005 Medical Services Premiums Budget Request, Exhibit EB-1			
E. Actual Growth from FY 03-04 to FY 04-05			11.11%
F. Projected Growth from FY 04-05 to FY 05-06			9.00%
G. Projected Growth from FY 05-06 to FY 06-07			8.23%
H. Growth from FY 03-04 to FY 06-07 [=((1+E)*(1+F)*(1+G))-1]			**31.08%**
I. Estimated Funding Needed for 3% Provider Rate Increase in FY 06-07 [=D*(1+H)]*			**$33,404,373**

* Math does not match exactly due to rounding caseload growth rates to two decimal places.