## Schedule 13
## Change Request for FY 08-09 Budget Request Cycle

| | | | | |
|---|---|---|---|---|
| | Decision Item FY 08-09 ☐ | Base Reduction Item FY 08-09 ☐ | Supplemental FY 07-08 ☑ | Budget Request Amendment FY 08-09 ☑ |
| **Request Title:** | Building Blocks to Health Care Reform | | | |
| **Department:** | Health Care Policy and Financing | **Dept. Approval by:** | John Bartholomew | **Date:** February 15, 2008 |
| **Priority Number:** | S-1A, BA-A1A | **OSPB Approval:** | | **Date:** 2/14/08 |

| | Fund | 1<br>Prior-Year Actual FY 06-07 | 2<br>Appropriation FY 07-08 | 3<br>Supplemental Request FY 07-08 | 4<br>Total Revised Request FY 07-08 | 5<br>Base Request FY 08-09 | 6<br>Decision/ Base Reduction FY 08-09 | 7<br>November 1 Request FY 08-09 | 8<br>Budget Amendment FY 08-09 | 9<br>Total Revised Request FY 08-09 | 10<br>Change from Base (Column 5) FY 09-10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total of All Line Items** | **Total** | 2,434,384,397 | 2,516,507,524 | 930,856 | 2,517,438,380 | 2,534,954,339 | 0 | 2,534,954,339 | 63,651,163 | 2,598,605,502 | 93,146,213 |
| | **FTE** | 225.40 | 245.30 | 0.00 | 245.30 | 259.50 | 0.00 | 259.50 | 1.00 | 260.50 | 1.00 |
| | **GF** | 758,385,425 | 768,356,827 | 263,444 | 768,620,271 | 771,800,841 | 0 | 771,800,841 | 25,044,378 | 796,845,219 | 36,678,226 |
| | **GFE** | 343,100,000 | 343,900,000 | 0 | 343,900,000 | 343,900,000 | 0 | 343,900,000 | 0 | 343,900,000 | 0 |
| | **CF** | 232,136 | 882,586 | 374 | 882,960 | 1,927,630 | 0 | 1,927,630 | 53,438 | 1,981,068 | 115,522 |
| | **CFE** | 94,145,006 | 124,684,364 | 127,220 | 124,811,584 | 130,271,258 | 0 | 130,271,258 | 5,942,469 | 136,213,727 | 8,403,828 |
| | **FF** | 1,238,521,830 | 1,278,683,747 | 539,818 | 1,279,223,565 | 1,287,054,610 | 0 | 1,287,054,610 | 32,610,878 | 1,319,665,488 | 47,948,637 |
| **(1) Executive Director's Office Personal Services** | **Total** | 15,260,951 | 16,715,590 | 0 | 16,715,590 | 18,860,743 | 0 | 18,860,743 | 882,525 | 19,743,268 | 959,963 |
| | **FTE** | 225.40 | 245.30 | 0.00 | 245.30 | 259.50 | 0.00 | 259.50 | 1.00 | 260.50 | 1.00 |
| | **GF** | 6,054,845 | 7,261,822 | 0 | 7,261,822 | 7,768,653 | 0 | 7,768,653 | 441,263 | 8,209,916 | 479,982 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 140,495 | 0 | 140,495 | 212,681 | 0 | 212,681 | 0 | 212,681 | 0 |
| | **CFE** | 399,006 | 592,486 | 0 | 592,486 | 2,121,195 | 0 | 2,121,195 | 0 | 2,121,195 | 0 |
| | **FF** | 8,807,100 | 8,720,787 | 0 | 8,720,787 | 8,758,214 | 0 | 8,758,214 | 441,262 | 9,199,476 | 479,981 |
| **(1) Executive Director's Office Operating Expenses** | **Total** | 1,196,014 | 1,039,465 | 0 | 1,039,465 | 1,023,940 | 0 | 1,023,940 | 4,405 | 1,028,345 | 950 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 586,457 | 494,229 | 0 | 494,229 | 486,342 | 0 | 486,342 | 2,203 | 488,545 | 475 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 14,395 | 0 | 14,395 | 3,800 | 0 | 3,800 | 0 | 3,800 | 0 |
| | **CFE** | 8,151 | 14,546 | 0 | 14,546 | 27,093 | 0 | 27,093 | 0 | 27,093 | 0 |
| | **FF** | 601,406 | 516,295 | 0 | 516,295 | 506,705 | 0 | 506,705 | 2,202 | 508,907 | 475 |

**Schedule 13**
**Change Request for FY 08-09 Budget Request Cycle**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Decision Item FY 08-09** ☐ | | | **Base Reduction Item FY 08-09** ☐ | | | **Supplemental FY 07-08** ☑ | | **Budget Request Amendment FY 08-09** ☑ | | |
| **Request Title:** | Building Blocks to Health Care Reform | | | | | | | | | | |
| **Department:** | Health Care Policy and Financing | | | **Dept. Approval by:** | | John Bartholomew | | **Date:** | February 15, 2008 | | |
| **Priority Number:** | S-1A, BA-A1A | | | **OSPB Approval:** | | | | **Date:** | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Fund | Prior-Year Actual FY 06-07 | Appropriation FY 07-08 | Supplemental Request FY 07-08 | Total Revised Request FY 07-08 | Base Request FY 08-09 | Decision/ Base Reduction FY 08-09 | November 1 Request FY 08-09 | Budget Amendment FY 08-09 | Total Revised Request FY 08-09 | Change from Base (Column 5) FY 09-10 |
| **(1) Executive Director's Office Medicaid Management Information System Contract** | **Total** | 26,018,831 | 22,306,209 | 263,718 | 22,569,927 | 22,817,549 | 0 | 22,817,549 | 45,990 | 22,863,539 | 0 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 6,204,550 | 5,265,858 | 65,930 | 5,331,788 | 5,228,266 | 0 | 5,228,266 | 11,497 | 5,239,763 | 0 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 368,971 | 0 | 368,971 | 1,303,749 | 0 | 1,303,749 | 0 | 1,303,749 | 0 |
| | **CFE** | 596,657 | 706,330 | 0 | 706,330 | 610,809 | 0 | 610,809 | 0 | 610,809 | 0 |
| | **FF** | 19,217,624 | 15,965,050 | 197,788 | 16,162,838 | 15,674,725 | 0 | 15,674,725 | 34,493 | 15,709,218 | 0 |
| **(1) Executive Director's Office Colorado Benefits Management System - Medical Assistance (New Line)** | **Total** | 0 | 0 | 250,000 | 250,000 | 0 | 0 | 0 | 10,100,000 | 10,100,000 | 7,975,468 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 0 | 0 | 119,634 | 119,634 | 0 | 0 | 0 | 4,833,204 | 4,833,204 | 3,259,485 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24,509 |
| | **CFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 532,547 |
| | **FF** | 0 | 0 | 130,366 | 130,366 | 0 | 0 | 0 | 5,266,796 | 5,266,796 | 4,158,927 |
| **(1) Executive Director's Office SB 97-05 Enrollment Broker** | **Total** | 860,786 | 700,000 | 2,200 | 702,200 | 700,000 | 0 | 700,000 | 364,482 | 1,064,482 | 145,000 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 411,485 | 316,486 | 1,100 | 317,586 | 316,486 | 0 | 316,486 | 182,241 | 498,727 | 72,500 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CFE** | 18,908 | 33,514 | 0 | 33,514 | 33,514 | 0 | 33,514 | 0 | 33,514 | 0 |
| | **FF** | 430,393 | 350,000 | 1,100 | 351,100 | 350,000 | 0 | 350,000 | 182,241 | 532,241 | 72,500 |

**Schedule 13**
**Change Request for FY 08-09 Budget Request Cycle**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Decision Item FY 08-09** ☐ | | **Base Reduction Item FY 08-09** ☐ | | | **Supplemental FY 07-08** ☑ | | **Budget Request Amendment FY 08-09** ☑ | | |
| **Request Title:** | Building Blocks to Health Care Reform | | | | | | | | | |
| **Department:** | Health Care Policy and Financing | | | **Dept. Approval by:** | | John Bartholomew | | **Date:** | February 15, 2008 | |
| **Priority Number:** | S-1A, BA-A1A | | | **OSPB Approval:** | | | | **Date:** | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Fund | Prior-Year Actual FY 06-07 | Appropriation FY 07-08 | Supplemental Request FY 07-08 | Total Revised Request FY 07-08 | Base Request FY 08-09 | Decision/ Base Reduction FY 08-09 | November 1 Request FY 08-09 | Budget Amendment FY 08-09 | Total Revised Request FY 08-09 | Change from Base (Column 5) FY 09-10 |
| **(1) Executive Director's Office County Administration** | **Total** | 24,003,023 | 23,756,209 | 0 | 23,756,209 | 23,803,133 | 0 | 23,803,133 | 0 | 23,803,133 | (7,918,736) |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 7,216,315 | 7,248,943 | 0 | 7,248,943 | 7,248,943 | 0 | 7,248,943 | 0 | 7,248,943 | (2,416,314) |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 73,526 | 0 | 73,526 | 120,450 | 0 | 120,450 | 0 | 120,450 | (24,509) |
| | **CFE** | 4,881,494 | 4,632,531 | 0 | 4,632,531 | 4,632,531 | 0 | 4,632,531 | 0 | 4,632,531 | (1,544,177) |
| | **FF** | 11,905,214 | 11,801,209 | 0 | 11,801,209 | 11,801,209 | 0 | 11,801,209 | 0 | 11,801,209 | (3,933,736) |
| **(1) Executive Director's Office Centralized Eligibility Vendor (New Line)** | **Total** | 0 | 0 | 153,600 | 153,600 | 0 | 0 | 0 | 2,260,800 | 2,260,800 | 18,657,430 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 0 | 0 | 73,503 | 73,503 | 0 | 0 | 0 | 1,081,872 | 1,081,872 | 8,928,234 |
| | **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 | 80,097 | 80,097 | 0 | 0 | 0 | 1,178,928 | 1,178,928 | 9,729,196 |
| **(1) Executive Director's Office Colorado Regional Health Information Organization (New Line)** | **Total** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 500,000 | 500,000 | 500,000 |
| | **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 | 250,000 | 250,000 | 250,000 |
| | **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 | 0 | 0 | 250,000 | 250,000 | 250,000 |

**Schedule 13**
**Change Request for FY 08-09 Budget Request Cycle**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Decision Item FY 08-09 ☐ | | Base Reduction Item FY 08-09 ☐ | | | Supplemental FY 07-08 ☑ | | Budget Request Amendment FY 08-09 ☑ | | | |
| **Request Title:** | Building Blocks to Health Care Reform | | | | | | | | | | |
| **Department:** | Health Care Policy and Financing | | | **Dept. Approval by:** | | John Bartholomew | | **Date:** | February 15, 2008 | | |
| **Priority Number:** | S-1A, BA-A1A | | | **OSPB Approval:** | | | | **Date:** | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | Fund | Prior-Year Actual FY 06-07 | Appropriation FY 07-08 | Supplemental Request FY 07-08 | Total Revised Request FY 07-08 | Base Request FY 08-09 | Decision/ Base Reduction FY 08-09 | November 1 Request FY 08-09 | Budget Amendment FY 08-09 | Total Revised Request FY 08-09 | Change from Base (Column 5) FY 09-10 |
| **(2) Medical Services Premiums** | **Total** | 2,061,396,808 | 2,147,858,908 | 253,740 | 2,148,112,648 | 2,147,626,990 | 0 | 2,147,626,990 | 30,915,666 | 2,178,542,656 | 44,801,899 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 633,377,714 | 652,421,500 | 0 | 652,421,500 | 651,512,742 | 0 | 651,512,742 | 14,647,539 | 666,160,281 | 21,499,896 |
| | **GFE** | 343,100,000 | 343,900,000 | 0 | 343,900,000 | 343,900,000 | 0 | 343,900,000 | 0 | 343,900,000 | 0 |
| | **CF** | 0 | 38,256 | 0 | 38,256 | 38,256 | 0 | 38,256 | 0 | 38,256 | 0 |
| | **CFE** | 48,860,206 | 76,001,368 | 126,870 | 76,128,238 | 76,794,167 | 0 | 76,794,167 | 810,293 | 77,604,460 | 991,812 |
| | **FF** | 1,036,058,888 | 1,075,497,784 | 126,870 | 1,075,624,654 | 1,075,381,825 | 0 | 1,075,381,825 | 15,457,834 | 1,090,839,659 | 22,310,191 |
| **(3) Medicaid Mental Health Community Programs (A) Mental Health Capitation Payments** | **Total** | 184,640,568 | 196,303,651 | 0 | 196,303,651 | 208,102,155 | 0 | 208,102,155 | 723,095 | 208,825,250 | 1,797,383 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 89,832,730 | 91,315,646 | 0 | 91,315,646 | 95,539,317 | 0 | 95,539,317 | 361,548 | 95,900,865 | 886,430 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CFE** | 2,481,026 | 6,829,511 | 0 | 6,829,511 | 8,503,229 | 0 | 8,503,229 | 0 | 8,503,229 | 24,523 |
| | **FF** | 92,326,812 | 98,158,494 | 0 | 98,158,494 | 104,059,609 | 0 | 104,059,609 | 361,547 | 104,421,156 | 886,430 |
| **(4) Indigent Care Program H.B. 97-1304 Children's Basic Health Plan Trust** | **Total** | 11,475,351 | 256,475 | 350 | 256,825 | 271,456 | 0 | 271,456 | 3,283,148 | 3,554,604 | 7,510,390 |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 11,243,215 | 11,011 | 350 | 11,361 | 22,762 | 0 | 22,762 | 3,230,084 | 3,252,846 | 7,394,868 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 232,136 | 245,464 | 0 | 245,464 | 248,694 | 0 | 248,694 | 53,064 | 301,758 | 115,522 |
| | **CFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **FF** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Schedule 13**
**Change Request for FY 08-09 Budget Request Cycle**

| | | | | |
|---|---|---|---|---|
| | Decision Item FY 08-09 ☐ | Base Reduction Item FY 08-09 ☐ | Supplemental FY 07-08 ☑ | Budget Request Amendment FY 08-09 ☑ |
| **Request Title:** | Building Blocks to Health Care Reform | | | |
| **Department:** | Health Care Policy and Financing | **Dept. Approval by:** | John Bartholomew | **Date:** February 15, 2008 |
| **Priority Number:** | S-1A, BA-A1A | **OSPB Approval:** | | **Date:** |

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Fund | Prior-Year Actual FY 06-07 | Appropriation FY 07-08 | Supplemental Request FY 07-08 | Total Revised Request FY 07-08 | Base Request FY 08-09 | Decision/ Base Reduction FY 08-09 | November 1 Request FY 08-09 | Budget Amendment FY 08-09 | Total Revised Request FY 08-09 | Change from Base (Column 5) FY 09-10 |
| **(4) Indigent Care Program Children's Basic Health Plan Administration** | Total | 5,507,031 | 5,541,590 | 1,000 | 5,542,590 | 5,536,590 | 0 | 5,536,590 | 16,000 | 5,552,590 | (3,879,590) |
| | 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 | 2,459,420 | 2,474,735 | 350 | 2,475,085 | 2,472,951 | 0 | 2,472,951 | 5,600 | 2,478,551 | (1,843,456) |
| | FF | 3,047,611 | 3,066,855 | 650 | 3,067,505 | 3,063,639 | 0 | 3,063,639 | 10,400 | 3,074,039 | (2,036,134) |
| **(4) Indigent Care Program Children's Basic Health Plan Premium Costs** | Total | 89,657,433 | 86,426,598 | 0 | 86,426,598 | 91,098,718 | 0 | 91,098,718 | 13,827,112 | 104,925,830 | 28,933,673 |
| | 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 | 1,479 | 0 | 1,479 | 0 | 0 | 0 | 0 | 0 | 0 |
| | CFE | 31,530,990 | 30,408,342 | 0 | 30,408,342 | 32,045,063 | 0 | 32,045,063 | 4,873,982 | 36,919,045 | 10,201,877 |
| | FF | 58,126,443 | 56,016,777 | 0 | 56,016,777 | 59,053,655 | 0 | 59,053,655 | 8,953,130 | 68,006,785 | 18,731,796 |
| **(4) Indigent Care Program Children's Basic Health Plan Dental Benefit Costs** | Total | 6,834,843 | 6,886,799 | 0 | 6,886,799 | 7,137,597 | 0 | 7,137,597 | 721,692 | 7,859,289 | 1,637,851 |
| | 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 | 2,392,195 | 2,410,380 | 0 | 2,410,380 | 2,498,159 | 0 | 2,498,159 | 252,594 | 2,750,753 | 573,249 |
| | FF | 4,442,648 | 4,476,419 | 0 | 4,476,419 | 4,639,438 | 0 | 4,639,438 | 469,098 | 5,108,536 | 1,064,602 |

**Schedule 13**
**Change Request for FY 08-09 Budget Request Cycle**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Decision Item FY 08-09** ☐ | | | **Base Reduction Item FY 08-09** ☐ | | | **Supplemental FY 07-08** ☑ | | **Budget Request Amendment FY 08-09** ☑ | | |
| **Request Title:** | Building Blocks to Health Care Reform | | | | | | | | | | |
| **Department:** | Health Care Policy and Financing | | | **Dept. Approval by:** | | | John Bartholomew | | **Date:** | February 15, 2008 | |
| **Priority Number:** | S-1A, BA-A1A | | | **OSPB Approval:** | | | | | **Date:** | | |
| | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| | **Fund** | **Prior-Year Actual FY 06-07** | **Appropriation FY 07-08** | **Supplemental Request FY 07-08** | **Total Revised Request FY 07-08** | **Base Request FY 08-09** | **Decision/ Base Reduction FY 08-09** | **November 1 Request FY 08-09** | **Budget Amendment FY 08-09** | **Total Revised Request FY 08-09** | **Change from Base (Column 5) FY 09-10** |
| **(6) Department of Human Services - Medicaid Funded Programs (B) Office of Information Technology Colorado Benefits Management System** | **Total** | 7,532,758 | 8,716,030 | 6,248 | 8,722,278 | 7,975,468 | 0 | 7,975,468 | 6,248 | 7,981,716 | (7,975,468) |
| | **FTE** | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **GF** | 3,458,114 | 4,021,332 | 2,927 | 4,024,259 | 3,677,330 | 0 | 3,677,330 | 2,927 | 3,680,257 | (3,677,330) |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 0 | 374 | 374 | 0 | 0 | 0 | 374 | 374 | 0 |
| | **CFE** | 516,953 | 580,621 | 0 | 580,621 | 532,547 | 0 | 532,547 | 0 | 532,547 | (532,547) |
| | **FF** | 3,557,691 | 4,114,077 | 2,947 | 4,117,024 | 3,765,591 | 0 | 3,765,591 | 2,947 | 3,768,538 | (3,765,591) |
| **Letternote revised text:** | | | | | | | | | | | |
| **Cash Fund name/number, Federal Fund Grant name:** | | | | CF: CBHP Enrollment Fees, Local Funds<br>CFE: Health Care Expansion Fund, Children's Basic Health Plan Trust Fund, Grant Funds; FF: Title XIX, Title XXI | | | | | | | |
| **IT Request:** ☑ **Yes** ☐ **No** | | | | | | | | | | | |
| **Request Affects Other Departments:** ☑ **Yes** ☐ **No** | | | | **If Yes, List Other Departments Here:** | | | **Department of Human Services** | | | | |

# CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

| | |
|---|---|
| Department: | Health Care Policy and Financing |
| Priority Number: | S-1A, BA-A1A |
| Change Request Title: | Building Blocks to Health Care Reform |

**SELECT ONE (click on box):**

☐ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☒ Supplemental Request FY 07-08
☒ Budget Request Amendment FY 08-09

**SELECT ONE (click on box):**

Supplemental or Budget Request Amendment Criterion:
☐ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☒ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: The Department requests $930,856 total funds in FY 07-08, $63,651,163 total funds in FY 08-09, and $93,146,213 total funds in FY 09-10 in order to: centralize Medicaid and Children's Basic Health Plan Eligibility; provide a Medical Home for over 270,000 children enrolled in Medicaid and the Children's Basic Health Plan; increase rates for physicians and dentists; enhance the Children's Basic Health Plan mental health benefit; enroll 200,000 Medicaid clients in an integrated care delivery model; and, fund the Colorado Regional Health Information Organization (CORHIO).

Background and Appropriation History: The Department of Health Care Policy and Financing administers both the Medicaid program and the Children's Basic Health Plan. Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, disabled, adults, and children. The Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX. The Children's Basic Health Plan, marketed as the Child Health Plan *Plus*, was enacted by Title XXI of the Social Security Act to provide affordable health insurance to children under the age of 19 in low-income families (up to 205% of the federal poverty level) who

do not qualify for Medicaid and do not have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration.

In 2006, SB 06-208 established the Blue Ribbon Commission on Health Care Reform ("the Commission"). The Commission was to study and establish health care reform models that expand health care coverage and decrease health care costs for Colorado residents. The Commission was authorized to examine options for expanding cost effective health coverage for all Colorado residents in both the public and private sector markets, with special attention given to the uninsured, underinsured, and those at risk of financial hardship due to medical expenses. The Commission released summary recommendations on November 19, 2007, with final recommendations due to the General Assembly on January 31, 2008.[1]

Many of the recommendations made by the Commission revolve around the expansion of the Medicaid program, including the expansion of both eligibility and benefits to clients. However, the Medicaid and Children's Basic Health Plans are not currently equipped to handle the comprehensive expansions that are being proposed. Therefore, in order to handle the coming expansion of its assistance programs, the Department is proposing significant enhancements to its most basic programs to ensure that clients enrolled in Medicaid will not be left behind by health care reform.

During FY 06-07 and FY 07-08, the Department met with the Primary Care Provider Rate Task Force, established in accordance with footnote 24 of the SB 07-239. The Task Force identified that Medicaid rates paid to physicians and pediatricians were inadequate, and in many cases were not covering the cost of providing the services. The Department cannot afford to have more physicians leave its fee-for-service network. Access-to-care is already a critical concern for the Department, and if more doctors are unwilling to provide services at current Medicaid rates, it is Medicaid clients who will pay the price. In previous Budget Requests, the Department has targeted the areas of greatest need to

[1] The Commission's summary recommendations are available on its website, http://www.colorado.gov/208commission/

ensure that the most basic levels of care are still available. But without wholesale changes, the Department will never be able to do better than the basic level of care. Medicaid clients need access to routine primary care to ensure that they do not suffer the sort of adverse health events that are devastating to a person's life. These events are not only bad for the client, but bad for the state, which foots the bill for care which may not have been needed if primary care was available at the appropriate time.

As Governor Ritter stated in the Colorado Promise, "…our health care system is broken, and this crisis will not be fixed by tinkering around the edges and making only small incremental changes. Solving this crisis is central to fulfilling the Colorado Promise." The Department seeks to ensure that individuals in Medicaid and the Children's Basic Health Plan are not left waiting unnecessarily while their applications are being processed, and to ensure that when they receive coverage there are doctors available to serve those clients in a comprehensive integrated care model which reimburses physicians and providers fairly for the work that they perform.

General Description of Request:

For FY 08-09, the Department is proposing to take 7 significant steps as the building blocks to prepare the Medicaid and Children's Basic Health Plan for comprehensive reforms. First, the Department would enhance the Colorado Benefits Management System to separate those functions related to determination of medical assistance under one federal authority. Second, the Department would centralize medical assistance eligibility processing within the framework of the Colorado Benefits Management System. Third, the Department would provide every child enrolled in the Medicaid and Children's Basic Health Plans the most cost effective health care with access to a Medical Home. Fourth, the Department would improve rates paid to its primary care physicians to ensure that there are doctors willing to accept Medicaid clients. Fifth, the Department would expand the Children's Basic Health Plan's mental health benefit to ensure that children have comparable mental health coverage to Medicaid. Sixth, the Department would expand its managed care program to cover at least half of the Medicaid population. Seventh, the Department would provide funding to the Colorado Regional Health Information Organization to ensure that the Department will be a partner and leader in the development of health information technology.

Part of this Request supersedes other Department Requests; those instances where prior requests have been superseded will be noted. A table is provided in appendix H of this document.

**Centralized Eligibility and Colorado Benefits Management System Enhancements**

The Blue Ribbon Commission for Health Care Reform (the "208 Commission") was created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal (as released on November 4, 2007) suggested creating a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility. This entity would replace the current multiple county-level processes that determine eligibility. The Department seeks funding to model this option, to specify an alternate state-based system and to issue a request for proposals (RFP) to contract with a vendor to provide modernized centralized eligibility services to match the eligibility system. The goal would be to improve navigation of Medicaid eligibility, create expedited eligibility and improve outreach and enrollment in Medicaid and Children's Basic Health Plan. In addition, the entity would modernize the current eligibility determination operations by implementing an automated customer contact center and an electronic document and workflow management system that would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. Further, by implementing a single state-level entity for determining eligibility with an automated customer contact center and an electronic document and workflow management system, the Department would build capacity for future health care expansions, such as the eligibility and enrollment center for a subsidized insurance program.

The Department proposes to contract with an outside vendor to administer the single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility (the "Centralized Eligibility Vendor") with an expected contract start date of July 1, 2009. In

order to assure a successful transition and implementation of centralized eligibility, the Department would require an outside vendor with the requisite experience, skills and knowledge (the "RFP Vendor"); in order to gather the requirements and draft the request for proposals for the Centralized Eligibility Vendor. The Department would have the RFP Vendor analyze and provide the Department best practices for administering a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility. Further, the RFP Vendor would be expected to conduct a comprehensive business process analysis, with accompanying cost benefit and return on investment analyses, to improve the efficiency and quality of the eligibility and enrollment operations for the Department's health care programs.

While implementing an automated customer contact center, an electronic document management system and workflow process management system for all eligibility related material would greatly increase the efficiency and effectiveness of Medicaid and Children's Basic Health Plan eligibility and enrollment, there are corresponding system changes that must also occur. In addition to the mail-in application options currently available to clients who apply for Medicaid and Children's Basic Health Plan, the Department proposes to develop a Virtual Application Gateway that would streamline the eligibility application process and create new alternative methods to apply for clients. The application for Medicaid and Children's Basic Health Plan could be completed electronically and submitted to the Centralized Eligibility Vendor through this process. Further, the system could be used to provide updated information and to process redeterminations.

In addition, the Department proposes changes to the Colorado Benefits Management System (CBMS) eligibility system that is jointly managed by the Department and the Department of Human Services. The Departments have a good relationship and are working together to identify top CBMS issues so that changes can be implemented into CBMS to enhance the system functionality. However, there are inherent challenges in managing the system jointly. Both Departments have different federal agencies that provide oversight responsibilities for the various high level programs contained within CBMS. The various security and other requirements of the high-level program groups

within CBMS add costs to implementing changes and new programs into CBMS. For example, implementing the presumptive eligibility program in Medicaid from SB 07-211 in CBMS cost an additional $240,000 in system fixes and programming to adhere to the federal Food and Nutrition Services security guidelines because the medical and financial functions are joined. With momentum growing for health care reform and possible expansions for new populations, it is imperative that the Department be able to respond quickly and economically for any contemplated changes to eligibility and the health care programs within CBMS. The Department proposes to continue to use CBMS as the systems tool to determine eligibility for its health care programs, but to separate the functions of CBMS into two separate systems. One system would contain all the financial programs administered by the Department of Human Services, while the other would contain the medical programs administered by the Department. This would allow the Department the flexibility to process applications outside of the county social/human services model and not impact the financial programs administered by the Department of Human Services when client information, such as income and resources, is modified. Finally, to meet the federal requirements under the Deficit Reduction Act (DRA), the Department proposes to build interfaces with the Department of Public Health and Environment and the Department of Revenue for the verification of citizenship and identity as a condition for Medical Assistance eligibility.

As the Department moves forward with these processes, there are some general business requirements that would be incorporated. These include:

- Eliminating the dependence on paper applications and supporting documents. The efficiencies gained from a paperless office are tremendous. These efficiencies would allow the Department to increase its processing speed, reduce its physical storage space, and improve security over the application process. It also allows the Department to backup the application and documentation records in case of a disaster and provide a centralized record that can be easily accessed for auditing purposes;
- Expediting the time to process an application. While the Department continues to monitor the performance of the counties with respect to the timely processing of applications, the Department recognizes that currently, many of the applications for

Medicaid and Children's Basic Health Plan are not processed within the federal guidelines (45 days for Medicaid applications, with an additional 45 days when a disability determination is necessary). It is the goal of the Department to expedite enrollment and significantly reduce the time needed to process a Medical Assistance application. When a client applies for a health care program, expedited enrollment means the client should be enrolled, denied enrollment, or receive communication on the status of the application within days, not months. Under this goal, the Department requires that there be multiple means of enrollment (face-to-face at a health care provider's location, by telephone, by mail and online), each of which is consumer-friendly based on the needs, skills, and abilities of the client. Further, by expediting applications, the Department could increase the number of individuals who maintain enrollment in Medicaid and Children's Basic Health Plan. Under this goal, the Department would assist members in maintaining enrollment until they no longer require state-sponsored health insurance;

- Enhancing the customer service capabilities of the Department and assure access to information and assistance – this goal is consistent with the Department's objectives of increased customer focus and support, and;
- Reducing the growth in staffing levels by reducing application processing time, automating the eligibility process, and increasing cost efficiencies. By planning and implementing system changes prior to any health care expansion, there will be reduced costs to the Department (i.e. staff, facilities) prior to implementation of broader health care expansions, as the automated systems can handle an increased caseload without the need to increase staff.

*RFP Vendor*

The Department would seek a RFP Vendor to provide professional and technical services to conduct a business process redesign of the Department's eligibility and enrollment functions to: (1) improve customer service, (2) increase application process efficiencies, and (3) attract and retain staff. The goal of this project is to evaluate health care eligibility and enrollment administration on a statewide level and recommend business process changes ranging from relatively straightforward technology support to wholesale changes

regarding acceptable staffing models to perform the work, where they should be performing, and the business processes they are following to perform the work. The RFP Vendor would examine other state models and established best practices to make recommendations on how the Department should structure the request for proposals for the Centralized Eligibility Vendor. Further, the Department would request a projected cost benefit analysis/return on investment based on implementing each recommended business process initiative individually and collectively.

Following the business process redesign, the RFP Vendor would be responsible for drafting a request for proposals for the Centralized Eligibility Vendor. A sufficiently detailed and comprehensive RFP to solicit a Centralized Eligibility Vendor to provide improvements or enhancements would include developing the following:

- Definition of qualifications for prospective offerors;
- Scope of work;
- Technical requirements, such as technical environment and configuration requirements, performance criteria for improvements or enhancements;
- Application systems requirements for the central processing of Medical Assistance applications, customer service and customer contact center, centralized electronic document and workflow management systems together with an incoming mail and document center, and;
- Cost proposal requirements.

Further, the RFP Vendor would be responsible for the following:

- Incorporating all required revisions to the request for proposals and creating a finalized request for proposals;
- Creating proposal evaluation criteria based on the finalized request for proposals and providing this to the Department and Centers for Medicare and Medicaid Services, as requested, for review and revision suggestions, and;
- Assisting the Department, as requested, with procurement activities related to the request for proposals. Activities would include preparing for bidders conference(s),

issuing documentation to provide answers to questions on the request for proposals, and/or participating in the evaluation process.

Based on the contract to develop the request for proposals for the Medicaid Management Information System (MMIS), the Department estimates that the total cost to procure the RFP vendor would be $614,400 total funds. This figure is based on 3,840 hours of work at $160/hour. For FY 07-08 it is estimated that the contractor will work 960 hours for a total of $153,600. The remainder of the cost, $460,800, would be in FY 09-10. These totals are shown in table C.2.

*Centralized Eligibility Vendor*

Upon award of the contract, the Centralized Eligibility Vendor would begin by assuming the operations of the Children's Basic Health Plan eligibility, enrollment and member services on July 1, 2009. These tasks include receiving applications, processing mail, processing applications, adding applicants' data to the CBMS system, confirming enrollment, disenrollment of members, providing other case maintenance tasks in CBMS, maintaining the program's toll-free lines, providing customer service, carrying out the program's financial administration, handling manual MCO enrollments, re-determining eligibility, and coordinating the program's non-medical appeal process. Further, the contractor would coordinate customer service activities with the MCOs, the State's health care provider network and dental vendor for the Children's Basic Health Plan program.

Within the first quarter of the contract, the Centralized Eligibility Vendor would begin the process to transition and manage the eligibility and enrollment activities for Medicaid, covering a single county. The transition would involve collecting and converting all case files into a centralized electronic document management system. In addition, the vendor would become responsible for managing all customer service calls for the Department and for those calls concerning Medicaid eligibility and enrollment for the county in transition. Once the process was completed for the first county, the Department expects the vendor would be capable of a consistent transition plan to convert one third of all counties within

the remainder of the fiscal year. Medicaid eligibility and enrollment activities in all counties would be converted to the Centralized Eligibility Vendor by June 30, 2011.

The Department expects that the Centralized Eligibility Vendor would have a single location within the state, which would be within a reasonable driving distance of the Department. Currently, a single eligibility or county technician is typically assigned to a case; under the centralized eligibility and enrollment model, any and all eligibility technicians would have the ability to answer any question about any case and have the ability to electronically view the client's file. This would eliminate the issues under the current model where a client is unable to reach their assigned technician timely or their current technician is unknown to the client because of high turnover at the county department of human/social services. Under the new centralized eligibility model, clients are expected to receive timely responses to their questions regarding the application process and the status of their application.

The contractor would be required to develop and implement a thorough and consistent training plan so all employees are trained on the same rules. Department staff would remain responsible for the general policy and operations training to the contractor's training staff, but the contractor would be responsible for the ongoing training of new employees and annual refresher courses. This centralized approach to eligibility would promote consistency with respect to day-to-day operations and allow for greater customer service and satisfaction. Historically, data suggests that clients enrolled in public health insurance programs are a mobile population and move to different counties. Because the 64 counties manage their eligibility processes in a variety of ways, clients often become frustrated and confused in their attempts to navigate the different requirements within a county. This results in a fragmented delivery system of care and comprises continuity of care issues for clients.

The Department envisions that the Centralized Eligibility Vendor would have a central processing unit, with an incoming mail center linked to the centralized electronic document management system. This unit would scan and data input all applications and documents mailed, faxed or electronically transmitted by or on behalf of clients. Once the

application and documents were electronically processed through CBMS, the case would be forwarded to either a unit that specialized in Family Medicaid (inducing Children's Basic Health Plan) or Adult Medicaid. These units would be responsible for determining eligibility and contacting clients when necessary. Since Adult Medicaid involves more upfront work to collect resource and asset information from the client and then coordinating with the Single Entry Points, Community Centered Boards, Consultative Examinations, Ltd and the Social Security Agency than Family Medicaid which focus more on case management, it is expected that technicians will be specialized by these two areas.

The Department expects that an immediate efficiency can be achieved through a triage of incoming applications in order to distribute the workload by complexity of the application. Through this approach, standard applications (complete application for simple family units with employment) can be processed more quickly. The workload for complex applications (self-employed, three generational, or immigrant families) can be distributed to more experienced eligibility and enrollment representatives to support a more timely process. The Department's goal would be to establish a process and systems that would eliminate the need for clients to have face-to-face interview with a technician and if not eliminate, significantly reduce, the need for clients to contact the eligibility technician by phone. Further, the Family Medicaid and Adult Medicaid units would be responsible for addressing client phone calls and facilitating problem resolution for all eligibility and enrollment questions and issues.

To manage all of the eligibility and enrollment activities for Medicaid and Children's Basic Health Plan and significantly reduce the time to process and determine eligibility, the Department expects the Centralized Eligibility Vendor to implement three critical systems: an Electronic Document Management System, a Workflow Process Management System and a Customer Contact Center. These systems are described below.

The Electronic Document Management System would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. The document management system would change workflows through the current county

model as well as how operational processes are performed. Rather than requiring county locations to store hard copies of case files, all documents would be electronically scanned and stored in a central location. This would significantly increase the ability to retrieve records for eligibility determinations, customer service activities, as well as serve to increase the ability to audit case files.

The Electronic Document Management System is a computer system (or set of computer programs) used to track and store electronic documents and/or images of paper documents. Document management systems commonly provide storage, versioning, security, as well as indexing and retrieval capabilities. Many document management systems attempt to integrate document management directly into other applications, so that users may retrieve existing documents directly from the document management system repository, make changes, and save the changed document back to the repository as a new version, all without leaving the application. Images of paper documents are created using scanners or multifunction printers. Optical character recognition software is often used, whether integrated into the hardware or as stand-alone software, in order to convert digital images into machine readable text. Simple retrieval of individual documents can be supported by allowing the user to specify the unique document identifier, and having the system use the basic index (or a non-indexed query on its data store) to retrieve the document. More flexible retrieval allows the user to specify partial search terms involving the document identifier and/or parts of the expected data file.

The Workflow Process Management System is an electronic document routing system that enables users to process work more efficiently, faster, and more accurately than with traditional paper processing. This system is beneficial whenever successive points of input or action are required in order to complete a task, process, or procedure. From processing applications to approving expense reports to managing remittance processing, workflow streamlines collaboration and accelerates the completion of critical business tasks. With workflow process management systems, users or integrators define and configure document states, rules, actions, and lifecycles with a comfortable Windows interface. Upon configuration, workflow instantly routes documents through the business process as each increment of user or system work is completed within a queue. Once applications

are imaged, the applications and related documents are routed to the appropriate work queues for follow-up and completion. Managers can then track the status of pended applications and use the system to monitor the performance of the staff and the timely processing of applications.

A Customer Contact Center would provide a single entry point for customers seeking information on the Department's health care programs and to provide assistance for eligibility and enrollment activities. A customer contact center is a central point which all customer contacts are managed. The customer contact center typically includes one or more call centers but may include other types of customer contact as well, including website inquiries, and the collection of information from customers. Further, the customer contact center would have the ability to handle a considerable volume of calls at the same time, to screen calls and forward calls to someone qualified to handle them, and to log calls. If the call related to Medicaid or Children's Basic Health Plan policy or other issue not relating to the activities of eligibility and enrollment, the call would be directed to the current Department's Customer Service Section or other appropriate contact. The Department expects that the customer contact center would utilize software, which will be linked to the Electronic Document Management System and would allow contact information to be routed to appropriate people, contacts to be tracked, and data to be gathered.

The Department assumes that a client phone call into the customer contact center would typically be a one-time event such that the client would not receive a message stating someone will call them back. Instead, the client's question or issue is resolved during that single phone call. The customer contact center would be expected to escalate the call while the client was on the phone, similar to private industry support call centers. Further, the customer contact center would provide, through the phone and internet, the ability for a client to check their enrollment, status of application, inquire about missing documents, find provider locations, and receive general information without directly speaking to a technician.

The total cost for the Centralized Eligibility Vendor to assume the Medicaid and Children's Basic Health Plan workload is $18,657,430 in FY 09-10 and $31,435,270 in FY 10-11. These figures include a phase-in during FY 09-10 as the Centralized Eligibility Vendor does not assume the full workload of the processing Medicaid eligibility until FY 10-11. The FY 10-11 total cost figures include the cost of the Electronic Document Management System and a Workflow Process Management Systems at $3,500,000, a Customer Contact Center at an additional $3,500,000, the need for eligibility and enrollment personnel at $17,925,140 to process applications, $1,470,000 in contractor leased space, $763,000 in staffing operating costs, and $397,540 in additional postage cost. These figures also include the Centralized Eligibility Vendor assuming the operations of the Children's Basic Health Plan eligibility, enrollment, and member services; based on the request for proposals covering the FY 08-09 contract period, the total cost for FY 09-10 is estimated to be $3,879,590 total funds. These totals are shown in table C.2.

The Department assumes that the costs would be consistent over the period of the contract from FY 10-11 to FY 13-14. Even though the Centralized Eligibility Vendor is only responsible for one third of all county cases in FY 09-10, there is a significant amount of infrastructure that must be built to transition the from the county based model to the centralized model. As such, the FY 09-10 budget is based on fifty percent of the FY 10-11 total costs with an additional $1.0 million for general startup activities.

Using the current appropriations for the Children's Basic Health Plan eligibility, enrollment and member services and the state and federal share of county administration dollars as an offset to the total cost for the for the Centralized Eligibility Vendor, the request for is for an additional $6,859,104 total funds in FY 09-10. The General Fund and federal funds portion of the County Administration appropriation for Medicaid eligibility operations would be reduced by one third and transferred to the Centralized Eligibility Vendor in FY 09-10. The FY 10-11 request is for $3,799,471 total funds.[2] The

[2] See tables C.3.1 and C.3.2. Note that the total funds decrease between FY 09-10 and FY 10-11 is a function of not receiving local funds from the counties. As a result, total General Fund need increases in FY 10-11.

appropriation for County Administration dollars for Medicaid eligibility operations would be reduced to zero as the Medicaid eligibility and enrollment activities in all counties would be converted to the Centralized Eligibility Vendor by June 30, 2011. Under the centralized eligibility system, the Department would forgo local matching funds from the counties.

*Virtual Application Gateway*

In an effort to help streamline the application process and provide alternate locations for clients to apply for Medicaid and Children's Basic Health Plan through the mail-in application process, the Department proposes to develop a Virtual Application Gateway. This gateway would be similar to the presumptive eligibility determination system for children and pregnant women that has been developed inside of CBMS. The complete application for Medicaid and Children's Basic Health Plan could be completed electronically and submitted to the Centralized Eligibility Vendor through CBMS. Further, the system could be used to provide updated information or to process redeterminations. The Virtual Application Gateway would be primarily used by hospitals, community health centers and other health care providers. The Department would require that only providers or users certified and trained by the Department could participate in the eligibility application process by assisting clients to electronically apply for coverage and manually process signature pages and income verification.

Under the current process, providers who provide facilitated enrollment and presumptive eligibility must submit a hard copy of the Medical Assistance Application to a county department of human/social services for final approval. This process can require multiple mailings and phone calls to verify that the application is complete and that the county department of human/social services has begun processing of the application. For applicants seeking care in their facilities, providers would have the ability to enter applicant data, check for prior eligibility, obtain applicant signatures on all necessary forms, and forward income verification data to the Centralized Eligibility Vendor. This represents an additional processing workload for providers. However, many providers have already indicated that they are open to absorbing the increased workload, staffing

and additional processing costs in order to facilitate a properly completed application and to obtain a more timely determination for eligibility.

The Department expects that the Virtual Application Gateway would have a logical sequencing that would guide the worker or applicant through a series of questions to obtain the necessary data to process eligibility in an automated fashion. Questions, for which the answer was not known, could generate an easy-to-understand, comprehensive request for verification that detailed necessary information needed for each household member. By using a 'logic tree', only appropriate and necessary questions would be asked. Information would be gathered once, at a single point of contact. In addition, this would aid workers by removing the necessity for the worker to remember which, if any, additional questions should be asked in specific circumstances.

Based on the total cost to implement presumptive eligibility for children and pregnant women in CBMS, the Department estimates that the development and programming time, additional user licenses, and hardware would cost $900,000 in total funds in FY 08-09. The Department anticipates that the development of the virtual application gateway would have similar technical requirements to the development of presumptive eligibility.

*Colorado Benefits Management System (CBMS) for Medical Programs*

As the Department moves to a Centralized Eligibility Vendor, implements a Virtual Application Gateway, and is planning for a significant increase of its client-base due to health care reform recommendations from the Blue Ribbon Commission for Health Care Reform, there is the need to separate the functions of CBMS into two distinct systems. One system would contain all the financial programs administered by the Department of Human Services, while the other would contain the medical programs administered by the Department. This would allow the Department the flexibility to process applications outside of the county social/human services model. Further, when client information, such as income and resources is modified, the Medical Assistance application information would not impact financial programs administered by the Department of Human Services.

The current database and system structure for CBMS would be maintained. The Department proposes that the current system would be copied onto new servers and then the windows and system functionality related to the financial programs administered by the Department of Human Services would be turned off in the CBMS for medical programs. Such system enhancement would accommodate the following issues/enhancements:

- Improve timely processing of applications; reduce the time it takes for a worker to enter a Medical Assistance application into CBMS;
- Increase the types of venues for applicants to submit his or her application and its required documentation, e.g. web frontend or kiosk-based application submission units;
- Ease in adding new programs to CBMS in a shorter period of time, e.g. employer-based model program whose clients may not qualify for any of the current CBMS programs and other programs created by the health care reform project. The current six to eight month implementation timeline causes problems with implementing the program by the required deadline as outlined by legislation or federal regulation;
- Provide the ability to allow more end users access to CBMS. Note that these end users may not be merit employees; this issue has caused a compliance issue with the Food and Nutrition Services regulations that prohibits access to food assistance program's data to non-merit employees but does not cause any concerns from the Centers for Medicare and Medicaid Services;
- Create an environment that allows for data entry to medical cases to not adversely impact other programs, such as food or cash assistance, and vice versa. Much of the adverse impacts are related to conflicts in program rules;
- Improve the ability to audit medical programs in CBMS and quickly identify the changes to the case which caused any change in eligibility without having to look at every field, every window and all historical records. A more clearly defined audit trail is needed;
- Capture medical eligibility span history to provide "point in time eligibility" functionality, and;

- Increase in help desk support and training to ensure all end users have the appropriate level of knowledge to effectively and efficiently use CBMS to make a more accurate eligibility determination.

The cost to separate the functions of CBMS into two separate systems is estimated at $250,000 in FY 07-08 for planning and initial design to separate the functions of CBMS into two distinct systems and then $10,000,000 in FY 08-09 for programming and development. Due to the complexity and fiscal impact of separating the functions of CBMS into two separate systems the Department requests an additional $100,000 in FY 08-09 to hire an independent contractor to review and audit the cost and timeline of the planning and initial design established by the current CBMS contractor. The cost to separate the functions of CBMS into two separate systems is a one time funding request.

The cost to maintain the CBMS for Medical Programs is $7,975,468 in FY 09-10 and is ongoing. This is the amount that the Department transfers to the Department of Human Services to manage the CBMS for Medical Assistance eligibility. The Department does not anticipate any increase in costs to perform these duties at this time. These totals are shown in table C.1.

*Citizenship and Identity Verifications*

To meet the federal requirements under Deficit Reduction Act (DRA), the Department proposes to build interfaces with the Department of Revenue and the Department of Public Health and Environment for the verification of citizenship and identity. Effective July 1, 2006, federal law requires verification of citizenship and identity as a condition for Medicaid eligibility. Applicants and recipients who declare that they are U.S. citizens must provide proof of both citizenship and identity. In order to ensure that this requirement is met, the Department proposes establishing an interface with the Department of Revenue that would allow the Central Eligibility Vendor to electronically view Colorado issued driver licenses and another interface with the Department of Public Health and Environment to view birth certificates. Such a process would allow the Central Eligibility Vendor to determine eligibility without requiring the applicant to mail-in

the original copy of such documents or have the applicant appear in person to provide the documents.

The cost to build the Citizenship and Identity Verification interfaces is $900,000 total funds. This figure is shown in Table C.2, and is included in the $2,260,800 request for the Centralized Eligibility Vendor in FY 08-09.

**Medical Homes**

To ensure that all children in Medicaid and the Children's Basic Health Plan have a medical home by January 1, 2010, the Department requests $335,698 total funds in FY 07-08 and $6,493,124 total funds in FY 08-09. The Department estimates that $7,078,708 would be required in FY 09-10 to finalize implementation of the program. This Request supersedes the Department's request for funding for a medical home pilot program from Decision Item 6 from the November 1, 2007 Budget Request. Calculations are available in Table D.1.1 and Table D.1.2.

SB 07-130 did not contain any appropriation for the purpose of raising provider rates associated with medical home services. During meetings associated with the Primary Care Provider Rate Task Force (as required by Footnote 22 of HB 06-1385), the Department learned that provider rates for medical home related services were not adequate enough to ensure provider participation. In Decision Item 6, the Department requested funding to begin a pilot program, with the goal of enrolling 124 providers and 10,000 children.

During FY 07-08, the Department learned that grant funding would be available to start the medical home program sooner than originally anticipated. The Department has been working since the beginning of the fiscal year to gauge provider interest, and currently has a number of providers who are interested in serving as medical homes for Medicaid children. In order to draw federal funds to maximize the revenue available for the pilot phase of the program, the Department is requesting explicit spending authority for the grant as Cash Funds Exempt and federal funds.

Providers enrolled as medical homes would be responsible for ensuring health maintenance and preventive care; anticipatory guidance and health education; acute and chronic illness care; coordination of medications, specialists, and therapies; provider participation in hospital care; and, twenty-four hour telephone care for all clients enrolled. Medical home providers who are eligible to do so would also participate in the Vaccines For Children Program (VFC) and utilize the Colorado Immunization Registry (CIIS). The pilot program would enroll approximately 15,000 Medicaid children. By FY 08-09, the Department seeks to begin a full implementation of the medical home program for both the Medicaid program and the Children's Basic Health Plan. Each program will be discussed separately below.

*Medicaid Children*

Providing medical homes to all Medicaid children is more complicated than just raising rates paid to physicians. The Department must ensure that there is an adequate network of primary care physicians who are willing to participate as medical homes. This means that the Department must ensure that rates paid to providers are fair and cover the costs of providing services. However, this also requires the Department to actively recruit physicians in the state who have previously not been willing to participate in the Medicaid program. The Department must also ensure that the physicians who are participating are qualified and able to provide the care required as a medical home, as defined by 25.5-1-103 (5.5), C.R.S. (2007).

To ensure that rates paid to providers are adequate, the Department is proposing two steps. The first, to increase all rates paid for preventive medicine codes to 90% of the equivalent Medicare rate. This portion of the Request affects more than just Medicaid children, and is described in separate detail later in the Request. The second is to enroll children with specific providers who will serve as the child's medical home. As described in the Department's original Decision Item 6, reimbursement rates for children ages 0-4 will be increased by $10.00 for the annual well child visit. Reimbursement rates for

children ages 5-20 will be increased by $40.00 for an annual well child visit.[3] These increased rates will allow the specific medical home providers to provide necessary, but non-reimbursed services, of a medical home. For instance, phone consultation with specialists as to appropriate treatment or access to timely appointments; consultation with community partners such as Part C and Part B regarding a child's Individual Family Service Plan or Individual Education Plan or consultation with a mental health specialist as to possible drug interactions or medication management for those with dual diagnosis. While the limited additional funding does not cover all expenses occurred by providers for these activities and others, they are willing to work with the Department in order to provide the highest possible care to the eligible children and youth. By the end of the implementation period, all eligible children will have access to a medical home.

Currently, Eligible Children between ages 0 and 4 utilize Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services at a rate of 73.04%, while Eligible Children between ages 5 and 20 utilize services at a rate of 43.07%. It is unrealistic to expect that all children would immediately begin to utilize medical home services; there will always be a number of children, particular older children and adolescents, who will not see a doctor in a given year. Therefore, the Department has set target utilization rates of 80% for children aged 0-4 and 60% for children aged 5-20. The Department anticipates that these targets can be met in FY 09-10; utilization rates for FY 08-09 are the midpoint between the current utilization rates and the target rates.

The Department estimates that the total cost of service paid through Medical Services Premiums in the Medicaid medical home program would be $253,740 total funds in FY 07-08, $4,694,490 total funds in FY 08-09, and $5,414,320 total funds in FY 09-10. Any savings identified from the program will be incorporated in the Department's annual Budget Request for Medical Services Premiums. The Department's calculations are contained in the "Calculations for Request" section of this document in Table D.2.2.

[3] Well child visits are restricted to once-per-year for children over two years of age. For infants less than two years old, the child may receive as many as 10 visits at specified intervals. Each visit receives the enhanced rate, and this is reflected in the Department's calculations.

*Children's Basic Health Plan*

As part of this request, the Department would also ensure that all children eligible for the Children's Basic Health Plan (CBHP) would have access to a medical home by the end of FY 09-10. Similar to the Medicaid program, providers in the Children's Basic Health Plan would be required to train and certify physicians to function as medical homes for enrolled children.

For clients enrolled in a managed care organization, the Department estimates that utilization targets would be similar to those in the Medicaid population: 80% for children under two, and 60% for children over two. The Department then estimates the cost of increasing payments to managed care providers based on the required number of visits per year. It must be noted that the Department does not control the rates that managed care organizations pay to their providers, and that the framework described above may not match how actual payments will be made to providers. However, in the absence of specific methodologies from providers, the Department feels that its calculation will adequately reflect the final impact of incentivizing medical homes in the managed care network.

For clients in the self-funded network, reimbursement rates for the medical home program would be similar to the Medicaid rates; the Department would pay the managed care organization an additional $10 for each code identified as a medical home procedure code. Because most clients which pass through the self-funded network move quickly to a managed care organization, the current utilization of well-child visits is artificially deflated by clients who receive these services when enrolled in a managed care organization. Therefore, the Department is targeting a 20% utilization rate across all clients in the self-funded network; this implies utilization rates on par with managed care organizations for clients who do not enter a managed care organization.

The Department calculates that total expenditure would be $494,460 total funds in FY 08-09, and $528,300 total funds in FY 09-10. Calculations for these figures are shown in the

"Calculations for Request" section, in Tables D.3.1 and D.3.2 and would be paid through the Children's Basic Health Plan Premiums Costs line item.

*Provider Recruitment*

The Department must also ensure that there are enough providers who are willing to serve Medicaid children. Without an active provider recruitment effort, the Department would not be able to enroll all children in medical homes. To do this, the Department proposes an active provider recruitment program. The Department believes that it would have enough willing providers to begin the pilot program and continue into the beginning of FY 08-09; however, a provider recruitment specialist would be required to continue to increase the number of participating providers. The Department intends to hire a contractor to perform this function, and anticipates that a request for proposals could be released in the beginning of FY 08-09, with the contractor starting no later than October 2008. The Department estimates that it would require an appropriation of $64,950 total funds in FY 08-09 and $86,600 total funds in FY 09-10, based on similar costs for regional outreach in the Children's Basic Health Plan. The estimate for FY 08-09 is adjusted to reflect the estimated October start date, and allows for the significant travel which would be required to visit providers throughout the state. The Department does not require any additional resources to write the request for proposals.

*Provider Certification and Training*

To ensure that all providers meet the requirements specified by SB 07-130 and the Department's rules for medical homes, the Department must certify that each participating provider is providing required medical home services to Medicaid clients. This includes an office visit with providers and their staff, a parent satisfaction survey regarding medical home activities within the practice, a review of records to ensure the quality of services that are being rendered; and training on medical home regulations, including specialized billing and coding training; training to maximize the working relationships with the Medicaid and Children Basic Health Plan programs; providing technical assistance to match providers and patients to local community services and programs which provide

medical and non-medical assistance; providing technical assistance for the Colorado Immunization Registry and Vaccines for Children programs; and, being available for follow-up questions. The Department anticipates that providers would need to be certified annually. In order to perform the certifications, the Department believes that it can amend current provider certification contracts related to the Early Periodic Screening Diagnosis and Treatment (EPSDT) program to increase the scope of work. Existing contracts would be amended to add the scope of work effective July 1, 2008. The Department anticipates that it would require a total funds appropriation of $603,902 total funds per year to perform provider certification, training, and technical assistance. This figure is based on similar contracts performed by the Department's EPSDT contractors, and includes costs for 7.0 FTE, supervision, mileage, conference expenses, equipment and other indirect costs including office space and technology costs. If this is not possible, the Department will release a request for proposals to solicit a vendor to certify providers, at the same cost. This cost would be paid out of Personal Services line item. Calculations can be found in Table D.1.1.

*Program Evaluation*

To ensure that the medical home program is providing beneficial services to Medicaid and Children's Basic Health Plan clients, the Department is requesting funding to perform comprehensive program evaluations. In SB 07-130, the Department was appropriated funding for a Statistical Analyst II, for the purpose of analyzing client utilization patterns; analyzing claim data to determine outcomes; and, providing data analysis for reporting requirements. The Department envisions this Statistical Analyst to be an expert on the Department's data related to medical homes. However, because SB 07-130 did not specify the complete scope of the medical home program, a single analyst will not be enough to complete the comprehensive program evaluation required.

The Department requests funding for a contractor who would be able to design specific performance measures intended to measure the success of the program. Additionally, the contractor would be required to perform client surveys designed to measure client satisfaction in the program, and would be required to administer, collect, and process

those surveys. Working in conjunction with Department staff, the contractor would be required to measure outcomes, combining claims data, survey data, provider data, and national data. Furthermore, the contractor would serve as an expert on national programs and trends, both to provide information to the Department, and as a conduit to provide information to other interested entities, including the Commonwealth Fund, the Centers for Health Care Strategies, the National Committee for Quality Assurance, and various other states. The Department would release a request for proposals in early FY 08-09, with the expectation that a contractor would be in place by October 1, 2008. The Department estimates that it would require an appropriation of $150,000 total funds in FY 08-09 and $200,000 total funds in FY 09-10, based on preliminary cost estimates provided by current Department contractors. The estimate for FY 08-09 is adjusted to reflect the estimated October start date. This cost would be paid out of the Department's Personal Services line item. Calculations can be found in Table D.1.1.

*Systems Changes and Technical Requirements*

In SB 07-130, the Department was appropriated $56,400 for systems changes to enable reporting of medical home provider claims and add a medical home flag to track participating framework. In the course of designing the program, it was determined that other existing elements in the Medicaid Management Information System could not be used to properly enroll clients in a medical home. Therefore, the Department requests an additional appropriation of $79,758 total funds in FY 07-08 to enable system features which would allow for clients to be enrolled with specific providers as their medical home. The Department's fiscal agent, Affiliated Computer Systems, has estimated that 633 hours of programming and testing will be required to implement the changes, at the standard cost of $126 per hour. For managed care organizations in the Children's Basic Health Plan, the Department estimates that each managed care plan will require $3,000, $15,000 total funds in all, in FY 08-09 to make systems modifications to allow clients to select a medical home and provide the required reporting to the Department on the progress of medical homes. This estimate is based on the amount that managed care contracts were increased in FY 07-08 to allow for implementation of requirements of SB 07-004.

Because the scope of work would be similar, the Department believes that the same amount would suffice to implement the program requirements for medical homes.

In addition to system changes, changes would need to be made to materials that are sent to clients. These materials would be the primary notice to clients that a medical home is available, and would contain instructions on how to enroll. In FY 08-09, all eligible Medicaid clients would be notified of the new medical home option; therefore, this request includes funding for printing and postage costs associated with notifying all Eligible Children of the medical home option. In order to prevent duplicative costs, the Department would take steps to ensure that the printing of new materials coincides with printing for the new fiscal year. New clients are included in the current cost of the contract.

Enrollment functions would be performed by the Department's enrollment broker. The enrollment broker would also handle customer service calls for clients who have questions about the process. Staffing for data entry and client calls is expected to continue through FY 09-10; after the medical home program is fully implemented, the Department would reevaluate the enrollment broker's need for additional staffing. Any adjustments would be requested through the normal budget process.

The Department estimates that initial changes to client materials can be made during FY 07-08, and will cost $2,200 total funds. The one-time mailings and staffing costs in FY 08-09 are estimated to cost $364,482 total funds; on-going costs in FY 09-10 are estimated at $145,000. This cost would be paid out of the Department's SB 97-05 Enrollment Broker line item. Calculations can be found in Table D.4.1.

**Eligible But Not Enrolled Improvements**

The Department anticipates that the implementation of Centralized Eligibility and enrolling children in medical homes would have a positive impact to Medicaid caseload. The Department requests $10,168,761 total funds in FY 08-09, $27,629,934 total funds in FY 09-10 total funds, and $28,647,786 total funds in FY 10-11 to account for the estimated

increase to Medicaid caseload. This caseload is anticipated to gain eligibility as a result of the aforementioned programs; even if this portion of the Request is not funded, the Department would still experience caseload growth as a result of the implementation of Centralized Eligibility and enrolling children in medical homes. Calculations are available in Appendix E.

It must be noted that this is not an expansion of eligibility; however, as previously documented, there are approximately 80,000 children, 14,000 parents, and 4,000 pregnant women in Colorado who currently qualify for either Medicaid or the Children's Basic Health Plan but have not applied. The Department anticipates that a simplified eligibility process and provider and community outreach will cause a number of these individuals to gain Medicaid eligibility.

As part of the implementation of its medical home initiative, the Department is partnering with a wide variety of physicians and physician-groups to ensure that the largest number of children that can be covered will be covered. These groups include The Children's Hospital, the University of Colorado Health Sciences Center, the Rose Community Foundation, Kaiser Permanente, Head Start, the Colorado Health Institute, and many more. This network of providers actively works to encourage families and children to apply for Medicaid when they know that the clients do not have health insurance.

With the streamlining of eligibility, the Department anticipates that clients who previously would not apply because they viewed the county-based process as too cumbersome would now complete applications and gain Medicaid eligibility. The implementation of a centralized eligibility vendor, along with a virtual application gateway and the reduction of application time would cause an increase in Medicaid and Children's Basic Health Plan caseload, as the number of new applications increase.

A large number of factors would influence the number of additional clients who choose to apply. For example, even though the Department does not intend to specifically market the new eligibility process, the Department's medical home initiative, in conjunction with willing providers, would naturally encourage clients to apply. Further, existing marketing

for the Children's Basic Health Plan may have a greater impact as clients complete the eligibility process more easily. The availability of the virtual application gateway at hospitals, community health centers, and rural health care providers would create additional opportunities for individuals and families to apply without having to make other visits.

Because of the large number of variables involved, the Department has no direct way to measure the effect of changes of this magnitude on Medicaid caseload. Prior changes to the eligibility system, namely, the implementation of CBMS, caused caseload to change in unforeseen and unexpected ways. Given the large amount of uncertainty, the Department assumes that there would be caseload growth above the forecasted base growth in FY 08-09 for Medicaid Eligible Children and the Children's Basic Health Plan, and continued caseload growth of 2% above the forecasted base growth in FY 09-10 for these populations. Further, the Department assumes that other populations would also see growth in FY 09-10 when the Centralized Eligibility system is operational: the Department assumes growth of 2% above forecasted growth in the Categorically Eligible Low Income Adults, Expansion Adults, Baby Care Program – Adults, and Children's Basic Health Plan Prenatal aid categories. Caseload growth is limited to children's populations in FY 08-09 because the medical home initiative is targeted at children, and centralized eligibility would not yet be operational. The Department does not anticipate a significant change in the elderly and disabled Medicaid populations. The Department anticipates this growth to be in addition to baseline growth accounted for in the Department's November 1, 2007 Request for Medical Services Premiums and Medicaid Mental Health Community Programs.

The Department estimates that an additional 5,344 children would gain eligibility in FY 08-09, and an additional 5,520 children will gain eligibility in FY 09-10. Additionally, the Department estimates that 1,238 low-income and pregnant adults will gain eligibility in FY 09-10. The Department assumes that, after FY 09-10, caseload growth will return to levels more in line with historical trends. As clients begin to gain eligibility, the Department will revise its estimates during the normal budget process for Requests for Medical Services Premiums, Medicaid Mental Health Community Programs, and the

Children's Basic Health Plan. The Department's calculations are contained in Appendix E.

**Expand the Children's Basic Health Plan to 225% of the Federal Poverty Level**

In addition to improving benefits for children currently in the Children's Basic Health Plan and Medicaid, the Department believes that expanding eligibility is an integral step in health care reform. As such, the Department is requesting funding to increase eligibility in the Children's Basic Health Plan to 225% of the federal poverty level.

To expand eligibility for children in the Children's Basic Health Plan, the Department would be required to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services in the quarter after implementing the expansion. As was done with the recent expansion to 205% of the federal poverty level, the expansion to 225% would be accomplished by retaining the current limit of 200% of the federal poverty level, and disregarding a portion of income above that level, up to an equivalent of 225%. In order to expand eligibility for the prenatal population, the Health Insurance Flexibility and Accountability (HIFA) section 1115 demonstration waiver under which these clients receive services would need to be amended. This amendment would require one month to write and nine to twelve months to receive approval from the Centers for Medicare and Medicaid Services. If the waiver amendment were to be submitted in July 2008, approval would not be expected before July 2009, shortly before the October 2009 deadline for renewal of this waiver. In the interest of administrative efficiency, the Department would move the waiver renewal to July 2009 and would add the expansion to the renewal application rather than submitting a separate amendment.

To estimate the caseload impact of expanding eligibility for children and pregnant women in the Children's Basic Health Plan to 225% of the federal poverty level, the Department has utilized data provided by The Lewin Group. This data includes estimates of the number of uninsured, based on the Current Population Survey that has been adjusted for a Medicaid undercount. In addition, The Lewin Group has provided estimates for the number of individuals currently in private insurance that would opt to switch their health

care due to an expansion in the public sector, known as "crowd-out". These crowd-out estimates assume voluntary health coverage and a six-month waiting period provision, and incorporate assumptions regarding the number of eligible individuals that would opt to enroll. Estimates of both the uninsured and crowd-out populations are split into demographic groups (i.e., children, parents, pregnant women, and childless adults), income level by federal poverty level, and citizenship status. Due to citizenship requirements for eligibility in Medicaid and the Children's Basic Health Plan, undocumented individuals are excluded from the analysis. In addition, legal non-residents in the United States less than 5 years are eligible for Medicaid or the Children's Basic Health Plan in very limited circumstances, so only 5% of this group is included in this analysis, along with all citizens and legal non-residents in the United States 5 years or longer. Please see Table F.4.1 for detailed estimates of uninsured and crowd-out populations.

The Department estimates that of the uninsured individuals in the proposed expansion range, 90% would ultimately apply and be found eligible for the program (known as the 'ultimate enrollment percent'). This ultimate enrollment percent is in line with Governor Ritter's goals regarding insuring the uninsured, and the Department believes that this enrollment target can be accomplished through current marketing efforts, expanded outreach as requested in the Department's November 1, 2007 DI-3A, and continued media attention on health care reform.

Caseload would not experience a one-time increase from this expansion, but would rather see a gradual increase as the program is established and the eligible individuals apply and enroll. The Department assumes that 40% of the ultimate enrollment level (90% of the uninsured in the eligibility range) will enroll in the first year, 80% in the second year, and 100% in the third (known as 'phase-in rates'). This is based on analysis provided by The Lewin Group, however this schedule is not known at this time. For the children's expansion, the Department has decreased the phase-in rates to 35% in FY 08-09 and 75% in FY 09-10, as the modifications to the Colorado Benefits Management System (CBMS) and Medicaid Management Information System (MMIS) will be completed at the beginning of FY 08-09.

Based on these assumptions, the Department estimates that the proposed expansion to 225% of the federal poverty level would increase the Children's Basic Health Plan children's caseload by 3,062 in FY 08-09; 6,666 in FY 09-10; 9,040 in FY 10-11, and; 9,204 in FY 11-12. The Department estimates the total cost of this expansion for children to be $5,732,118 in FY 08-09; $12,996,550 in FY 09-10; $18,356,060 in FY 10-11, and; $19,435,236 in FY 11-12. See Table F.1.1 for detailed calculations. Per capita costs include the proposed benefit expansions contained in this Request, including medical home and mental health services. Per capita costs are shown in Table F.5.1.

Similar assumptions are used to produce the caseload estimate for increasing eligibility for women in the Children's Basic Health Plan prenatal program. Due to the time required to attain the federal waiver renewal for this population, the caseload for the prenatal expansion does not begin until FY 09-10. The Department estimates that the proposed expansion to 225% of the federal poverty level would increase the Children's Basic Health Plan prenatal caseload by 338 in FY 09-10; 686 in FY 10-11, and; 869 in FY 11-12. The Department estimates the total cost of this expansion for pregnant women to be $4,585,139 in FY 09-10; $9,921,988 in FY 10-11, and; $13,400,875 in FY 11-12. See Table F.1.2 for detailed calculations. Per capita costs are shown in Table F.5.1.

In addition to the benefit costs outlined above, the Department anticipates a number of administrative costs to implement this eligibility expansion. The Department assumes that additional funding for actuarial services is needed to include the new income categories in the calculation of children and prenatal rates. The estimated cost is $1,000 in FY 07-08 to add the new income range to medical and dental rates for the children's expansion in FY 08-09, and $1,000 in FY 08-09 to add the new income range to the medical rate for the prenatal expansion in FY 09-10.

With the eligibility expansion, the Department anticipates an increase to the volume of new and redetermination applications to be processed by the counties and the external Children's Basic Health Plan eligibility and enrollment vendor. The caseload impact of this expansion is estimated to be 3,062 in FY 08-09, or approximately 4.5% of the base

caseload forecast. The Department assumes that the application volume would increase by a like percent. Because the anticipated volume increase is below 10%, the standard level which would require the contract to be renegotiated, the Department assumes that no additional funding would be required in FY 08-09 for the current Children's Basic Health Plan eligibility and enrollment vendor. The Department also assumes that any additional application volume processed at counties can be absorbed with existing resources. Further, the Department assumes that these functions would be performed by the proposed Centralized Eligibility Vendor beginning July 1, 2009.

Modifications to the existing CBMS and MMIS will be required in FY 07-08 to expand eligibility for children beginning July 1, 2008. These include updating the decision tables to determine eligibility using the new income limit and updating the managed care extract file which relays enrollment information to the MMIS. These modifications will be required twice, once for the children's expansion and once for the prenatal expansion. The Department assumes that the modifications for the prenatal expansion will be completed in FY 08-09, simultaneously with the CBMS decoupling and programming. In Table F.2.1, the Department estimates the additional costs of modifying the CBMS to expand eligibility for children. These costs are separate from costs associated with Centralized Eligibility. The Department estimates that $18,000 will be needed in both FY 07-08 and FY 08-09 to complete all required changes. Calculations are available in Table F.2.2.

Required modifications to the Medicaid Management Information System include updating the enrollment data file transferred from the CBMS to allow capitations to be paid for the newly eligible population; adding a new income rating code to the MMIS to allow the new clients to be tracked separately for budgeting purposes; adding new category of service, sub-category of service, and general ledger codes; updating the Managed Care R4300 report for the new income rating code. The Department assumes that a majority of the programming required for the expansion of the prenatal program can be completed along with that for the children's expansion in FY 07-08. However, an additional 25% of the original programming time will be required in FY 08-09 to activate the changes for the prenatal program expansion and to perform testing. The Department

estimates that the modifications to both the CBMS and MMIS will take approximately 6 months. The Department anticipates the total cost to the Department of Human Services for CBMS modifications to be $18,000 in FY 07-08, and the total cost of the MMIS modifications to be $183,960 in FY 07-08 and $45,990 in FY 08-09. Calculations are available in Table F.2.2.

**Benefits Improvements**

*Preventive Medicine*

The Department requests $11,858,258 total funds to raise all evaluation and management procedure codes to 90% of the equivalent Medicare rate. This Request supersedes the Department's request for additional funding for evaluation and management codes from Decision Item 6 from the November 1, 2007 Budget Request.

Evaluation and management procedure codes are used by physicians for general preventive and routine primary care. These codes are the most frequently used codes by physicians, containing a wide variety of services, with modifiers to distinguish between levels of severity. In its November 1, 2007 Decision Item 6, the Department requested moving 12 specific evaluation and management procedure codes to 90% of the Medicare rate. Additionally, the Department requested to raise all other evaluation and management procedure codes to the extent possible; the Department estimated that it would be able to raise other codes to approximately 83.4% of the equivalent Medicare rate. However, the Department believes that all evaluation and management codes should be raised to the 90% level as soon as possible.

Primary care is essential for the effective and efficient functioning of America's health care delivery system. It is well established that having a regular source of care and continuous care with the same physician over time has been associated with better health outcomes and lower total costs.[4,5,6] It has also been demonstrated that among 18 wealthy

[4] Starfield B, Shi L, Macinko J: Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly 2005; 83(3):457-502 PMID 16202000

Organization for Economic Co-operation and Development (OECD) countries a strong primary care system and practice characteristics such as geographic regulation, continuity, coordination, and community orientation were associated with improved population health. Data suggest that increased use of primary care physicians resulted in reduced hospitalizations and reduced spending for other non–primary-care specialist services with improvements in morbidity and mortality rates.

Therefore, the Department believes that it is in the best interests of Medicaid clients to increase all rates for evaluation and management codes to the 90% level. Although this requires an initial investment to raise rates, the Department believes that over the long term, this will result in lower per capita cost trends for Medicaid clients, including reducing growth in emergency and inpatient care.

*Dental Services*

The Department requests $11,880,289 total funds to raise all rates paid for Dental services to 52% of average commercial rates, as published by the American Dental Association. This Request supersedes the Department's request for additional funding for dental rates from Decision Item 6 from the November 1, 2007 Budget Request.

Comprehensive dental services are a Colorado Medical Assistance Program benefit under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for clients from birth through the age of 20. The Department is required by Federal law to provide "[d]ental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health" (42 CFR § 441.56 (c) (2) [2006]). Only limited medically necessary dental benefits are available for adults, age 21 and older, and for non-citizens. Colorado Medical Assistance Program dental benefits for adults can be provided only when there is a dental emergency, when an approved concurrent medical

[5] Starfield B, Shi L: The medical home, access to care, and insurance: a review of evidence. Pediatrics 2004; 113(5 Suppl):1493-8 PMID 15121917

[6] Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R: The Relationship Between Primary Care, Income Inequality, and Mortality in US States, 1980-1995. J Am Board Fam Pract 2003; 16(5):412-422 PMID 14645332

condition is present, or when prior authorization has been approved for a non-emergency dental service.

Dental rates were increased by 3.25% in FY 06-07, and most rates remain between 33% and 50% of average 2008 commercial rates (as published by the American Dental Association), with many rates below 20% of the commercial level. Because of low reimbursement rates, only a limited number of dentists provide services to adult Medicaid clients. Therefore, the Department requests to raise rates to 60% of the American Dental Association's average rates. Rates which are currently above the 60% level would not be reduced. Although this requires an initial investment to raise rates, the Department believes that over the long term, this would result in lower per capita cost trends for Medicaid clients, with reduced utilization of more costly emergency dental services and preventable dental diseases.

*Mental Health Benefit Expansion for the Children's Basic Health Plan*

Children in Medicaid receive medically necessary mental health services through behavior health organizations in Colorado. Children do not have limits on most services, which include, but are not limited to, inpatient hospitalization, psychiatric care, rehabilitation and outpatient care, clinic services, case and medication management, and physician care. In addition, each behavioral health organization proposes a set of Alternative Services, which may include services such as drop-in centers, assertive community treatment, and respite care.

Children in the Children's Basic Health Plan receive mental health services through their physical health delivery system, which may be either the State's self-funded network or a health maintenance organization (HMO). While children with certain mental disorders receive unlimited services, most treatments have limited coverage with caps on the number of allowed visits. This request seeks funding to expand the mental health benefits provided to children enrolled in the Children's Basic Health Plan to those provided in Medicaid, in order to eliminate the benefit disparity between the two programs.

The Department worked with the Children's Basic Health Plan's contracted actuary to identify mental health benefit costs currently included in the FY 08-09 children's capitation rates. Mental health costs were identified using mental health diagnosis codes in the claims data used to set the FY 08-09 rates. Including administration expenses, the estimated monthly costs for mental health services is $6.56 in the HMO capitation and $3.66 in the self-funded network capitation. The Department assumes that approximately 58% of children in the Children's Basic Health Plan in FY 08-09 would be enrolled in an HMO and the remaining 42% would be served in the self-funded network (see the Department's November 1, 2007 Budget Request, DI-3, page G-12). Applying these rates to the estimated cost of current mental health services yields a monthly blended rate of $5.34 for all children in FY 08-09. This represents approximately 4.34% of the total FY 08-09 blended monthly capitation of $123.04. This percent is applied to the projected Children's Basic Health Plan children's per capitas to estimate the annual cost of $69.92 per client for existing mental health costs.

The Department's estimate for the per capita cost to provide expanded mental health services to Children's Basic Health Plan children is based on that for Medicaid children. However, because children in the Children's Basic Health Plan would continue to receive mental health services through their physical health delivery system rather than a dedicated behavior health organization, the Department assumes that utilization of such services would be lower than experienced in Medicaid. The Department estimates that utilization would be approximately 20% lower in the Children's Basic Health Plan, though this percent is unknown at this time. The Medicaid per capita is reduced by this amount to estimate a total cost of $147.05 per client per year to provide the expanded services to Children's Basic Health Plan children. Thus, the estimated incremental annual cost for providing expanded mental health benefits is $77.13 per client. Using the forecasted FY 08-09 Children's Basic Health Plan children's caseload, the Department estimates the total cost of this request to be $5,823,099 in FY 08-09. Based on the enhanced federal match for the Children's Basic Health Plan and the funding to come from the Health Care Expansion Fund, the General Fund needed for this request is estimated to be $1,136,224. Please see Table G.1 for details and calculations.

*Integrated Care Delivery Model Financing*

The Department requests $3,604,417 total funds in FY 08-09, FY 09-10, and FY 10-11 to account for cash flow issues involved in implementing an integrated care delivery model. This Request supersedes a portion of the Department's January 2, 2008 Supplemental Request S-13 ("Adjust Cash Flow for Integrated Care Delivery Model").[7]

Since the passage of HB 07-1346, the Department has received numerous inquiries from managed care organizations seeking to join the Medicaid program. Of the managed care organizations interested, the Department anticipates that one provider will be able to serve Medicaid clients starting on April 1, 2008, and a second provider will be able to serve Medicaid clients starting July 1, 2008. At this time, it is unknown when other managed care organizations will be able to join the program; however, a significant number of managed care plans have expressed interest in serving Medicaid clients. Therefore, the Department believes that enough managed care organizations will be available to serve 200,000 Medicaid clients by the end of FY 10-11. Therefore, the Department is requesting funding to account for the additional costs associated with enrolling existing Medicaid clients in managed care.

Under section 25.5-4-201 (a) C.R.S. (2007), the Department utilizes the cash system of accounting for the Medicaid program. This means that expenditures for services are recorded against the appropriation based on when claims are paid, not when those claims are incurred. In a fee-for-service delivery model, there is a billing lag between claims that are incurred and when claims are paid by the Department. For example, if a client receives a service on June 30 (the last day of a fiscal year), but the provider bills the Department on or after July 1, the claim is recorded against the appropriation for the new fiscal year. However, in a risk-based capitation system, the Department pays the managed care organization a capitation in the month of service for all claims.

[7] In particular, this Request supersedes the portion of S-13 which requests financing for new managed care plans in starting in FY 08-09 (known in S-13 as "Plan B"). This Request does <u>not</u> supersede the Request for funding for "Plan A" in S-13.

Because of cash accounting, when a client who is in fee-for-service transitions to managed care, the Department will be required to pay for both the fee-for-service claims that were incurred prior to the client's enrollment in managed care and the capitation to the managed care organization at the same time. The Department is not "double-paying," as the Department is not paying two providers to provide the same service. However, because of the billing lag in cash-based fee-for-service, the Department will pay for prior months and the current month concurrently. This increase in expenditure is unavoidable when transitioning clients from fee-for-service to managed care. New clients who enroll directly in managed care upon gaining Medicaid eligibility do not contribute to this phenomenon, as those clients do not have any prior fee-for-service claims.

The Department estimates that approximately 200,000 Medicaid clients would be enrolled in managed care organizations by the end of FY 10-11. As part of the Department's original Supplemental Budget Amendment (S-13, January 2, 2008), the Department estimated that for each 20,000 clients enrolled in a managed care organization, the Department would be required to finance $1,081,325 total funds to pay for claims for existing Medicaid clients who enrolled in a managed care organization (page S.13-14, Table 2, Column H). This figure is based on the assumption that of each 20,000 enrolled, 5,417 will come from existing Medicaid clients. The Department anticipates that this relationship will hold during the initial phase-in of the expanded managed care program.

The Department assumes that, of the 200,000 clients expected to be enrolled in managed care, 66,667 will be enrolled in each fiscal year. Based on the assumptions in S-13, the Department therefore estimates that it will require $3,604,417 total funds in each of FY 08-09, FY 09-10, and FY 10-11. The Department does not anticipate further impact from the transition to managed care after FY 10-11.

**Colorado Regional Health Information Organization**

In 2005, the Secretary of Health and Human Services formed the American Health Information Community to recommend ways to advance health information technology so that most Americans will have access to secure electronic health records by 2014. The

Colorado Regional Health Information Organization, under the auspices of the Colorado Health Institute, is part of a nationwide effort to oversee operations for a virtual national health information network and develop a statewide electronic health information exchange.

The Colorado Regional Health Information Organization (CORHIO) is a not-for-profit, regional health exchange organization with a mission to provide statewide health information exchange for individuals, health care providers, agencies and organizations. As the development of CORHIO progresses, the Department will want to be a partner and leader in the development of health information technology and information exchange in an effort to provide more transparency of quality and cost data, and to exchange information between providers that fosters better integration of health care.

The Department requests $500,000 total funds in FY 08-09, FY 09-10, and FY 10-11 to provide seed money for the development of the Colorado Regional Health Information Organization, and to allow the Department to participate in developing appropriate policies and procedures for data exchange between the Department as the state Medicaid agency and health providers that are participating in CORHIO. As a condition of participation, the funding provided by the Department to CORHIO would require dollar-for-dollar matching by private sector health plans, hospitals, and physician groups.

**Additional Budget Division Staff**

As the Department establishes the building blocks for comprehensive health care reform, the Department must also evaluate its own staffing levels to ensure that qualified employees are available to perform the complex work required to move these initiatives forward. In particular, the Department's Budget Division performs the majority of analysis and technical work to prepare documents for publication. This includes comprehensive background research into the proposed policy, research into compliance with state and federal law and regulations, calculation of the impacts of the proposed policy, and authoring the final documents, including Change Requests, fiscal notes, and other informal documents. The Department's Budget Division coordinates all aspects of

the Department's fiscal process, including communication with the Governor's Office of State Planning and Budgeting, Legislative Council, and external agencies and contractors who have input into the process.

Additionally, the Department's Budget Division has been increasingly subject to more numerous and more complex requests from legislative agencies. For example, for the Department's December 13, 2007 Joint Budget Committee Hearing, the Department was asked to comment on its ability to produce 13 new reports to provide to the Committee's staff. As the Department stated at its hearing, the Department's Budget Division can not absorb a significant increase to its workload without additional resources.

The Department requests $68,078 total funds in FY 08-09 for 1.0 FTE Budget and Policy Analyst III to assume a large part of the additional workload that is being generated by new policy initiatives. The Department is requesting a creation of a new senior position in order to take a leadership role in pricing health care reform proposals, and reduce workloads for current staff. The Department believes that a senior position is required because of the complex nature of the work that will be required of this analyst, including strong familiarity with national data sets (such as the Current Population Study and the Census) and statistically valid forecasting methodologies. Calculations are available in Table I.1.

The Department requested 7.3 FTE for FY 08-09 in its November 1, 2007 Decision Item 7 to address on-going staff shortage issues, brought on by the Department absorbing additional workloads during budget-cut years. This Request is *in addition to* the November 1, 2007 Request, which includes a request for an entry-level budget analyst. Decision Item 7 addresses long-standing Department needs; this Request is a result of the additional work which is currently being generated by health care reform initiatives.

Consequences if Not Funded:

In his January 10, 2008 State-of-the-State address, the Governor charged the Department and his health policy team to focus on cost, quality, and access to health care, and to take a realistic, building-block approach to making progress toward covering more of the uninsured. As the Department finds efficiencies in the system, cuts waste and brings more

transparency to the system, it can reinvest those savings toward coverage and access. The Department views each of the steps outlined in this Change Request as critical in order to prepare for broader health care reform in the State of Colorado. Under the current structure for eligibility and the provision of services, the Department will not be able to keep pace with large shifts in enrollment and the expansion of benefits. More so, the enhancements defined in this Request are all interrelated: for example, at current Medicaid rates, providers may be unwilling to serve more Medicaid clients; therefore, even if a large expansion of eligibility is authorized as requested in the Department's FY 08-09 Budget Request, DI-3A, "Additional Children's Basic Health Plan Outreach", those clients may not have access to physicians. Failure to fund analysis and support of eligibility systems infrastructure is likely to result in a destabilized system environment that will significantly reduce the Department's ability to meet its state and federal obligations to determine eligibility for health care programs. The administrative and systems barriers to enrollment must be addressed before the Department can expand coverage for children and families; to increase eligibility but then continue to make it difficult for families to enroll their children and for those children to get health care is counter-productive.

Calculations for Request:

| Summary of Request FY 07-08 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Request** | **$930,856** | **$263,444** | **$374** | **$127,220** | **$539,818** |
| Centralized Eligibility | $403,600 | $193,137 | $0 | $0 | $210,463 |
| Medical Homes | $335,698 | $21,040 | $0 | $126,870 | $187,788 |
| Expansion of CBHP to 225% FPL | $191,558 | $49,267 | $374 | $350 | $141,567 |

| Summary of Request FY 08-09 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Incremental Request** | **$63,651,163** | **$25,044,378** | **$53,438** | **$5,942,469** | **$32,610,878** |
| Offsets from Exisiting Requests | ($8,068,327) | ($3,915,472) | $0 | ($118,693) | ($4,034,162) |
| **Total Request** | **$71,719,490** | **$28,959,850** | **$53,438** | **$6,061,162** | **$36,645,040** |
| Centralized Eligibility | $12,360,800 | $5,915,076 | $0 | $0 | $6,445,724 |
| Medical Homes | $6,493,124 | $3,044,752 | $0 | $178,311 | $3,270,061 |
| Eligible But Not Enrolled Improvements | $10,168,761 | $3,834,818 | $0 | $874,696 | $5,459,247 |
| Expansion of CBHP to 225% FPL | $7,826,440 | $2,002,444 | $53,438 | $2,041,084 | $3,729,474 |
| Benefit Changes | $34,302,287 | $13,878,720 | $0 | $2,967,071 | $17,456,496 |
| Colorado Regional Health Information Organization | $500,000 | $250,000 | $0 | $0 | $250,000 |
| Additional Department Staff | $68,078 | $34,040 | $0 | $0 | $34,038 |

| Summary of Request FY 09-10 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Incremental Request** | **$93,146,213** | **$36,678,226** | **$115,522** | **$8,403,828** | **$47,948,637** |
| Offsets from Exisiting Requests | ($8,068,327) | ($3,915,472) | $0 | ($118,693) | ($4,034,162) |
| **Total Request** | **$101,214,540** | **$40,593,698** | **$115,522** | **$8,522,521** | **$51,982,799** |
| Centralized Eligibility | $6,859,104 | $6,094,075 | $0 | ($3,387,633) | $4,152,662 |
| Medical Homes | $7,078,708 | $3,325,497 | $0 | $184,906 | $3,568,305 |
| Eligible But Not Enrolled Improvements | $27,629,934 | $10,852,142 | $0 | $2,207,906 | $14,569,886 |
| Expansion of CBHP to 225% FPL | $23,810,370 | $6,113,159 | $115,522 | $6,228,681 | $11,353,008 |
| Benefit Changes | $35,266,013 | $13,923,619 | $0 | $3,288,661 | $18,053,733 |
| Colorado Regional Health Information Organization | $500,000 | $250,000 | $0 | $0 | $250,000 |
| Additional Department Staff | $70,411 | $35,206 | $0 | $0 | $35,205 |

| Summary of Request FY 10-11 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Incremental Request** | **$106,225,587** | **$42,163,849** | **$156,663** | **$9,362,074** | **$54,543,001** |
| Offsets from Exisiting Requests | ($8,068,327) | ($3,915,472) | $0 | ($118,693) | ($4,034,162) |
| **Total Request** | **$114,293,914** | **$46,079,321** | **$156,663** | **$9,480,767** | **$58,577,163** |
| Centralized Eligibility | $3,799,471 | $7,376,089 | $0 | ($6,475,987) | $2,899,369 |
| Medical Homes | $7,078,708 | $3,325,497 | $0 | $184,906 | $3,568,305 |
| Eligible But Not Enrolled Improvements | $28,647,786 | $11,281,086 | $0 | $2,270,892 | $15,095,808 |
| Expansion of CBHP to 225% FPL | $38,277,197 | $9,842,486 | $156,663 | $9,999,149 | $18,278,899 |
| Benefit Changes | $35,920,341 | $13,968,957 | $0 | $3,501,807 | $18,449,577 |
| Colorado Regional Health Information Organization | $500,000 | $250,000 | $0 | $0 | $250,000 |
| Additional Department Staff | $70,411 | $35,206 | $0 | $0 | $35,205 |

Because of the complex and lengthy nature of the calculations, detailed tables supporting these figures are available in the following Appendices:

- Appendix A: Summary by Long Bill Line Item;
- Appendix B: Summary of Caseload Increases;
- Appendix C: Calculations for Centralized Eligibility;
- Appendix D: Calculations for Medical Homes;
- Appendix E: Calculations for Eligible but not Enrolled Improvements;
- Appendix F: Expansion of CBHP to 225% of the Federal Poverty Level;
- Appendix G: Calculations for CBHP Mental Health Benefit;
- Appendix H: Offsets to Existing Department FY 08-09 Budget Requests, and;
- Appendix I: FTE Calculations.

Assumptions for Calculations:

Where applicable, assumptions are noted in the relevant locations in each table in the relevant appendix, and in the narrative above. The Department has estimated projected expenditure and utilization based on historical information and assumptions about future increases in caseload. Additionally, as the Department receives actual bids from contractors through the request for proposals process, the Department may require more or less funding to implement the specified programs. As actual experience with new programs is obtained, the Department would use the standard budget process to request adjustments to funding as appropriate.

In some instances, the Department's Requests supersede funding requests from its November 1, 2007 Decision Item 6, and its January 2, 2008 Supplemental 13. The Schedule 13 at the front of this Request reflects the incremental request. However, in all other tables, except where specifically indicated, totals reflect the total amount of funding required.

Impact on Other Government Agencies:

| **Department of Human Services FY 07-08** | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| (2) Office of Information Technology Services Colorado Benefits Management System | $18,000 | $2,826 | $1,445 | $6,248 | $7,481 |
| **Department of Human Services FY 08-09** | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
| (2) Office of Information Technology Services Colorado Benefits Management System | $18,000 | $2,826 | $1,445 | $6,248 | $7,481 |
| **Department of Human Services FY 09-10** | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
| (2) Office of Information Technology Services Colorado Benefits Management System | ($7,975,468) | $0 | $0 | ($7,975,468) | $0 |

At this time, the Department does not anticipate that the Citizenship and Identify Verification system will require a transfer of funds to the Department of Revenue. However, if such as transfer is required, the Department will request transfer authority as part of the normal budget process.

Cost Benefit Analysis:

For this Request, a quantitative cost-benefit analysis is not applicable. Cost savings may not be realized in the near future but costs avoided over the long term may be considerable. The Department believes that there are significant benefits to this proposal, including:

- Reducing the time between when a client applies for Medicaid and when a client is granted eligibility;
- Creating a medical home for all children;
- Expanding the number of children eligible for health care;
- Improving client access to primary care and dental services;

- Increasing provider participation in the Medicaid program, and;
- Preventing adverse health outcomes, which are generally more costly than primary care services.

For these reasons, the Department believes that the short- and long-term benefits of this proposal outweigh the costs.

Implementation Schedule:

**Tentative Timeline for RFP Vendor and Centralized Eligibility Vendor**

| Main Task | Assignment | Start | Complete |
|---|---|---|---|
| Develop request for proposals for a RFP Vendor | Department Staff | January 15, 2008 | February 15, 2008 |
| **Release request for proposals for a RFP Vendor** | **Department Staff** | **February 15, 2008** | **March 18, 2008** |
| Develop request for information for a Centralized Eligibility Vendor | Department Staff | February 15, 2008 | March 18, 2008 |
| Responses due from RFP Vendor | RFP Vendor | March 18, 2008 | March 18, 2008 |
| Request for information for Centralized Eligibility Vendor released | Department Staff | March 18, 2008 | May 15, 2008 |
| Review request for information responses from RFP Vendor | Department Staff | March 20, 2008 | April 4, 2008 |
| Intent to award contract for RFP Vendor/Protest Period | Department Staff | April 4, 2008 | April 15, 2008 |
| Draft and negotiate RFP Vendor contract | Department Staff | April 15, 2008 | April 28, 2008 |
| Contract clearance process | Department Staff | April 28, 2008 | May 12, 2008 |
| **RFP Vendor contract executed** | **Department Staff** | **May 15, 2008** | **December 17, 2009** |
| Response due from request for information for Centralized Eligibility Vendor | Centralized Eligibility Vendor | May 15, 2008 | May 15, 2008 |

| Main Task | Assignment | Start | Complete |
|---|---|---|---|
| Review request for information responses, including presentations from vendors | Department Staff, RFP Vendor | May 15, 2008 | June 30, 2008 |
| Review business processes, including assessment of other states and best practice review | RFP Vendor | May 15, 2008 | June 30, 2008 |
| Develop request for proposals for Centralized Eligibility Vendor | RFP Vendor | July 1, 2008 | August 30, 2008 |
| Department work on request for proposals for Centralized Eligibility Vendor | Department Staff | September 1, 2008 | September 30, 2008 |
| Develop criteria to review request for proposals for Centralized Eligibility Vendor | RFP Vendor | September 1, 2008 | September 30, 2008 |
| **Release request for proposals for Centralized Eligibility Vendor** | **Department Staff** | **October 1, 2008** | **December 2, 2008** |
| Response to vendor questions on request for proposals | Department Staff, RFP Vendor | October 15, 2008 | October 30, 2008 |
| Proposals due from Centralized Eligibility Vendor | Centralized Eligibility Vendor | December 2, 2008 | December 2, 2008 |
| Review Responses from Centralized Eligibility Vendor RFP | Department Staff, RFP Vendor | December 4, 2008 | December 17, 2009 |
| Intent to award Centralized Eligibility Vendor contract/protest period | Department Staff | January 5, 2009 | January 12, 2009 |
| Draft and negotiate Centralized Eligibility Vendor contract | Department Staff, Centralized Eligibility Vendor | January 12, 2009 | April 30, 2009 |
| **Centralized Eligibility Vendor contract executed** | **Department Staff** | **May 1, 2009** | **June 30, 2014** |
| Centralized Eligibility Vendor begin systems development (phone/call center, database/archive) and general start-up activities | Centralized Eligibility Vendor | May 1, 2009 | June 30, 2009 |
| Centralized Eligibility Vendor begin CHP+ contract work | Centralized Eligibility Vendor | July 1, 2009 | June 30, 2014 |

| Main Task | Assignment | Start | Complete |
|---|---|---|---|
| Centralized Eligibility Vendor begin work Medicaid eligibility for one county | Centralized Eligibility Vendor | July 1, 2009 | September 30, 2009 |
| Centralized Eligibility Vendor begin Medicaid Eligibility transition for 1/3 of counties | Centralized Eligibility Vendor | October 1, 2009 | June 30, 2010 |
| Centralized Eligibility Vendor begin Medicaid eligibility transition for all counties | Centralized Eligibility Vendor | July 1, 2010 | June 30, 2011 |
| Centralized Eligibility Vendor continue Medicaid eligibility for all counties | Centralized Eligibility Vendor | July 1, 2011 | June 30, 2014 |

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2007). Program of medical assistance - single state agency.
*(1) The state department, by rules, 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 and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.*

25.5-8-104, C.R.S. (2007). Children's basic health plan - rules.
*The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.*

Performance Measures:

This Change Request affects the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs;

- Increase the number of children served through a dedicated medical home service delivery model;
- Improve access to and the quality of Medicaid health care as demonstrated through improvements in the Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures;
- Increase number of managed care options for clients enrolling in Medicaid;
- Improve access to health care, increase health outcomes and provide more cost effective services using information technology;
- Increase the number of clients enrolled in viable managed care options, and;
- Expand coverage in the Child Health Plan Plus program.

The Department believes that centralizing eligibility, providing medical homes, expanding the Children's Basic Health Plan, increasing the mental health benefit in the Children's Basic Health Plan, increasing provider rates, and enrolling Medicaid clients in managed care will improve the health outcomes for those clients enrolled in the Medicaid and Children's Basic Health Plan programs.

**Appendix A: Summary by Line Item**

| Summary of Request FY 07-08 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Request** | **$930,856** | **$263,444** | **$374** | **$127,220** | **$539,818** |
| **Centralized Eligibility** | | | | | |
| (1) Executive Director's Office<br>Colorado Benefits Management System - Medical Assistance | $250,000 | $119,634 | $0 | $0 | $130,366 |
| (1) Executive Director's Office<br>Centralized Eligibility Vendor | $153,600 | $73,503 | $0 | $0 | $80,097 |
| *Subtotal Centralized Eligibility* | *$403,600* | *$193,137* | *$0* | *$0* | *$210,463* |
| **Medical Homes** | | | | | |
| (1) Executive Director's Office<br>Medicaid Management Information System Contract | $79,758 | $19,940 | $0 | $0 | $59,818 |
| (1) Executive Director's Office<br>SB 97-05 Enrollment Broker | $2,200 | $1,100 | $0 | $0 | $1,100 |
| (2) Medical Services Premiums | $253,740 | $0 | $0 | $126,870 | $126,870 |
| *Subtotal Medical Homes* | *$335,698* | *$21,040* | *$0* | *$126,870* | *$187,788* |
| **Expansion of CBHP to 225% FPL** | | | | | |
| (1) Executive Director's Office<br>Medicaid Management Information System Contract | $183,960 | $45,990 | $0 | $0 | $137,970 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $350 | $350 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Administration | $1,000 | $0 | $0 | $350 | $650 |
| (6) Department of Human Services - Medicaid Funded Programs<br>(B) Office of Information Technology - Medicaid Funded<br>Colorado Benefits Management System | $6,248 | $2,927 | $374 | $0 | $2,947 |
| *Subtotal CBHP Expansion* | *$191,558* | *$49,267* | *$374* | *$350* | *$141,567* |

**Appendix A: Summary by Line Item**

| Summary of Request FY 08-09 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Request** | **$71,719,490** | **$28,959,850** | **$53,438** | **$6,061,162** | **$36,645,040** |
| **Centralized Eligibility** | | | | | |
| (1) Executive Director's Office<br>Colorado Benefits Management System - Medical Assistance | $10,100,000 | $4,833,204 | $0 | $0 | $5,266,796 |
| (1) Executive Director's Office<br>Centralized Eligibility Vendor | $2,260,800 | $1,081,872 | $0 | $0 | $1,178,928 |
| *Subtotal Centralized Eligibility* | *$12,360,800* | *$5,915,076* | *$0* | *$0* | *$6,445,724* |
| **Medical Homes** | | | | | |
| (1) Executive Director's Office<br>Personal Services | $818,852 | $409,426 | $0 | $0 | $409,426 |
| (1) Executive Director's Office<br>SB 97-05 Enrollment Broker | $364,482 | $182,241 | $0 | $0 | $182,241 |
| (2) Medical Services Premiums | $4,694,490 | $2,347,245 | $0 | $0 | $2,347,245 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $105,840 | $105,840 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Administration | $15,000 | $0 | $0 | $5,250 | $9,750 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $494,460 | $0 | $0 | $173,061 | $321,399 |
| *Subtotal Medical Homes* | *$6,493,124* | *$3,044,752* | *$0* | *$178,311* | *$3,270,061* |
| **Eligible But Not Enrolled Improvements** | | | | | |
| (2) Medical Services Premiums | $6,946,539 | $3,473,270 | $0 | $0 | $3,473,269 |
| (3) Medicaid Mental Health Community Programs<br>(A) Mental Health Capitation Payments | $723,095 | $361,548 | $0 | $0 | $361,547 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $2,271,581 | $0 | $0 | $795,054 | $1,476,527 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Dental Benefit Costs | $227,546 | $0 | $0 | $79,642 | $147,904 |
| *Subtotal Eligible But Not Enrolled Improvements* | *$10,168,761* | *$3,834,818* | *$0* | *$874,696* | *$5,459,247* |

**Appendix A: Summary by Line Item**

| Summary of Request FY 08-09 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Expansion of CBHP to 225% FPL** | | | | | |
| (1) Executive Director's Office<br>Medicaid Management Information System Contract | $45,990 | $11,497 | $0 | $0 | $34,493 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $2,041,084 | $1,988,020 | $53,064 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Administration | $1,000 | $0 | $0 | $350 | $650 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $5,237,972 | $0 | $0 | $1,867,782 | $3,370,190 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Dental Benefit Costs | $494,146 | $0 | $0 | $172,952 | $321,194 |
| (6) Department of Human Services - Medicaid Funded Programs<br>(B) Office of Information Technology - Medicaid Funded<br>Colorado Benefits Management System | $6,248 | $2,927 | $374 | $0 | $2,947 |
| *Subtotal CBHP Expansion* | *$7,826,440* | *$2,002,444* | *$53,438* | *$2,041,084* | *$3,729,474* |
| **Benefit Changes**<br>Evaluation and Management Rates, Dental Rates, CBHP Mental Health Benefit, Integrated Care Delivery Model Financing | | | | | |
| (2) Medical Services Premiums | $27,342,964 | $12,742,496 | $0 | $928,986 | $13,671,482 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $1,136,224 | $1,136,224 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $5,823,099 | $0 | $0 | $2,038,085 | $3,785,014 |
| *Subtotal Benefit Changes* | *$34,302,287* | *$13,878,720* | *$0* | *$2,967,071* | *$17,456,496* |

**Appendix A: Summary by Line Item**

| Summary of Request FY 08-09 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Colorado Regional Health Information Organization** | | | | | |
| (1) Executive Director's Office<br>Colorado Regional Health Information Organization | $500,000 | $250,000 | $0 | $0 | $250,000 |
| **Additional Department Staff** | | | | | |
| (1) Executive Director's Office<br>Personal Services | $63,673 | $31,837 | $0 | $0 | $31,836 |
| (1) Executive Director's Office<br>Operating Expenses | $4,405 | $2,203 | $0 | $0 | $2,202 |
| *Subtotal Additional Department Staff* | *$68,078* | *$34,040* | *$0* | *$0* | *$34,038* |
| *Offsets to existing funding requests are not shown in this table. | | | | | |

**Appendix A: Summary by Line Item**

| Summary of Request FY 09-10 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Request** | $101,214,540 | $40,593,698 | $115,522 | $8,522,521 | $51,982,799 |
| **Centralized Eligibility** | | | | | |
| (1) Executive Director's Office<br>Colorado Benefits Management System - Medical Assistance | $7,975,468 | $3,259,485 | $24,509 | $532,547 | $4,158,927 |
| (1) Executive Director's Office<br>Centralized Eligibility Vendor | $18,657,430 | $8,928,234 | $0 | $0 | $9,729,196 |
| (1) Executive Director's Office<br>County Administration | ($7,918,736) | ($2,416,314) | ($24,509) | ($1,544,177) | ($3,933,736) |
| (4) Indigent Care Program<br>Children's Basic Health Plan Administration | ($3,879,590) | $0 | $0 | ($1,843,456) | ($2,036,134) |
| (6) Department of Human Services - Medicaid Funded Programs<br>(B) Office of Information Technology - Medicaid Funded<br>Colorado Benefits Management System | ($7,975,468) | ($3,677,330) | $0 | ($532,547) | ($3,765,591) |
| *Subtotal Centralized Eligibility* | *$6,859,104* | *$6,094,075* | *$0* | *($3,387,633)* | *$4,152,662* |
| **Medical Homes** | | | | | |
| (1) Executive Director's Office<br>Personal Services | $890,502 | $445,251 | $0 | $0 | $445,251 |
| (1) Executive Director's Office<br>SB 97-05 Enrollment Broker | $145,000 | $72,500 | $0 | $0 | $72,500 |
| (2) Medical Services Premiums | $5,414,320 | $2,707,160 | $0 | $0 | $2,707,160 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $100,586 | $100,586 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $528,300 | $0 | $0 | $184,906 | $343,394 |
| *Subtotal Medical Homes* | *$7,078,708* | *$3,325,497* | *$0* | *$184,906* | *$3,568,305* |

**Appendix A: Summary by Line Item**

| Summary of Request FY 09-10 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Eligible But Not Enrolled Improvements** | | | | | |
| (2) Medical Services Premiums | $20,112,942 | $9,965,712 | $0 | $181,519 | $9,965,711 |
| (3) Medicaid Mental Health Community Programs<br>(A) Mental Health Capitation Payments | $1,797,383 | $886,430 | $0 | $24,523 | $886,430 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $5,221,177 | $0 | $0 | $1,827,412 | $3,393,765 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Dental Benefit Costs | $498,432 | $0 | $0 | $174,452 | $323,980 |
| *Subtotal Eligible But Not Enrolled Improvements* | *$27,629,934* | *$10,852,142* | *$0* | *$2,207,906* | *$14,569,886* |
| **Expansion of CBHP to 225% FPL** | | | | | |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $6,228,681 | $6,113,159 | $115,522 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $16,442,270 | $0 | $0 | $5,829,884 | $10,612,386 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Dental Benefit Costs | $1,139,419 | $0 | $0 | $398,797 | $740,622 |
| *Subtotal CBHP Expansion* | *$23,810,370* | *$6,113,159* | *$115,522* | *$6,228,681* | *$11,353,008* |

**Appendix A: Summary by Line Item**

| Summary of Request FY 09-10 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Benefit Changes**<br>Evaluation and Management Rates, Dental Rates, CBHP Mental Health Benefit, Integrated Care Delivery Model Financing | | | | | |
| (2) Medical Services Premiums | $27,342,964 | $12,742,496 | $0 | $928,986 | $13,671,482 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $1,181,123 | $1,181,123 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $6,741,926 | $0 | $0 | $2,359,675 | $4,382,251 |
| *Subtotal Benefit Changes* | *$35,266,013* | *$13,923,619* | *$0* | *$3,288,661* | *$18,053,733* |
| **Colorado Regional Health Information Organization** | | | | | |
| (1) Executive Director's Office<br>Colorado Regional Health Information Organization | $500,000 | $250,000 | $0 | $0 | $250,000 |
| **Additional Department Staff** | | | | | |
| (1) Executive Director's Office<br>Personal Services | $69,461 | $34,731 | $0 | $0 | $34,730 |
| (1) Executive Director's Office<br>Operating Expenses | $950 | $475 | $0 | $0 | $475 |
| *Subtotal Additional Department Staff* | *$70,411* | *$35,206* | *$0* | *$0* | *$35,205* |
| *Offsets to existing funding requests are not shown in this table. | | | | | |

**Appendix A: Summary by Line Item**

| Summary of Request FY 10-11 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Total Request** | $114,293,914 | $46,079,321 | $156,663 | $9,480,767 | $58,577,163 |
| **Centralized Eligibility** | | | | | |
| (1) Executive Director's Office<br>Colorado Benefits Management System - Medical Assistance | $7,975,468 | $3,259,485 | $73,526 | $532,547 | $4,109,910 |
| (1) Executive Director's Office<br>Centralized Eligibility Vendor | $31,435,270 | $15,042,877 | $0 | $0 | $16,392,393 |
| (1) Executive Director's Office<br>County Administration | ($23,756,209) | ($7,248,943) | ($73,526) | ($4,632,531) | ($11,801,209) |
| (4) Indigent Care Program<br>Children's Basic Health Plan Administration | ($3,879,590) | $0 | $0 | ($1,843,456) | ($2,036,134) |
| (6) Department of Human Services - Medicaid Funded Programs<br>(B) Office of Information Technology - Medicaid Funded<br>Colorado Benefits Management System | ($7,975,468) | ($3,677,330) | $0 | ($532,547) | ($3,765,591) |
| *Subtotal Centralized Eligibility* | *$3,799,471* | *$7,376,089* | *$0* | *($6,475,987)* | *$2,899,369* |
| **Medical Home** | | | | | |
| (1) Executive Director's Office<br>Personal Services | $890,502 | $445,251 | $0 | $0 | $445,251 |
| (1) Executive Director's Office<br>SB 97-05 Enrollment Broker | $145,000 | $72,500 | $0 | $0 | $72,500 |
| (2) Medical Services Premiums | $5,414,320 | $2,707,160 | $0 | $0 | $2,707,160 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $100,586 | $100,586 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $528,300 | $0 | $0 | $184,906 | $343,394 |
| *Subtotal Medical Homes* | *$7,078,708* | *$3,325,497* | *$0* | *$184,906* | *$3,568,305* |

**Appendix A: Summary by Line Item**

| Summary of Request FY 10-11 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Eligible But Not Enrolled Improvements** | | | | | |
| (2) Medical Services Premiums | $20,911,146 | $10,359,910 | $0 | $191,326 | $10,359,910 |
| (3) Medicaid Mental Health Community Programs<br>(A) Mental Health Capitation Payments | $1,867,834 | $921,176 | $0 | $25,483 | $921,175 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $5,340,864 | $0 | $0 | $1,869,303 | $3,471,561 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Dental Benefit Costs | $527,942 | $0 | $0 | $184,780 | $343,162 |
| *Subtotal Eligible But Not Enrolled Improvements* | *$28,647,786* | *$11,281,086* | *$0* | *$2,270,892* | *$15,095,808* |
| **Expansion of CBHP to 225% FPL** | | | | | |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $9,999,149 | $9,842,486 | $156,663 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $26,641,356 | $0 | $0 | $9,426,306 | $17,215,050 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Dental Benefit Costs | $1,636,692 | $0 | $0 | $572,843 | $1,063,849 |
| *Subtotal CBHP Expansion* | *$38,277,197* | *$9,842,486* | *$156,663* | *$9,999,149* | *$18,278,899* |
| **Benefit Changes**<br>Evaluation and Management Rates, Dental Rates, CBHP Mental Health Benefit, Integrated Care Delivery Model Financing | | | | | |
| (2) Medical Services Premiums | $27,342,964 | $12,742,496 | $0 | $928,986 | $13,671,482 |
| (4) Indigent Care Program<br>H.B. 97-1304 Children's Basic Health Plan Trust | $1,226,461 | $1,226,461 | $0 | $0 | $0 |
| (4) Indigent Care Program<br>Children's Basic Health Plan Premium Costs | $7,350,916 | $0 | $0 | $2,572,821 | $4,778,095 |
| *Subtotal Benefit Changes* | $35,920,341 | $13,968,957 | $0 | $3,501,807 | $18,449,577 |

**Appendix A: Summary by Line Item**

| Summary of Request FY 10-11 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Colorado Regional Health Information Organization** | | | | | |
| (1) Executive Director's Office<br>Colorado Regional Health Information Organization | $500,000 | $250,000 | $0 | | $250,000 |
| **Additional Department Staff** | | | | | |
| (1) Executive Director's Office<br>Personal Services | $69,461 | $34,731 | $0 | $0 | $34,730 |
| (1) Executive Director's Office<br>Operating Expenses | $950 | $475 | $0 | $0 | $475 |
| *Subtotal Additional Department Staff* | *$70,411* | *$35,206* | *$0* | *$0* | *$35,205* |

*Offsets to existing funding requests are not shown in this table.

## Appendix B: Summary of Caseload Increases

**Table B.1**
**Combined Caseload Impact**

| | Medicaid | | | | Children's Basic Health Plan | | TOTAL |
|---|---|---|---|---|---|---|---|
| **Item** | **Categorically Eligible Low-Income Adults (AFDC-A)** | **Expansion Adults** | **Eligible Children (AFDC-C/BC)** | **Baby Care Program-Adults** | **Children** | **Prenatal** | **All Clients** |
| **Base Caseload** | | | | | | | |
| FY 08-09 Projection | 44,183 | 9,462 | 196,717 | 5,649 | 70,481 | 1,497 | 327,989 |
| FY 09-10 Projection | 43,993 | 10,518 | 196,755 | 5,808 | 73,899 | 1,612 | 332,585 |
| FY 10-11 Projection | 43,804 | 11,692 | 196,793 | 5,971 | 75,701 | 1,736 | 335,697 |
| **Eligible But Not Enrolled Improvements** | | | | | | | |
| FY 08-09 Projection | - | - | 3,934 | - | 1,410 | - | 5,344 |
| FY 09-10 Projection | 880 | 210 | 7,948 | 116 | 2,916 | 32 | 12,102 |
| FY 10-11 Projection | 880 | 210 | 7,948 | 116 | 2,916 | 32 | 12,102 |
| **Expansion of CBHP to 225% FPL** | | | | | | | |
| FY 08-09 Projection | - | - | - | - | 3,062 | - | 3,062 |
| FY 09-10 Projection | - | - | - | - | 6,666 | 338 | 7,004 |
| FY 10-11 Projection | - | - | - | - | 9,040 | 686 | 9,726 |
| **Final Caseload** | | | | | | | |
| FY 08-09 Projection | 44,183 | 9,462 | 200,651 | 5,649 | 74,953 | 1,497 | 336,395 |
| FY 09-10 Projection | 44,873 | 10,728 | 204,703 | 5,924 | 83,481 | 1,982 | 351,691 |
| FY 10-11 Projection | 44,684 | 11,902 | 204,741 | 6,087 | 87,657 | 2,454 | 357,525 |

**Table B.2**
**Total Caseload with Only Eligible But Not Enrolled Improvements**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| FY 08-09 Projection | 44,183 | 9,462 | 200,651 | 5,649 | 71,891 | 1,497 | 333,333 |
| FY 09-10 Projection | 44,873 | 10,728 | 204,703 | 5,924 | 76,815 | 1,644 | 344,687 |
| FY 10-11 Projection | 44,684 | 11,902 | 204,741 | 6,087 | 78,617 | 1,768 | 347,799 |

## Appendix C: Calculations for Centralized Eligibility

**Table C.1**
**Summary of CBMS - Medical Assistance Funding**

| **CBMS - Medical Assistance** | **FY 07-08** | **FY 08-09** | **FY 09-10** | **FY 10-11** |
|---|---|---|---|---|
| CBMS Decoupling Study | $250,000 | $0 | $0 | $0 |
| Verification of Decoupling Costs | $0 | $100,000 | $0 | $0 |
| CBMS Decoupling Development and Programming | $0 | $10,000,000 | $0 | $0 |
| Medicaid CBMS Operations | $0 | $0 | $7,975,468 | $7,975,468 |
| **CBMS Changes Total** | **$250,000** | **$10,100,000** | **$7,975,468** | **$7,975,468** |
| **Offsets** | | | | |
| Existing CBMS Funding (Transfer to Department of Human Services) | $0 | $0 | ($7,975,468) | ($7,975,468) |
| **Grand Total CBMS - Medical Assistance** | **$250,000** | **$10,100,000** | **$0** | **$0** |

## Appendix C: Calculations for Centralized Eligibility

**Table C.2**
**Summary of Centralized Eligibility Funding**

| **Centralized Eligibility Vendor** | **FY 07-08** | **FY 08-09** | **FY 09-10** | **FY 10-11** |
|---|---|---|---|---|
| Centralized Eligibility RFP Vendor | $153,600 | $460,800 | $0 | $0 |
| Vendor Startup Costs | $0 | $0 | $1,000,000 | $0 |
| Electronic Document Management | $0 | $0 | $1,750,000 | $3,500,000 |
| Customer Contact Center | $0 | $0 | $1,750,000 | $3,500,000 |
| Medicaid Eligibility and Enrollment Personnel | $0 | $0 | $8,962,570 | $17,925,140 |
| CBHP Eligibility and Enrollment Personnel | $0 | $0 | $3,879,590 | $3,879,590 |
| Personnel Operating | $0 | $0 | $381,500 | $763,000 |
| Contractor Leased Space | $0 | $0 | $735,000 | $1,470,000 |
| Increased Postage | $0 | $0 | $198,770 | $397,540 |
| Virtual Application Gateway | $0 | $900,000 | $0 | $0 |
| Citizenship and Identity Verifications | $0 | $900,000 | $0 | $0 |
| **Total** | **$153,600** | **$2,260,800** | **$18,657,430** | **$31,435,270** |
| **Offsets** | | | | |
| County Administration | $0 | $0 | ($7,918,736) | ($23,756,209) |
| CBHP Eligibility and Enrollment Personnel | $0 | $0 | ($3,879,590) | ($3,879,590) |
| **Total Offsets** | $0 | $0 | **($11,798,326)** | **($27,635,799)** |
| **Grand Total Centralized Eligibility** | **$153,600** | **$2,260,800** | **$6,859,104** | **$3,799,471** |

## Appendix C: Calculations for Centralized Eligibility

**Table C.3.1**
**Centralized Eligibility Fund Splits**

| FY 07-08 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Costs** | | | | | |
| Colorado Benefits Management System - Medical Assistance | $250,000 | $119,634 | $0 | $0 | $130,366 |
| Centralized Eligibility Vendor | $153,600 | $73,503 | $0 | $0 | $80,097 |
| **Offsets** | | | | | |
| *None* | $0 | $0 | $0 | $0 | $0 |
| **Total** | **$403,600** | **$193,137** | **$0** | **$0** | **$210,463** |
| **FY 08-09** | **Total Funds** | **General Fund** | **Cash Funds** | **Cash Funds Exempt** | **Federal Funds** |
| **Costs** | | | | | |
| Colorado Benefits Management System - Medical Assistance | $10,100,000 | $4,833,204 | $0 | $0 | $5,266,796 |
| Centralized Eligibility Vendor | $2,260,800 | $1,081,872 | $0 | $0 | $1,178,928 |
| **Offsets** | | | | | |
| *None* | $0 | $0 | $0 | $0 | $0 |
| **Total** | **$12,360,800** | **$5,915,076** | **$0** | **$0** | **$6,445,724** |

*General Fund portion for Medicaid-related costs is 50% of the total. General Fund portion for CBHP-related costs is 35% of the total funds. The Department estimates that the total General Fund share, based on a weighted average of Medicaid and CBHP costs, is 47.85% of the total.

## Appendix C: Calculations for Centralized Eligibility

**Table C.3.2**
**Centralized Eligibility Fund Splits**

| FY 09-10 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Costs** | | | | | |
| Colorado Benefits Management System - Medical Assistance | $7,975,468 | $3,259,485 | $24,509 | $532,547 | $4,158,927 |
| Centralized Eligibility Vendor | $18,657,430 | $8,928,234 | $0 | $0 | $9,729,196 |
| **Offsets** | | | | | |
| County Administration | ($7,918,736) | ($2,416,314) | ($24,509) | ($1,544,177) | ($3,933,736) |
| CBHP Administration (Eligibility Contract) | ($3,879,590) | $0 | $0 | ($1,843,456) | ($2,036,134) |
| Colorado Benefits Management System (Department of Human Services) | ($7,975,468) | ($3,677,330) | $0 | ($532,547) | ($3,765,591) |
| **Total** | **$6,859,104** | **$6,094,075** | **$0** | **($3,387,633)** | **$4,152,662** |

| FY 10-11 | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|
| **Costs** | | | | | |
| Colorado Benefits Management System - Medical Assistance | $7,975,468 | $3,259,485 | $73,526 | $532,547 | $4,109,910 |
| Centralized Eligibility Vendor | $31,435,270 | $15,042,877 | $0 | $0 | $16,392,393 |
| **Offsets** | | | | | |
| County Administration | ($23,756,209) | ($7,248,943) | ($73,526) | ($4,632,531) | ($11,801,209) |
| CBHP Administration (Eligibility Contract) | ($3,879,590) | $0 | $0 | ($1,843,456) | ($2,036,134) |
| Colorado Benefits Management System (Department of Human Services) | ($7,975,468) | ($3,677,330) | $0 | ($532,547) | ($3,765,591) |
| **Total** | **$3,799,471** | **$7,376,089** | **$0** | **($6,475,987)** | **$2,899,369** |

*General Fund portion for Medicaid-related costs is 50% of the total. General Fund portion for CBHP-related costs is 35% of the total funds. The Department estimates that the total General Fund share, based on a weighted average of Medicaid and CBHP costs, is 47.85% of the total.

## Appendix D: Calculations for Medical Homes

**Table D.1.1**
**Medical Home Funding Summary (FY 07-08, FY 08-09)**

| FY 07-08 | Description | Total Funds | General Fund | Grant Funding | CBHP Trust | Health Care Expansion Fund | Federal Funds |
|---|---|---|---|---|---|---|---|
| Medicaid Management Information System | System Changes | $79,758 | $19,940 | $0 | $0 | $0 | $59,818 |
| Enrollment Broker | Materials Redesign | $2,200 | $1,100 | $0 | $0 | $0 | $1,100 |
| Medical Services Premiums | Medicaid Services | $253,740 | $0 | $126,870 | $0 | $0 | $126,870 |
| **Total** | | **$335,698** | **$21,040** | **$126,870** | **$0** | **$0** | **$187,788** |
| **FY 08-09** | **Description** | **Total Funds** | **General Fund** | **Grant Funding** | **CBHP Trust** | **Health Care Expansion Fund** | **Federal Funds** |
| Personal Services | Provider Education, Certification, Etc | $603,902 | $301,951 | $0 | $0 | $0 | $301,951 |
| Personal Services | Program Evaluation | $150,000 | $75,000 | $0 | $0 | $0 | $75,000 |
| Personal Services | Physician Recruitment | $64,950 | $32,475 | $0 | $0 | $0 | $32,475 |
| Enrollment Broker | Data entry, materials, etc | $364,482 | $182,241 | $0 | $0 | $0 | $182,241 |
| Medical Services Premiums | Medicaid Services | $4,694,490 | $2,347,245 | $0 | $0 | $0 | $2,347,245 |
| CBHP Admin | System Changes | $15,000 | $0 | $0 | $5,250 | $0 | $9,750 |
| CBHP Premiums | CBHP Services Traditional Clients | $287,400 | $0 | $0 | $100,590 | $0 | $186,810 |
| CBHP Premiums | CBHP Services Expansion Clients | $207,060 | $0 | $0 | $0 | $72,471 | $134,589 |
| CBHP Trust | Funding Source | $105,840 | $105,840 | $0 | $0 | $0 | $0 |
| **Total** | | **$6,493,124** | **$3,044,752** | **$0** | **$105,840** | **$72,471** | **$3,270,061** |

## Appendix D: Calculations for Medical Homes

**Table D.1.2**
**Medical Home Funding Summary (FY 09-10)**

| FY 09-10 | Description | Total Funds | General Fund | Grant Funding | CBHP Trust | Health Care Expansion Fund | Federal Funds |
|---|---|---|---|---|---|---|---|
| Personal Services | Provider Education, Certification, Etc | $603,902 | $301,951 | $0 | $0 | $0 | $301,951 |
| Personal Services | Program Evaluation | $200,000 | $100,000 | $0 | $0 | $0 | $100,000 |
| Personal Services | Physician Recruitment | $86,600 | $43,300 | $0 | $0 | $0 | $43,300 |
| Enrollment Broker | Data entry, materials, etc | $145,000 | $72,500 | $0 | $0 | $0 | $72,500 |
| Medical Services Premiums | Medicaid Services | $5,414,320 | $2,707,160 | $0 | $0 | $0 | $2,707,160 |
| CBHP Admin | System Changes | $0 | $0 | $0 | $0 | $0 | $0 |
| CBHP Premiums | CBHP Services Traditional Clients | $287,386 | $0 | $0 | $100,586 | $0 | $186,800 |
| CBHP Premiums | CBHP Services Expansion Clients | $240,914 | $0 | $0 | $0 | $84,320 | $156,594 |
| CBHP Trust | Funding | $100,586 | $100,586 | $0 | $0 | $0 | $0 |
| **Total** | | **$7,078,708** | **$3,325,497** | **$0** | **$100,586** | **$84,320** | **$3,568,305** |

*Note: Estimates for FY 10-11 are held constant at the FY 09-10 levels.

## Appendix D: Calculations for Medical Homes

**Table D.2.1**
**Estimated Medicaid Medical Home Utilization**

| **Medical Home Caseload** | **FY 07-08 Pilot Phase** | **FY 08-09** | **FY 09-10** | **FY 10-11** |
|---|---|---|---|---|
| Total Eligible Children | 15,000 | 200,651 | 204,703 | 204,741 |
| Children 0-1 | 3,439 | 46,008 | 46,937 | 46,946 |
| Target Utilization Rate | 60.00% | 73.56% | 76.78% | 80.00% |
| **Number of Children Receiving Medical Home Services** | **2,063** | **33,842** | **36,038** | **37,557** |
| Children 2-4 | 3,438 | 45,993 | 46,922 | 46,930 |
| Target Utilization Rate | 60.00% | 73.56% | 76.78% | 80.00% |
| **Number of Children Receiving Medical Home Services** | **2,063** | **33,831** | **36,026** | **37,544** |
| Children 5-20 | 8,123 | 154,643 | 157,766 | 157,795 |
| Utilization Rate | 40.00% | 43.07% | 51.53% | 60.00% |
| **Number of Children Receiving Medical Home Services** | **3,249** | **66,602** | **81,304** | **94,677** |

* Note: Estmimated caseload varies from the November 1 Budget Request by the estimated increase in caseload due to the implementation of Centralized Eligibility, Medical Homes, and additional CBHP Marketing

## Appendix D: Calculations for Medical Homes

### Table D.2.2
### Estimated Medicaid Medical Home Expenditure

| **FY 07-08** | Age Range | Children Enrolled | Rate Enhancement | Total Cost |
|---|---|---|---|---|
| Well-Child | 0-1 | 2,063 | $50 | $103,150 |
| Well-Child | 2-4 | 2,063 | $10 | $20,630 |
| Well-Child | 5-20 | 3,249 | $40 | $129,960 |
| *Well-Child Subtotal* | | 7,375 | | $253,740 |

| **FY 08-09** | Age Range | Children Enrolled | Rate Enhancement | Total Cost |
|---|---|---|---|---|
| Well-Child | 0-1 | 33,842 | $50 | $1,692,100 |
| Well-Child | 2-4 | 33,831 | $10 | $338,310 |
| Well-Child | 5-20 | 66,602 | $40 | $2,664,080 |
| *Well-Child Subtotal* | | 134,275 | | $4,694,490 |

| **FY 09-10** | Age Range | Children Enrolled | Rate Enhancement | Total Cost |
|---|---|---|---|---|
| Well-Child | 0-1 | 36,038 | $50 | $1,801,900 |
| Well-Child | 2-4 | 36,026 | $10 | $360,260 |
| Well-Child | 5-20 | 81,304 | $40 | $3,252,160 |
| *Well-Child Subtotal* | | 153,368 | | $5,414,320 |

| **FY 10-11** | Age Range | Children Enrolled | Rate Enhancement | Total Cost |
|---|---|---|---|---|
| Well-Child | 0-1 | 37,557 | $50 | $1,877,850 |
| Well-Child | 2-4 | 37,544 | $10 | $375,440 |
| Well-Child | 5-20 | 94,677 | $40 | $3,787,080 |
| *Well-Child Subtotal* | | 169,778 | | $6,040,370 |

**Appendix D: Calculations for Medical Homes**

**Table D.3.1**
**CBHP Children Enrolled in a Managed Care Organization**

| Row | Item | FY 08-09 | FY 09-10 | Notes |
|---|---|---|---|---|
| A | Estimated Children's Basic Health Plan Caseload | 71,891 | 76,815 | Table B.2<br>Totals do not include CBHP Expansion to 225% FPL |
| B | Percentage of Children Enrolled in a Managed Care Organization | 60% | 60% | Average figure based on historical CBHP enrollment levels |
| C | Total Estimated Caseload Enrolled in a Managed Care Organization | 43,135 | 46,089 | Row A * Row B |
| D | Estimated Percentage of Children Under 2 Years Old | 10.50% | 10.50% | Based on information used in CBHP rate setting |
| E | Estimated Children Under 2 Years Old Enrolled in a Managed Care Plan | 4,529 | 4,839 | Row C * Row D |
| F | Estimated Medical Home Utilization Rate | 80.00% | 80.00% | Based on simliar assumptions for Medicaid -- See narrative |
| G | **Estimated Children Under 2 Years Old Utilizing Medical Home Services** | **3,623** | **3,871** | Row E * Row F |
| H | Estimated Cost Per Medical Home Visit | $10 | $10 | See narrative |
| I | Estimated Number of Visits Per Year | 5 | 5 | See narrative |
| J | Estimated Medical Home Payments Per Client Per Year | $50 | $50 | Row H * Row I |
| K | **Estimated Cost for Children Under 2** | **$181,150** | **$193,550** | Row G * Row J |
| | | | | |
| L | Estimated Children Over 2 Years Old Enrolled in a Managed Care Plan | 38,606 | 41,250 | Row A - Row C |
| M | Estimated Utilization Rate | 60.00% | 60.00% | Based on simliar assumptions for Medicaid -- See narrative |
| N | **Estimated Children Over 2 Years Old Utilizing Medical Home Services** | **23,164** | **24,750** | Row L * Row M |
| O | Estimated Cost Per Medical Home Visit | $10 | $10 | See narrative |
| P | Estimated Number of Visits Per Year | 1 | 1 | See narrative |
| Q | Estimated Medical Home Payments Per Client Per Year | $10 | $10 | Row O * Row P |
| R | **Estimated Cost for Children Over 2** | **$231,640** | **$247,500** | Row N * Row Q |
| S | **Estimated Cost for Children Enrolled in a Managed Care Organization** | **$412,790** | **$441,050** | Row K + Row R |

**Appendix D: Calculations for Medical Homes**

**Table D.3.2**
**CBHP Children Enrolled in the Self-Funded Network**

| Row | Item | FY 08-09 | FY 09-10 | Notes |
|---|---|---|---|---|
| A | Estimated Children's Basic Health Plan Caseload | 71,891 | 76,815 | Table B.2<br>Totals do not include CBHP Expansion to 225% FPL |
| B | Percentage of Children Enrolled in Self Funded Network | 40% | 40% | Average figure based on historical CBHP enrollment levels |
| C | Total Estimated Caseload Enrolled in Self Funded Network | 28,756 | 30,726 | Row A * Row B |
| D | Estimated Percentage of Children Under 2 Years Old | 10.50% | 10.50% | Based on information used in CBHP rate setting |
| E | Estimated Children Under 2 Years Old Enrolled in Self Funded Network | 3,019 | 3,226 | Row C * Row D |
| F | Estimated Utilization Rate | 20.00% | 20.00% | Based on simliar assumptions for Medicaid -- See narrative |
| G | **Estimated Children Under 2 Years Old Utilizing Medical Home Services** | **604** | **645** | Row E * Row F |
| H | Estimated Cost Per Medical Home Visit | $10 | $10 | See narrative |
| I | Estimated Number of Visits Per Year | 5 | 5 | See narrative |
| J | Estimated Medical Home Payments Per Client Per Year | $50 | $50 | Row H * Row I |
| K | **Estimated Cost** | **$30,200** | **$32,250** | Row G * Row J |
| | | | | |
| L | Estimated Children Over 2 Years Old Enrolled in Self Funded Network | 25,737 | 27,500 | Row A - Row C |
| M | Estimated Utilization Rate | 20.00% | 20.00% | Based on simliar assumptions for Medicaid -- See narrative |
| N | **Estimated Children Over 2 Years Old Utilizing Medical Home Services** | **5,147** | **5,500** | Row L * Row M |
| O | Estimated Cost Per Medical Home Visit | $10 | $10 | See narrative |
| P | Estimated Number of Visits Per Year | 1 | 1 | See narrative |
| Q | Estimated Medical Home Payments Per Client Per Year | $10 | $10 | Row O * Row P |
| R | **Estimated Cost** | **$51,470** | **$55,000** | Row N * Row Q |
| S | **Estimated Cost for Children Enrolled in Self Funded Network** | **$81,670** | **$87,250** | Row K + Row R |

**Appendix D: Calculations for Medical Homes**

**Table D.3.3**
**CBHP Premiums Total and Per Capita Impact**

| Row | Item | FY 08-09 | FY 09-10 | Notes |
|---|---|---|---|---|
| A | Total Managed Care Cost | $412,790 | $441,050 | Table D.3.1, Row S |
| B | Total Self Funded Network Cost | $81,670 | $87,250 | Table D.3.2, Row S |
| C | Total Cost | $494,460 | $528,300 | Row A + Row B |
| D | Estimated Children's Basic Health Plan Caseload | 71,891 | 76,815 | Table B.2<br>Totals do not include CBHP Expansion to 225% FPL |
| E | Total Per Capita Cost Increase | $6.88 | $6.88 | Row C / Row D |
| | | | | |
| F | Total Costs for Traditional Population | $287,400 | $287,386 | Row E * 41,786<br>Costs for caseload exceeding the FY 03-04 levels have a different fund source than caseload below the FY 03-04 level. |
| G | Total Costs for Expansion Population | $207,060 | $240,914 | Row C - Row F |

## Appendix D: Calculations for Medical Homes

**Table D.3.4**
**CBHP Medical Home Fund Splits**

| Fiscal Year | Type of Caseload | Total Funds | CBHP Trust | Health Care Expansion Fund | Federal Funds |
|---|---|---|---|---|---|
| **FY 08-09** | Traditional | $287,400 | $100,590 | $0 | $186,810 |
| | Expansion | $207,060 | $0 | $72,471 | $134,589 |
| | **Total** | **$494,460** | **$100,590** | **$72,471** | **$321,399** |
| **FY 09-10** | Traditional | $287,386 | $100,586 | $0 | $186,800 |
| | Expansion | $240,914 | $0 | $84,320 | $156,594 |
| | **Total** | **$528,300** | **$100,586** | **$84,320** | **$343,394** |

## Appendix D: Calculations for Medical Homes

**Table D.4.1**
**Enrollment Broker Medical Home Costs**

| Item | FY 07-08 | FY 08-09 | FY 09-10 | Rates |
|---|---|---|---|---|
| Redesign / Add Information to Comparison Chart and Brochure | $1,600 | $0 | $0 | 16 hours @ $100.00/hour |
| Document Translation Services | $600 | $0 | $0 | 6 hours @ $100.00/hour |
| Notification to Current Medicaid Clients of Medical Home Option[(1)] | $0 | $255,732 | $0 | 196,717 packets @ $1.30<br>Includes mailing, postage, and materials<br>Based on FY 08-09 projected |
| Call Center Staff | $0 | $72,500 | $72,500 | Includes annual salary, benefits, and adminstrative costs. |
| Data Processing Staff | $0 | $36,250 | $72,500 | 0.5 FTE in FY 08-09, 1.0 FTE in FY 09-10. Includes annual salary, benefits, and administrative costs. |
| **Total** | **$2,200** | **$364,482** | **$145,000** | |

(1) Estimated impact is based on base caseload, without any growth for Centralized Eligibility or the Medical Home Initiative. This is because the additional costs incurred by the Enrollment Broker will be based on existing Medicaid caseload at the time. New caseload is covered under exisitng

## Appendix E: Calculations for Eligible but not Enrolled Improvements

**Table E.1.1**
**Estimate of Increased Caseload due to Centralized Eligibility and Medical Home Initiative**

| | Medicaid | | | | Children's Basic Health Plan | | TOTAL |
|---|---|---|---|---|---|---|---|
| **Item** | **Categorically Eligible Low-Income Adults (AFDC-A)** | **Expansion Adults** | **Eligible Children (AFDC-C/BC)** | **Baby Care Program-Adults** | **Children** | **Prenatal** | **All Clients** |
| **Base Caseload** | | | | | | | |
| FY 08-09 Projection | 44,183 | 9,462 | 196,717 | 5,649 | 70,481 | 1,497 | - |
| FY 09-10 Projection | 43,993 | 10,518 | 196,755 | 5,808 | 73,899 | 1,612 | - |
| FY 10-11 Projection | 43,804 | 11,692 | 196,793 | 5,971 | 75,701 | 1,736 | - |
| **Medical Per Capita** | | | | | | | |
| FY 08-09 Projection | $4,313.73 | $1,640.14 | $1,765.77 | $10,099.97 | $1,611.05 | $12,723.22 | - |
| FY 09-10 Projection | $4,546.77 | $1,728.75 | $1,830.87 | $10,318.89 | $1,641.66 | $13,565.50 | - |
| FY 10-11 Projection | $4,792.40 | $1,822.15 | $1,898.37 | $10,542.56 | $1,672.85 | $14,463.54 | - |
| **Mental Health Per Capita** | | | | | | | |
| FY 08-09 Projection | $224.75 | $224.75 | $183.81 | $204.62 | $0.00 | $0.00 | - |
| FY 09-10 Projection | $233.55 | $233.55 | $191.01 | $212.55 | $0.00 | $0.00 | - |
| FY 10-11 Projection | $242.70 | $242.70 | $198.50 | $220.80 | $0.00 | $0.00 | - |
| **Dental Per Capita** | | | | | | | |
| FY 08-09 Projection | $0.00 | $0.00 | $0.00 | $0.00 | $161.38 | $0.00 | - |
| FY 09-10 Projection | $0.00 | $0.00 | $0.00 | $0.00 | $170.93 | $0.00 | - |
| FY 10-11 Projection | $0.00 | $0.00 | $0.00 | $0.00 | $181.05 | $0.00 | - |

## Appendix E: Calculations for Eligible but not Enrolled Improvements

**Table E.1.2**
**Estimate of Increased Caseload due to Centralized Eligibility and Medical Home Initiative**

| | Medicaid | | | | Children's Basic Health Plan | | TOTAL |
|---|---|---|---|---|---|---|---|
| **Item** | **Categorically Eligible Low-Income Adults (AFDC-A)** | **Expansion Adults** | **Eligible Children (AFDC-C/BC)** | **Baby Care Program-Adults** | **Children** | **Prenatal** | **All Clients** |
| **FY 08-09 Impact** | | | | | | | |
| Caseload Increase (Percent) | 0.00% | 0.00% | 2.00% | 0.00% | 2.00% | 0.00% | |
| Caseload Increase (Total) | - | - | 3,934 | - | 1,410 | - | **5,344** |
| Medical Premiums Cost | $0 | $0 | $6,946,539 | $0 | $2,271,581 | $0 | **$9,218,120** |
| Mental Health Cost | $0 | $0 | $723,095 | $0 | $0 | $0 | **$723,095** |
| Dental Cost | $0 | $0 | $0 | $0 | $227,546 | $0 | **$227,546** |
| **FY 09-10 Impact** | | | | | | | |
| Caseload Increase (Percent) | 2.00% | 2.00% | 2.00% | 2.00% | 2.00% | 2.00% | |
| Caseload Increase (Incremental) | 880 | 210 | 4,014 | 116 | 1,506 | 32 | **6,758** |
| Caseload Increase (Cumulative) | 880 | 210 | 7,948 | 116 | 2,916 | 32 | **12,102** |
| Medical Premiums Cost | $4,001,158 | $363,038 | $14,551,755 | $1,196,991 | $4,787,081 | $434,096 | **$25,334,119** |
| Mental Health Cost | $205,525 | $49,046 | $1,518,156 | $24,656 | $0 | $0 | **$1,797,383** |
| Dental Cost | $0 | $0 | $0 | $0 | $498,432 | $0 | **$498,432** |
| **FY 10-11 Impact** | | | | | | | |
| Caseload Increase (Percent) | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | |
| Caseload Increase (Incremental) | - | - | - | - | - | - | - |
| Caseload Increase (Cumulative) | 880 | 210 | 7,948 | 116 | 2,916 | 32 | **12,102** |
| Medical Premiums Cost | $4,217,312 | $382,652 | $15,088,245 | $1,222,937 | $4,878,031 | $462,833 | **$26,252,010** |
| Mental Health Cost | $213,576 | $50,967 | $1,577,678 | $25,613 | $0 | $0 | **$1,867,834** |
| Dental Cost | $0 | $0 | $0 | $0 | $527,942 | $0 | **$527,942** |

* Per Capita totals do not include additional payments for medical homes or expanded CBHP mental health benefits. The caseload impacts in those portions of this Request reflect the revised caseload estimated from centralizing eligibility, and include additional Eligible Children from the Department's Decision Item 3A from November 1, 2007.

## Appendix E: Calculations for Eligible but not Enrolled Improvements

**Table E.2**
**Fund Splits for Increased Caseload**

| FY 08-09 | Total Funds | General Fund | Health Care Expansion Fund | Federal Funds |
|---|---|---|---|---|
| Medical Services Premiums | $6,946,539 | $3,473,270 | $0 | $3,473,269 |
| Medicaid Mental Health Community Programs | $723,095 | $361,548 | $0 | $361,547 |
| Children's Basic Health Plan Premiums Costs | $2,271,581 | $0 | $795,054 | $1,476,527 |
| Children's Basic Health Plan Dental Benefit Costs | $227,546 | $0 | $79,642 | $147,904 |
| **Total** | **$10,168,761** | **$3,834,818** | **$874,696** | **$5,459,247** |
| **FY 09-10** | **Total Funds** | **General Fund** | **Health Care Expansion Fund** | **Federal Funds** |
| Medical Services Premiums | $20,112,942 | $9,965,712 | $181,519 | $9,965,711 |
| Medicaid Mental Health Community Programs | $1,797,383 | $886,430 | $24,523 | $886,430 |
| Children's Basic Health Plan Premiums Costs | $5,221,177 | $0 | $1,827,412 | $3,393,765 |
| Children's Basic Health Plan Dental Benefit Costs | $498,432 | $0 | $174,452 | $323,980 |
| **Total** | **$27,629,934** | **$10,852,142** | **$2,207,906** | **$14,569,886** |
| | | | | |
| **FY 10-11** | **Total Funds** | **General Fund** | **Health Care Expansion Fund** | **Federal Funds** |
| Medical Services Premiums | $20,911,146 | $10,359,910 | $191,326 | $10,359,910 |
| Medicaid Mental Health Community Programs | $1,867,834 | $921,176 | $25,483 | $921,175 |
| Children's Basic Health Plan Premiums Costs | $5,340,864 | $0 | $1,869,303 | $3,471,561 |
| Children's Basic Health Plan Dental Benefit Costs | $527,942 | $0 | $184,780 | $343,162 |
| **Total** | **$28,647,786** | **$11,281,086** | **$2,270,892** | **$15,095,808** |

**Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL**

**Table F.1.1**
**Children's Basic Health Plan Children to 225% FPL**

| | | | |
|---|---|---|---|
| 1 | 2007 Estimated Uninsured | 5,649 | Source: The Lewin Group, based on Current Population Survey data that has been adjusted for a Medicaid undercount. Includes all citizens and 5% of legal non-residents. The Department assumes that the uninsured are evenly distributed between 200% and 250% FPL, so 40% of this group lies in 206-225% FPL. These estimates are shown in Table F.4.1. |
| 2 | 2007 Estimated Crowd-out | 3,520 | Crowd-out represents the number of individuals currently in private insurance that would opt to switch their health care due to expansion in the public sector. These crowd-out estimates assume voluntary health coverage and incorporate assumptions regarding ultimate take-up rates, and are based on a 6 month crowd-out provision Source: The Lewin Group. Includes all citizens and 5% of legal non-residents. The Department assumes that the uninsured are evenly distributed between 200% and 250% FPL, so 40% of this group lies in 206-225% FPL. These estimates are shown in Table F.4.1. |

| | | FY 08-09 | FY 09-10 | FY 10-11 | FY 11-12 | Description |
|---|---|---|---|---|---|---|
| 3 | Population Growth Rate | 1.69% | 1.58% | 1.71% | 1.82% | Source: Department of Local Affairs, Demography Division. Growth for population through age 18. See Table F.4.2. |
| 4 | Estimated Uninsured | 5,744 | 5,835 | 5,935 | 6,043 | Prior year's estimated uninsured increased by the population growth |
| 5 | Ultimate Enrollment Percent | 90% | 90% | 90% | 90% | The Department assumes that of the estimated uninsured, approximately 90% of children would ultimately enroll in the program. |
| 6 | Estimated Newly Covered | 5,170 | 5,252 | 5,342 | 5,439 | Row 4 * Row 5 |
| 7 | Estimated Crowd-out | 3,579 | 3,636 | 3,698 | 3,765 | Prior year's estimated uninsured increased by the population growth |
| 8 | Estimated Total Eligible Population | 8,749 | 8,888 | 9,040 | 9,204 | Row 6 + Row 7 |
| 9 | Phase-in Rate | 35% | 75% | 100% | 100% | Phase-in rate represents the rate that the Department expects eligible individuals to enroll. |
| 10 | **Estimated Caseload Impact** | **3,062** | **6,666** | **9,040** | **9,204** | Row 8 * Row 9 |
| 11 | Medical Per Capita | $1,710.64 | $1,778.75 | $1,849.49 | $1,919.84 | The Department assumes that the cost for clients will be equal to that for current children in the Children's Basic Health Plan. See Table F.3.1. Totals include both the Medical Home initiative and the Mental |
| 12 | **Estimated Total Benefit Costs** | **$5,237,972** | **$11,857,131** | **$16,719,368** | **$17,670,185** | Row 10 * Row 11 |
| 13 | Estimated Client Enrollment Fees | $53,064 | $115,522 | $156,663 | $159,505 | Based on analysis of children enrolled in December 2007, the Department estimates that there are approximately 1.75 children per family required to pay enrollment fees, for an average collection of $17.33 per child. The Department assumes this will remain constant for the expansion population. |
| 14 | Estimated State Cost (General Fund) | $1,814,718 | $4,109,563 | $5,796,947 | $6,128,738 | Row 12 - Row 13 - Row 15. |
| 15 | Estimated Federal Funds | $3,370,190 | $7,632,046 | $10,765,758 | $11,381,942 | (Row 12 - Row 13) * 65%. Collected annual enrollment fees are not eligible for a federal match. |
| 16 | Dental Per Capita | $161.38 | $170.93 | $181.05 | $191.77 | The Department assumes that the cost for the expansion clients will be equal to that for current children in the Children's Basic Health Plan. See Table F.5.1. |
| 17 | **Estimated Total Benefit Costs** | **$494,146** | **$1,139,419** | **$1,636,692** | **$1,765,051** | Row 10 * Row 16 |
| 18 | Estimated State Cost (General Fund) | $172,952 | $398,797 | $572,843 | $617,768 | Row 17 * 35% |
| 19 | Estimated Federal Funds | $321,194 | $740,622 | $1,063,849 | $1,147,283 | Row 17 * 65% |

**Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL**

**Table F.1.2**
**Children's Basic Health Plan Prenatal Program to 225% FPL**

| | | | |
|---|---|---|---|
| 1 | 2007 Uninsured | 329 | Source: The Lewin Group, based on Current Population Survey data that has been adjusted for a Medicaid undercount. Includes all citizens and 5% of legal non-residents. The Department assumes that the uninsured are evenly distributed between 200% and 250% FPL, so 40% of this group lies in 206-225% FPL. These FY 07-08 estimates, shown in Table F.4.1. |
| 2 | 2007 Estimated Crowd-out | 524 | Crowd-out represents the number of individuals currently in private insurance that would opt to switch their health care due to expansion in the public sector. These crowd-out estimates assume voluntary health coverage and incorporate assumptions regarding ultimate take-up rates, and are based on a 6 month crowd-out provision Source: The Lewin Group. Includes all citizens and 5% of legal non-residents. The Department assumes that the uninsured are evenly distributed between 200% and 250% FPL, so 40% of this group lies in 206-225% FPL. These FY 07-08 estimates, shown in Table F.4.1. |

| | | FY 08-09 | FY 09-10 | FY 10-11 | FY 11-12 | Description |
|---|---|---|---|---|---|---|
| 3 | Population Growth Rate | 1.63% | 1.36% | 1.39% | 1.31% | Source: Department of Local Affairs, Demography Division. Growth for population through age 18. See Table F.4.2. |
| 4 | Estimated Uninsured | 334 | 339 | 344 | 349 | Prior year's estimated uninsured increased by the population growth |
| 5 | Ultimate Enrollment Percent | 90% | 90% | 90% | 90% | The Department assumes that of the estimated uninsured, approximately 90% of pregnant women would ultimately enroll in the |
| 6 | Estimated Newly Covered | 301 | 305 | 310 | 314 | Row 4 * Row 5 |
| 7 | Estimated Crowd-out | 533 | 540 | 548 | 555 | Prior year's estimated uninsured increased by the population growth |
| 8 | Estimated Total Eligible Population | 834 | 845 | 858 | 869 | Row 6 + Row 7 |
| 9 | Phase-in Rate | 0% | 40% | 80% | 100% | Phase-in rate represents the rate that the Department expects eligible individuals to enroll. This assumes that the re-approval of necessary HIFA waiver will take at least one year. |
| 10 | **Estimated Caseload Impact** | **-** | **338** | **686** | **869** | Row 8 * Row 9 |
| 11 | Medical Per Capita | $12,723.22 | $13,565.50 | $14,463.54 | $15,421.03 | The Department assumes that the cost for the expansion clients will be equal to that for current prenatal women in the Children's Basic Health Plan. See Table F.5.1. |
| 12 | **Estimated Total Benefit Costs** | **$0** | **$4,585,139** | **$9,921,988** | **$13,400,875** | Row 10 * Row 11 |
| 13 | **Estimated State Cost (General Fund)** | **$0** | **$1,604,799** | **$3,472,696** | **$4,690,306** | Row 12 * 35% |
| 14 | Estimated Federal Funds | $0 | $2,980,340 | $6,449,292 | $8,710,569 | Row 12 * 65% |

**Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL**

**Table F.2.1**
**Administrative Costs**

| | | FY 07-08 | FY 08-09 |
|---|---|---|---|
| 1 | Estimated Total Actuarial Cost | $1,000 | $1,000 |
| 2 | Estimated State Funds | $350 | $350 |
| 3 | Estimated Federal Funds | $650 | $650 |

**Table F.2.2**
**System Costs**

| | | FY 07-08 | FY 08-09 | |
|---|---|---|---|---|
| 1 | CBMS Modifications | $18,000 | $18,000 | Modifications include updating decision tables and the managed care extract file which relays enrollment information to the Medicaid Management Information System. Estimated 120 contractor hours at $150 per hour in each year. |
| 5 | MMIS Modifications | $183,960 | $45,990 | Modifications include updating managed care extract file transferred from CBMS to allow capitations to be paid for the expansion population; adding a new income rating code, category of service, sub-category of service, and general ledger codes, and; updating the Managed Care R4300 report. Estimated 1,460 contractor hours at $126 per hour. The required modifications to expand the prenatal program will be nearly completed in FY 07-08 when the modifications are being made to expand the children. However, an additional 25% of the original time will be required in FY 08-09 to activate the changes and perform testing. |

**Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL**

**Table F.3.1**
**CBHP Expansion Fund Splits - Premiums Costs**

| Fiscal Year | Source | Total Funds | General Fund | Enrollment Fees | Federal Funds |
|---|---|---|---|---|---|
| **FY 08-09** | Children - Medical | $5,237,972 | $1,814,718 | $53,064 | $3,370,190 |
| | Children - Dental | $494,146 | $172,952 | $0 | $321,194 |
| | Prenatal | $0 | $0 | $0 | $0 |
| | **Total** | **$5,732,118** | **$1,987,670** | **$53,064** | **$3,691,384** |
| **FY 09-10** | Children - Medical | $11,857,131 | $4,109,563 | $115,522 | $7,632,046 |
| | Children - Dental | $1,139,419 | $398,797 | $0 | $740,622 |
| | Prenatal | $4,585,139 | $1,604,799 | $0 | $2,980,340 |
| | **Total** | **$17,581,689** | **$6,113,159** | **$115,522** | **$11,353,008** |
| **FY 10-11** | Children - Medical | $16,719,368 | $5,796,947 | $156,663 | $10,765,758 |
| | Children - Dental | $1,636,692 | $572,843 | $0 | $1,063,849 |
| | Prenatal | $9,921,988 | $3,472,696 | $0 | $6,449,292 |
| | **Total** | **$28,278,048** | **$9,842,486** | **$156,663** | **$18,278,899** |

* This table does not list the required appropriation to the CBHP Trust Fund. Required appropriations to the CBHP Trust are shown in Appendix A.

**Table F.3.2**
**CBHP Expansion Fund Splits - Appropriations by Line Item**

| Fiscal Year | Source | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|---|
| **FY 08-09** | CBHP Trust | $2,041,084 | $1,988,020 | $53,064 | $0 | $0 |
| | Administration | $1,000 | $0 | $0 | $350 | $650 |
| | Premiums | $5,237,972 | $0 | $0 | $1,867,782 | $3,370,190 |
| | Dental | $494,146 | $0 | $0 | $172,952 | $321,194 |
| | **Total** | **$7,774,202** | **$1,988,020** | **$53,064** | **$2,041,084** | **$3,692,034** |
| **FY 09-10** | CBHP Trust | $6,228,681 | $6,113,159 | $115,522 | $0 | $0 |
| | Premiums | $16,442,270 | $0 | $0 | $5,829,884 | $10,612,386 |
| | Dental | $1,139,419 | $0 | $0 | $398,797 | $740,622 |
| | **Total** | **$23,810,370** | **$6,113,159** | **$115,522** | **$6,228,681** | **$11,353,008** |
| **FY 10-11** | CBHP Trust | $9,999,149 | $9,842,486 | $156,663 | $0 | $0 |
| | Premiums | $26,641,356 | $0 | $0 | $9,426,306 | $17,215,050 |
| | Dental | $1,636,692 | $0 | $0 | $572,843 | $1,063,849 |
| | Total | **$38,277,197** | **$9,842,486** | **$156,663** | **$9,999,149** | **$18,278,899** |

**Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL**

**Table F.3.3**
**CBHP Expansion Fund Splits - Systems Costs**

| Fiscal Year | Source | Total Funds | General Fund | Cash Funds | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|---|
| FY 07-08 | MMIS | $183,960 | $45,990 | $0 | $0 | $137,970 |
| | CBMS - HCPF | $6,248 | $2,927 | $374 | $0 | $2,947 |
| | CBMS - DHS | $18,000 | $2,826 | $1,445 | $6,248 | $7,481 |
| | **Total** | **$208,208** | **$51,743** | **$1,819** | **$6,248** | **$148,398** |
| **Fiscal Year** | **Source** | **Total Funds** | **General Fund** | **Cash Funds** | **Cash Funds Exempt** | **Federal Funds** |
| FY 08-09 | MMIS | $45,990 | $11,497 | $0 | $0 | $34,493 |
| | CBMS - HCPF | $6,248 | $2,927 | $374 | $0 | $2,947 |
| | CBMS - DHS | $18,000 | $2,826 | $1,445 | $6,248 | $7,481 |
| | **Total** | **$70,238** | **$17,250** | **$1,819** | **$6,248** | **$44,921** |

# Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL

**Table F.4.1: FY 07-08 Uninsured and Crowd-out Estimates**

| | Children to Age 5 | | Children Age 6 to 19 | | Parents | | Pregnant Women | | Childless Adults | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Income Level** | Uninsured | Crowd-out | Uninsured | Crowd-out | Uninsured | Crowd-out | Uninsured | Crowd-out | Uninsured | Crowd-out |
| 0-100% FPL | 4,966 | 2,492 | 29,516 | 23,691 | 56,293 | 3,483 | 2,005 | 353 | 66,792 | 26,368 |
| 100-133% FPL | 1,727 | 280 | 11,781 | 4,916 | 22,123 | 1,888 | 237 | 126 | 20,132 | 8,634 |
| 133-150% FPL | 1,042 | 392 | 5,111 | 764 | 11,503 | 1,574 | 338 | 948 | 9,469 | 7,511 |
| 150-185% FPL | 4,787 | 826 | 13,149 | 3,621 | 25,760 | 3,971 | 1,043 | 76 | 32,462 | 5,881 |
| 185-200% FPL | 2,659 | 2,418 | 4,042 | 3,569 | 8,556 | 5,474 | 332 | 0 | 12,221 | 4,743 |
| 200-250% FPL | 5,725 | 5,351 | 8,398 | 3,449 | 19,533 | 3,720 | 823 | 1,309 | 35,878 | 8,594 |
| 250-300% FPL | 3,563 | 1,378 | 8,511 | 5,313 | 13,474 | 4,111 | 208 | 701 | 16,959 | 17,729 |
| 300-350% FPL | 8,979 | 0 | 6,392 | 28 | 11,048 | 488 | 336 | 0 | 28,555 | 2,017 |
| 350-400% FPL | 3,929 | 0 | 3,975 | 760 | 4,343 | 618 | 171 | 0 | 17,730 | 742 |
| >400% FPL | 15,942 | 0 | 15,222 | 872 | 24,636 | 2,326 | 2,251 | 38 | 59,649 | 11,270 |
| Total | 53,319 | 13,137 | 106,097 | 46,983 | 197,269 | 27,653 | 7,744 | 3,551 | 299,847 | 93,489 |

1. Source: The Lewin Group. For all uninsured and crowd-out estimates, the Department assumes that all individuals that are citizens and Legal Immigrants in the US 5 years or longer, and 5% of the Legal Immigrants in the US less than 5 years, would be eligible for Medicaid. The Department uses these estimates to calculate all caseloads.

2. Crowd-out represents the number of individuals currently in private insurance that would opt to switch their health care due to expansion in the public sector. These crowd-out estimates assume voluntary health coverage and incorporate assumptions regarding ultimate take-up rates, and are based on a 6 month crowd-out provision

**Table F.4.2: Population Growth Rates**

| | FY 08-09 | FY 09-10 | FY 10-11 | FY 11-12 |
|---|---|---|---|---|
| Total Population- Children | 1.69% | 1.58% | 1.71% | 1.82% |
| Total Population- Adults 19-59 | 1.63% | 1.36% | 1.39% | 1.31% |
| Total Population- Adults 19-90+ | 2.24% | 2.09% | 2.04% | 2.00% |
| Total Population | 2.10% | 1.96% | 1.98% | 2.01% |
| Source: Department of Local Affairs, Demography Division. | | | | |

**Appendix F: Expansion of the Children's Basic Health Plan to 225% FPL**

**Table F.5.1**
**CBHP Premiums Per Capitas**

| | FY 07-08 Projection | FY 08-09 Projection | FY 09-10 Projection | FY 10-11 Projection | FY 11-12 Projection |
|---|---|---|---|---|---|
| Children's Basic Health Plan Children Base Per Capita | $1,581.01 | $1,626.07 | $1,691.11 | $1,758.75 | $1,829.10 |
| *Medical Home Add-On* | $0.00 | $6.88 | $6.88 | $6.88 | $6.88 |
| *Mental Health Add-On* | $0.00 | $77.69 | $80.76 | $83.86 | $83.86 |
| **Children's Basic Health Plan Children Total Per Capita** | **$1,581.01** | **$1,710.64** | **$1,778.75** | **$1,849.49** | **$1,919.84** |
| | | | | | |
| **Children's Basic Health Plan Dental** | **$152.36** | **$161.38** | **$170.93** | **$181.05** | **$191.77** |
| **Children's Basic Health Plan Prenatal** | **$11,933.24** | **$12,723.22** | **$13,565.50** | **$14,463.54** | **$15,421.03** |

**Sources:**

Base Per Capitas: February 15, 2008 Budget Request, Exhibit C.10

Medical Home Add-On: Appendix D

Mental Health Add-On: Appendix G

**Appendix G: Calculations for Children's Basic Health Plan Mental Health Benefit**

**Table G.1**
**Calculation of Costs for CBHP Expanded Mental Health Benefits**

| | | FY 08-09 | FY 09-10 | FY 10-11 | |
|---|---|---|---|---|---|
| 1 | FY 08-09 CBHP Blended Children's Monthly Capitation Rate | $123.04 | | | The Department's November 1, 2007 Budget Request, Exhibit C.5. |
| 2 | Estimated Blended Monthly Mental Health Costs | $5.34 | | | From the Department's contracted actuary. This represents the estimated monthly cost of mental health benefits provided under the current CBHP benefits |
| 3 | Estimated Percent of CBHP Per Capita for Mental Health Costs | 4.34% | | | Row 2 / Row 1 |
| | | | | | |
| | | **FY 08-09** | **FY 09-10** | **FY 10-11** | |
| 4 | Estimated CBHP Per Medical Per Capita | $1,626.07 | $1,691.11 | $1,758.75 | February 15, 2008 Budget Request, Exhibit C.10 |
| 5 | Estimated Percent of CBHP Per Capita for Mental Health Costs | 4.34% | 4.34% | 4.34% | Row 3 |
| 6 | Estimated CBHP Mental Health Per Capita | $70.57 | $73.39 | $76.33 | Row 4 * Row 5 |
| 7 | Estimated Medicaid Mental Health Per Capita for Eligible Children | $185.33 | $192.69 | $200.24 | February 15, 2008 Budget Request, Exhibit EE. |
| 8 | Adjustment for Assumed Utilization | 80% | 80% | 80% | The Department assumes that utilization of expanded mental health benefits will be lower for CBHP clients because they are receiving services through either the State's self-funded network or their HMO, and not through the Medicaid Behavioral Health Organization network. |
| 9 | Estimated CBHP Mental Health Per Capita with Expanded Benefits | $148.26 | $154.15 | $160.19 | Row 7 * Row 8 |
| 10 | **Estimated Incremental Cost for Expanded Benefits** | **$77.69** | **$80.76** | **$83.86** | Row 9 - Row 6 |
| 11 | Estimated CBHP Caseload | 74,953 | 83,481 | 87,657 | The Department's November 1, 2007 Budget Request, Exhibit C.10. Includes adjustments for CBHP Outreach (Decision Item 3A), and all aspects of this Request. |
| 12 | **Estimated Total Cost of Expanded Mental Health Benefits** | **$5,823,099** | **$6,741,926** | **$7,350,916** | Row 10 * Row 11 |
| 13 | Estimated State Funds | $2,038,085 | $2,359,675 | $2,572,821 | Row 12 * 35% |
| 14 | Estimated Federal Funds | $3,785,014 | $4,382,251 | $4,778,095 | Row 12 * 65% |
| | | | | | |
| 15 | Estimated State Funds | $2,038,085 | $2,359,675 | $2,572,821 | Row 13. |
| 16 | **Estimated General Fund** | **$1,136,224** | **$1,181,123** | **$1,226,461** | This is the State share of the cost for the first 41,786 CBHP children, which are funded through the Children's Basic Health Plan Trust Fund.<br>Row 10 * 41,786 * 35% |
| 17 | Estimated Health Care Expansion Fund | $901,861 | $1,178,552 | $1,346,360 | This is the State share of the cost for the remaining Children's Basic Health Plan children, which are funded through the Health Care Expansion Fund.<br>Row 15 - Row 16 |

## Appendix H: Offsets to Existing Department FY 08-09 Budget Requests

### Table H.1
### Offsets to Previous FY 08-09 Budget Requests

| Request | Date | Description | Total Funds | General Fund | Cash Funds Exempt | Federal Funds |
|---|---|---|---|---|---|---|
| DI-6 | November 1, 2007 | Evaluation and Management Rates | $3,264,747 | $1,576,914 | $55,460 | $1,632,373 |
| DI-6 | November 1, 2007 | Dental Rates | $3,500,000 | $1,690,543 | $59,457 | $1,750,000 |
| DI-6 | November 1, 2007 | Medical Home Pilot Program | $222,255 | $107,352 | $3,776 | $111,127 |
| *DI-6* | *November 1, 2007* | *Subtotal DI-6* | *$6,987,002* | *$3,374,809* | *$118,693* | *$3,493,500* |
| S-13 | January 2, 2008 | Cash Flow for Integrated Care Plan "B" | $1,081,325 | $540,663 | $0 | $540,662 |
| Total Offsets | | Medical Services Premiums | $8,068,327 | $3,915,472 | $118,693 | $4,034,162 |

## Appendix I: FTE Calculations

**Table I.1**
**FTE and Operating Expenses**

| | | | | *GRAND TOTAL* | |
|---|---|---|---|---|---|
| **Fiscal Year(s) of Request** | | **FY 08-09** | **FY 09-10** | **FY 08-09** | **FY 09-10** |
| ***PERSONAL SERVICES*** | **Title:** | **Budget and Policy Analyst III** | | | |
| Number of PERSONS / class title | | 1 | 1 | | |
| Number of months working in FY 08-09 and FY 09-10 | | 12 | 12 | - | - |
| Number months paid in FY 08-09 and FY 09-10* | | 11 | 12 | - | - |
| Calculated FTE per classification | | **0.9** | **1.0** | 0.92 | 1.00 |
| Annual base salary | | $61,092 | $61,092 | - | - |
| Salary | | $56,001 | $61,092 | $56,001 | $61,092 |
| PERA | **10.15%** | $5,684 | $6,201 | $5,684 | $6,201 |
| AED | **1.60%** | $896 | $977 | $896 | $977 |
| SAED | **0.50%** | $280 | $305 | $280 | $305 |
| FICA | **1.45%** | $812 | $886 | $812 | $886 |
| **Subtotal Personal Services** | | **$63,673** | **$69,461** | **$63,673** | **$69,461** |
| ***OPERATING EXPENSES*** | | | | | |
| Supplies @ $500/$500** | **$500** | $500 | $500 | $500 | $500 |
| Computer @ $900/$0 | **$900** | $900 | $0 | $900 | $0 |
| Office Suite Software @ $330/$0 | **$330** | $330 | $0 | $330 | $0 |
| Office Equipment @ $2,225 /$0 | **$2,225** | $2,225 | $0 | $2,225 | $0 |
| Telephone Base @ $450/$450** | **$450** | $450 | $450 | $450 | $450 |
| **Subtotal Operating Expenses** | | **$4,405** | **$950** | **$4,405** | **$950** |
| | | | | | |
| ***GRAND TOTAL ALL COSTS*** | | **$68,078** | **$70,411** | **$68,078** | **$70,411** |

Acronyms: PERA: Public Employees' Retirement Association contribution; AED: Amortization Equalization Disbursement; SAED: Supplemental Amortization Equalization Disbursement; FICA: Federal Insurance Contributions Act tax

*Initial year full salary is 11 months to account for Pay Date Shift.

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