Updated Schedule 10
Summary of FY 08-09 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 2, 2008

Total Impact of FY 08-09 Change Requests				$190,165,322	7.30	$92,378,478	$61,226	($17,195,050)	$114,920,668
Schedule 10 Priority	**November 1 Priority**	**Title**	**IT Request?**	**Total Request (FY 08-09)**	**FTE**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 08-09 Decision Items									
1	DI - 1	Request for FY 08-09 Medical Services Premiums	No	$113,786,826	0.00	$60,266,483	($38,256)	($2,888,520)	$56,447,119
2	DI - 2	Request for FY 08-09 Medicaid Community Mental Health Programs	No	($22,530,475)	0.00	$4,140,689	$0	($31,568,588)	$4,897,424
3	DI - 3	Children's Basic Health Plan Medical Premium and Dental Benefit Costs	No	$33,995,928	0.00	$2,382,423	$59,962	$11,083,854	$20,469,689
3A	DI - 3A	Additional Children's Basic Health Plan Outreach	No	$23,933,495	0.00	$4,415,375	$39,520	$5,526,162	$13,952,438
4	DI - 4	Increase Funding for State Contribution Payment	No	$2,854,636	0.00	$2,854,636	$0	$0	$0
5	DI - 5	MMIS Fixed Price Increase	No	$313,010	0.00	$75,905	$0	$3,287	$233,818
6	DI - 6	Provider Rate Increases	No	$17,091,875	0.00	$8,264,081	$0	$281,858	$8,545,936
7	DI - 7	Additional FTE to Restore Department Efficiency and Functionality	No	$488,048	7.30	$269,735	$0	($51,420)	$269,733
8	DI - 8	Training for Department Staff	No	$100,000	0.00	$50,000	$0	$0	$50,000
9	DI - 9	Information Technology Replacement Plan	No	$94,337	0.00	$47,169	$0	$0	$47,168
10	DI - 10	Funding for Additional Leased Space	No	$286,534	0.00	$143,267	$0	$0	$143,267
11	DI - 11	Restore Enrollment Broker Contract Funding	No	$159,570	0.00	$79,785	$0	$0	$79,785
12	DI - 12	Increase Health Maintenance Organization Rates to 100% of Fee-for-Service	No	$4,372,996	0.00	$2,186,498	$0	$0	$2,186,498
13	DI - 13	Web Portal Contract Adjustments and Enhancements	No	$117,833	0.00	$29,458	$0	$0	$88,375
14	DI - 14	Move Non-Emergency Transportation Services to Medical Services Premiums	No	$0	0.00	$0	$0	$0	$0
15	DI - 15	Accuracy in Budgeting - Administrative Case Management	No	$1,300,000	0.00	$650,000	$0	$0	$650,000
FY 08-09 Decision Item Subtotal				**$176,364,613**	**7.30**	**$85,855,504**	**$61,226**	**($17,613,367)**	**$108,061,250**
FY 08-09 Base Reduction Items									
1	BRI - 1	Revised Tobacco Tax Funding for CBMS	No	$0	0.00	($417,996)	$0	$417,996	$0
2	BRI - 2	Implement Preferred Drug List	No	($793,091)	0.00	($320,510)	$0	$0	($472,581)
FY 08-09 Base Reduction Item Subtotal				**($793,091)**	**0.00**	**($738,506)**	**$0**	**$417,996**	**($472,581)**

Updated Schedule 10
Summary of FY 08-09 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 2, 2008

Total Impact of FY 08-09 Change Requests				$190,165,322	7.30	$92,378,478	$61,226	($17,195,050)	$114,920,668
Schedule 10 Priority	**November 1 Priority**	**Title**	**IT Request?**	**Total Request (FY 08-09)**	**FTE**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 08-09 Non-Prioritized Items									
1	NP - 1	DHS - Population Impact on Contract Placement	No	$41,208	0.00	$20,604	$0	$0	$20,604
2	NP - 2	Commission on Family Medicine - Leveraging Federal Matching Funds	No	$270,000	0.00	$135,000	$0	$0	$135,000
3	NP - 3	DHS - Human Resources Staff	No	$32,915	0.00	$16,458	$0	$0	$16,457
4	NP - 4	DHS - Regional Center ICF - MR Conversion and Year 2 of Staffing Study	No	$2,201,627	0.00	$1,065,711	$0	$0	$1,135,916
5	NP - 5	DHS - IT Infrastructure Support	No	$6,552	0.00	$3,276	$0	$0	$3,276
6	NP - 6	DHS - Adjustment to Statewide Multiuse Network Payments	No	$12,377	0.00	$6,189	$0	$0	$6,188
7	NP - 7	DHS - Statewide C-SEAP Program Staffing	No	$27,178	0.00	$13,589	$0	$0	$13,589
8	NP - 8	DHS - Adjustment to Statewide Vehicle Lease Payments	No	($35,715)	0.00	($17,857)	$0	$0	($17,858)
9	NP - 9	DHS - Provider Rate Increase	No	$4,696,011	0.00	$2,347,686	$0	$321	$2,348,004
10	NP - 10	DHS - Division for Developmental Disabilities New Resources Request	No	$7,341,299	0.00	$3,670,650	$0	$0	$3,670,649
11	NP - 11	DPA - Statewide C-SEAP Program Staffing	No	$348	0.00	$174	$0	$0	$174
FY 08-09 Non-Prioritized Items Subtotal				**$14,593,800**	**0.00**	**$7,261,480**	**$0**	**$321**	**$7,331,999**
GRAND TOTAL FY 08-09				**$190,165,322**	**7.30**	**$92,378,478**	**$61,226**	**($17,195,050)**	**$114,920,668**

Schedule 11
Summary of Supplemental Requests for FY 07-08

Department Name: Health Care Policy and Financing
Submission Date: January 2, 2008
Number of Prioritized Supplemental Requests: 17

Priority #	Page #	Tab #	Title	IT Request	Total Request (FY 07-08)	FTE	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
FY 07-08 Prioritized Supplemental Requests										
S-1	S.1-1	1	Request for FY 08-09 Medical Services Premiums	No	$9,724,208	0.00	$12,296,825	($38,256)	($6,627,187)	$4,092,826
S-2	S.2-1	2	Request for FY 08-09 Medicaid Community Mental Health Programs	No	($32,251,956)	0.00	($353,258)	$0	($31,934,530)	$35,832
S-3	S.3-1	3	Children's Basic Health Plan Medical Premium and Dental Benefit Costs	No	$19,644,330	0.00	$0	$30,729	$6,885,695	$12,727,906
S-4	S.4-1	4	Adjust State Contribution Payment for Caseload and Rates	No	$2,942,893	0.00	$2,942,893	$0	$0	$0
S-5	S.5-1	5	Request for FY 06-07 Medicaid Programs Overexpenditure	No	$0	0.00	$0	$0	$0	$0
S-6	S.6-1	6	Health Care Policy and Financing Medical Director Consortium	No	$80,000	0.00	$10,000	$0	$0	$70,000
S-7	S.7-1	7	Funding for Additional Leased Space	No	$146,484	0.00	$73,242	$0	$0	$73,242
S-8	S.8-1	8	Additional Financing for the Implementation of SB 07-211	No	$17,879	0.00	$0	$0	$0	$17,879
S-9	S.9-1	9	Implement Preferred Drug List	No	$422,556	0.00	$287,314	$0	$0	$135,242
S-10	S.10-1	10	Increased Funding for Non-Emergency Transportation Services	No	$144,963	0.00	$72,482	$0	$0	$72,481
S-11	S.11-1	11	Restore Enrollment Broker Contract Funding	No	$159,570	0.00	$79,785	$0	$0	$79,785
S-12	S.12-1	12	Increase Health Maintenance Organization Rates to 99% of Fee-for-Service	No	$3,372,648	0.00	$1,686,324	$0	$0	$1,686,324
S-13	S.13-1	13	Adjust Cash Flow for Integrated Care Delivery Model	No	$2,392,954	0.00	$1,196,477	$0	$0	$1,196,477
S-14	S.14-1	14	Implement Mental Health Audit Findings	No	$125,000	0.00	$62,500	$0	$0	$62,500
S-15	S.15-1	15	General Fund Request for CMS Disallowances	No	$10,926,331	0.00	$10,926,331	$0	$0	$0
S-16	S.16-1	16	Federal Funds Appropriation for Health Care Services Fund Line Items	No	$16,225,421	0.00	$0	$0	$0	$16,225,421
S-17	S.17-1	17	Federal Funds Match for Local Government Provider Fees	No	$10,211,350	0.00	$0	$0	$5,105,675	$5,105,675
FY 07-08 Supplemental Request Subtotal					**$44,284,631**	**0.00**	**$29,280,915**	**($7,527)**	**($26,570,347)**	**$41,581,590**

Schedule 11
Summary of Supplemental Requests for FY 07-08

Department Name: Health Care Policy and Financing
Submission Date: January 2, 2008
Number of Prioritized Supplemental Requests: 17

Priority #	Page #	Tab #	Title	IT Request	Total Request (FY 07-08)	FTE	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
FY 07-08 Non-Prioritized Supplemental Requests										
NP-S1	S.18-1	18	DHS - Workers' Compensation Common Policy Adjustment	No	($352,827)	0.00	($176,414)	$0	$0	($176,413)
NP-S2	S.18-2	18	DHS - Division for Developmental Disabilities Medicaid Waiver Reform Transition Costs	No	$59,742	0.00	$29,871	$0	$0	$29,871
NP-S3	S.18-3	18	DHS - Risk Management and Property Funds Common Policy Adjustment	No	($33,303)	0.00	($16,652)	$0	$0	($16,651)
NP-S4	S.18-4	18	DHS - Colorado Benefits Management System (CBMS) Refinancing FY 2004-05	No	$359,018	0.00	$0	$0	$0	$359,018
NP-S5	S.18-5	18	DHS - Regional Center Operating Shortfall	No	$112,253	0.00	$56,127	$0	$0	$56,126
NP-S6	S.18-6	18	DHS - Regional Center Clinical Security System Program	No	$174,978	0.00	$87,489	$0	$0	$87,489
NP-S7	S.18-7	18	DHS - Funding Adjustments Related to Residential Child Health Care Program	No	($11,480,794)	0.00	($5,740,397)	$0	$0	($5,740,397)
NP-S8	S.18-8	18	DHS - Department Wide Technical Supplemental (Systemic Alien Verification for Eligibility - SAVE)	No	$3,019	0.00	$0	$0	$0	$3,019
NP-S9	S.18-9	18	DPA - Administrative Law Judge Common Policy Adjustment	No	$32,649	0.00	$16,325	$0	$0	$16,324
NP-S10	S.18-10	18	DPA - Capitol Complex Leased Space Common Policy Adjustments	No	$6,159	0.00	$3,080	$0	$0	$3,079
NP-S11	S.18-11	18	DPA - Payments to Risk Management and Property Funds Common Policy Adjustments	No	($27,990)	0.00	($13,995)	$0	$0	($13,995)
NP-S12	S.18-12	18	DPA - Purchase of Services from Computer Center Common Policy Adjustments	No	$96,945	0.00	$48,473	$0	$0	$48,472
NP-S13	S.18-13	18	DPA - Workers' Compensation Common Policy Adjustments	No	$1,306	0.00	$653	$0	$0	$653
NP-S14	S.18-14	18	DHS - Adjustment to Statewide Multiuse Network Payments	No	$8,290	0.00	$4,145	$0	$0	$4,145
NP-S15	S.18-15	18	DHS - GGCC Supplemental True-up	No	($435)	0.00	($218)	$0	$0	($217)
NP-S16	S.18-16	18	DHS - Adjustment to Statewide Vehicle Lease Payments	No	($18,009)	0.00	($9,005)	$0	$0	($9,004)
Non-Prioritized FY 07-08 Supplemental Requests Subtotal					**($11,058,999)**	**0.00**	**($5,710,518)**	**$0**	**$0**	**($5,348,481)**

Schedule 11
Summary of Supplemental Requests for FY 07-08

Department Name: Health Care Policy and Financing
Submission Date: January 2, 2008
Number of Prioritized Supplemental Requests: 17

Priority #	Page #	Tab #	Title	IT Request	Total Request (FY 07-08)	FTE	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
Emergency FY 07-08 Supplementals Already Submitted										
Sent to JBC Date				**JBC Decision**						
20-Jun-07			Office of Colorado Benefit Management System Staff	Approved	$1,454,759	12.00	($77,483)	$0	$1,609,582	($77,340)
Approved Emergency FY 07-08 Supplemental Requests Subtotal					**$1,454,759**	**12.00**	**($77,483)**	**$0**	**$1,609,582**	**($77,340)**
GRAND TOTAL FY 07-08 Supplemental Requests					**$34,680,391**	**12.00**	**$23,492,914**	**($7,527)**	**($24,960,765)**	**$36,155,769**

Schedule 12

Summary of FY 08-09 Budget Request Amendments

Department Name: Health Care Policy and Financing
Submission Date: January 2, 2008
Number of Prioritized Budget Amendments: 7

Priority#	Page #	Tab #	Title	IT Request	Total Request (FY 08-09)	FTE	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
Health Care Policy and Financing FY 08-09 Budget Request Amendments Associated with Supplementals										
BA-1	S.6-1	6	Health Care Policy and Financing Medical Director Consortium	No	$200,000	0.00	$40,000	$0	$0	$160,000
BA-2	S.7-1	7	Funding for Additional Leased Space	No	$6,634	0.00	$3,317	$0	$0	$3,317
BA-3	S.9-1	9	Implement Preferred Drug List	No	($50,579)	1.00	($90,043)	$0	$0	$39,464
BA-4	S.13-1	13	Adjust Cash Flow for Integrated Care Delivery Model	No	$1,404,939	0.00	$702,470	$0	$0	$702,469
BA-5	S.14-1	14	Implement Mental Health Audit Findings	No	$250,000	0.00	$125,000	$0	$0	$125,000
BA-10	S.16-1	16	Federal Funds Appropriation for Health Care Services Fund Line Items	No	$15,000,000	0.00	$0	$0	$0	$15,000,000
BA-11	S.17-1	17	Federal Funds Match for Local Government Provider Fees	No	$5,205,696	0.00	$0	$0	$2,602,848	$2,602,848
FY 08-09 HCPF Budget Request Amendments Associated with Supplementals Subtotal					**$22,016,690**	**1.00**	**$780,744**	**$0**	**$2,602,848**	**$18,633,098**
Health Care Policy and Financing FY 08-09 Non-Prioritized Budget Request Amendments Associated with Supplementals										
NP-BA1	S.18-2	18	DHS - Division for Developmental Disabilities Medicaid Waiver Reform Transition Costs	No	$79,028	0.00	$39,514	$0	$0	$39,514
NP-BA2	S.18-14	18	DHS - Adjustment to Statewide Multiuse Network Payments	No	($1,650)	0.00	($825)	$0	$0	($825)
NP-BA3	S.18-15	18	DHS - GGCC Supplemental True-up	No	$170	0.00	$85	$0	$0	$85
NP-BA4	S.18-7	18	DHS - Funding Adjustments Related to Residential Child Health Care Program	No	($11,480,794)	0.00	($5,740,397)	$0	$0	($5,740,397)
NP-BA5	S.18-8	18	DHS - Department Wide Technical Supplemental (Systemic Alien Verification for Eligibility - SAVE)	No	$3,194	0.00	$0	$0	$0	$3,194
NP-BA6	S.18-10	18	DPA - Capitol Complex Leased Space Common Policy Adjustments	No	$238	0.00	$119	$0	$0	$119
NP-BA7	S.18-11	18	DPA - Payments to Risk Management and Property Funds Common Policy Adjustments	No	$2,289	0.00	$1,144	$0	$0	$1,145
NP-BA8	S.18-12	18	DPA - Purchase of Services from Computer Center Common Policy Adjustments	No	$103,484	0.00	$47,020	$0	$0	$56,464
NP-BA9	S.18-13	18	DPA - Workers' Compensation Common Policy Adjustments	No	($779)	0.00	($390)	$0	$0	($389)
NP-BA10	S.18-1	18	DHS - Workers' Compensation Common Policy Adjustment	No	($60,632)	0.00	($30,316)	$0	$0	($30,316)
NP-BA11	S.18-3	18	DHS - Risk Management and Property Funds Common Policy Adjustment	No	$4,908	0.00	$2,454	$0	$0	$2,454
FY 08-09 HCPF Non-Prioritized Budget Request Amendments Associated with Supplementals Subtotal					**($11,350,544)**	**0.00**	**($5,681,592)**	**$0**	**$0**	**($5,668,952)**
GRAND TOTAL FY 08-09 Budget Request Amendments					**$10,666,146**	**1.00**	**($4,900,848)**	**$0**	**$2,602,848**	**$12,964,146**

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:	Request for FY 08-09 Medical Services Premiums			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-1	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	2,061,396,808	2,147,658,908	9,724,208	2,157,583,116	2,147,626,990	113,786,826	2,261,413,816	0	2,261,413,816	113,786,826
	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	12,296,825	664,718,325	651,512,742	60,266,483	711,779,225	0	711,779,225	60,266,483
	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	(38,256)	0	38,256	(38,256)	0	0	0	(38,256)
	CFE	48,860,206	76,001,368	(6,627,187)	69,374,181	76,794,167	(2,888,520)	73,905,647	0	73,905,647	(2,888,520)
	FF	1,036,058,888	1,075,497,784	4,092,826	1,079,590,610	1,075,381,825	56,447,119	1,131,828,944	0	1,131,828,944	56,447,119
(2) Medical Services Premiums	Total	2,061,396,808	2,147,658,908	9,724,208	2,157,583,116	2,147,626,990	113,786,826	2,261,413,816	0	2,261,413,816	113,786,826
	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	12,296,825	664,718,325	651,512,742	60,266,483	711,779,225	0	711,779,225	60,266,483
	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	(38,256)	0	38,256	(38,256)	0	0	0	(38,256)
	CFE	48,860,206	76,001,368	(6,627,187)	69,374,181	76,794,167	(2,888,520)	73,905,647	0	73,905,647	(2,888,520)
	FF	1,036,058,888	1,075,497,784	4,092,826	1,079,590,610	1,075,381,825	56,447,119	1,131,828,944	0	1,131,828,944	56,447,119

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

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:	Request for FY 08-09 Medicaid Community Mental Health Programs			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-2	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	220,303,164	230,114,249	(32,251,956)	197,862,293	231,955,670	(22,530,475)	209,425,195	0	209,425,195	(22,530,475)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	90,516,664	92,060,148	(353,258)	91,706,890	92,060,148	4,140,689	96,200,837	0	96,200,837	4,140,689
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	36,775,755	39,151,106	(31,934,530)	7,216,576	40,071,817	(31,568,588)	8,503,229	0	8,503,229	(31,568,588)
	FF	93,010,745	98,902,995	35,832	98,938,827	99,823,705	4,897,424	104,721,129	0	104,721,129	4,897,424
(3) Medicaid Mental Health Community Programs (A) Mental Health Capitation Payments	**Total**	184,640,568	196,303,651	242,857	196,546,508	198,145,072	9,957,083	208,102,155	0	208,102,155	9,957,083
	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	(266,649)	91,048,997	91,315,646	4,223,671	95,539,317	0	95,539,317	4,223,671
	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	387,065	7,216,576	7,750,222	753,007	8,503,229	0	8,503,229	753,007
	FF	92,326,812	98,158,494	122,441	98,280,935	99,079,204	4,980,405	104,059,609	0	104,059,609	4,980,405
(3) Medicaid Mental Health Community Programs (B) Other Medicaid Mental Health Payments (1) Medicaid Mental Health Fee for Service Payments	**Total**	1,367,867	1,489,003	(173,218)	1,315,785	1,489,003	(165,963)	1,323,040	0	1,323,040	(165,963)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	683,934	744,502	(86,609)	657,893	744,502	(82,982)	661,520	0	661,520	(82,982)
	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	683,933	744,501	(86,609)	657,892	744,501	(82,981)	661,520	0	661,520	(82,981)

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:	Request for FY 08-09 Medicaid Community Mental Health Programs										
Department:	Health Care Policy and Financing			**Dept. Approval by:**		John Bartholomew			**Date:**	January 2, 2008	
Priority Number:	S-2			**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
(3) Medicaid Mental Health Community Programs (B) Other Medicaid Mental Health Payments (3) Medicaid Anti-Psychotic Pharmaceuticals	**Total**	34,294,729	32,321,595	(32,321,595)	0	32,321,595	(32,321,595)	0	0	0	(32,321,595)
	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	34,294,729	32,321,595	(32,321,595)	0	32,321,595	(32,321,595)	0	0	0	(32,321,595)
	FF	0	0	0	0	0	0	0	0	0	0
Letternote revised text:											
Cash Fund name/number, Federal Fund Grant name:				CFE: Health Care Expansion Fund - Fund 18K				FF: Title XIX			
				CFE: Prevention, Early Detection, and Treatment Fund				FF: Title XIX			
IT Request: ☐ Yes ☑ No											
Request Affects Other Departments: ☐ Yes ☑ No				**If Yes, List Other Departments Here:**							

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:	Children's Basic Health Plan Medical Premium and Dental Benefit Costs			
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:** January 2, 2008	
Priority Number:	S-3	**OSPB Approval:**	**Date:** 12/26/07	

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	107,967,627	93,569,872	19,644,330	113,214,202	98,507,771	33,995,928	132,503,699	0	132,503,699	31,613,505
	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	0	11,011	22,762	2,382,423	2,405,185	0	2,405,185	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	232,136	246,943	30,729	277,672	248,694	59,962	308,656	0	308,656	59,962
	CFE	33,923,185	32,818,722	6,885,695	39,704,417	34,543,222	11,083,854	45,627,076	0	45,627,076	11,083,854
	FF	62,569,091	60,493,196	12,727,906	73,221,102	63,693,093	20,469,689	84,162,782	0	84,162,782	20,469,689
(4) Indigent Care Program HB 97-1304 Children's Basic Health Plan Trust	**Total**	11,475,351	256,475	32,208	288,683	271,456	2,442,385	2,713,841	0	2,713,841	59,962
	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	0	11,011	22,762	2,382,423	2,405,185	0	2,405,185	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	232,136	245,464	32,208	277,672	248,694	59,962	308,656	0	308,656	59,962
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(4) Indigent Care Program Children's Basic Health Plan Premium Costs	**Total**	89,657,433	86,426,598	17,928,518	104,355,116	91,098,718	28,607,957	119,706,675	0	119,706,675	28,607,957
	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	(1,479)	0	0	0	0	0	0	0
	CFE	31,530,990	30,408,342	6,296,434	36,704,776	32,045,063	10,052,899	42,097,962	0	42,097,962	10,052,899
	FF	58,126,443	56,016,777	11,633,563	67,650,340	59,053,655	18,555,058	77,608,713	0	77,608,713	18,555,058

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:	Children's Basic Health Plan Medical Premium and Dental Benefit Costs										
Department:	Health Care Policy and Financing			**Dept. Approval by:** John Bartholomew				**Date:** January 2, 2008			
Priority Number:	S-3			**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	**Total**	6,834,843	6,886,799	1,683,604	8,570,403	7,137,597	2,945,586	10,083,183	0	10,083,183	2,945,586
Plan Dental Benefit Costs	**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	589,261	2,999,641	2,498,159	1,030,955	3,529,114	0	3,529,114	1,030,955
	FF	4,442,648	4,476,419	1,094,343	5,570,762	4,639,438	1,914,631	6,554,069	0	6,554,069	1,914,631
Letternote revised text:											
Cash Fund name/number, Federal Fund Grant name:				CF: Annual enrollment fees of CBHP enrollees. CFE: Tobacco Master Settlement Funds, Fund 11G (CBHP Trust Fund), Fund 18K (Health Care Expansion Fund), Supplemental Tobacco Litigation Settlement Account in the CBHP Trust Fund, and Colorado Immunization Fund; FF: Title XXI							
IT Request: ☐ Yes ☑ No											
Request Affects Other Departments: ☐ Yes ☑ No				**If Yes, List Other Departments Here:**							

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:	Adjust State Contribution Payment for Caseload and Rates			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-4	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	72,494,301	69,546,453	2,942,893	72,489,346	76,719,821	0	76,719,821	0	76,719,821	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	72,494,301	69,546,453	2,942,893	72,489,346	76,719,821	0	76,719,821	0	76,719,821	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(5) Other Medical Services Medicare Modernization Act of 2003 State Contribution Payment	Total	72,494,301	69,546,453	2,942,893	72,489,346	76,719,821	0	76,719,821	0	76,719,821	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	72,494,301	69,546,453	2,942,893	72,489,346	76,719,821	0	76,719,821	0	76,719,821	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0

Letternote revised text:
Cash Fund name/number, Federal Fund Grant name:
IT Request: ☐ Yes ☑ No
Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

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

	Decision Item FY 08-09	Base Reduction Item FY 08-09	Supplemental FY 06-07 ✔	Budget Request Amendment FY 08-09
Request Title:	Request for FY 06-07 Medicaid Programs Overexpenditure			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-5	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 05-06	2 Appropriation FY 06-07	3 Supplemental Request FY 06-07	4 Total Revised Request FY 06-07	5 Base Request FY 07-08	6 Decision/ Base Reduction FY 07-08	7 November 1 Request FY 07-08	8 Budget Amendment FY 07-08	9 Total Revised Request FY 07-08	10 Change from Base (Column 5) FY 08-19
Total of All Line Items	Total	2,166,269,390	2,247,272,450	11,861,237	2,259,133,687	2,345,161,276	0	2,345,161,276	0	2,345,161,276	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	699,411,374	722,684,543	3,616,986	726,301,528	744,236,505	0	744,236,505	0	744,236,505	0
	GFE	361,644,803	343,100,000	0	343,100,000	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	23,860,773	55,913,012	0	55,913,012	82,830,879	0	82,830,879	0	82,830,879	0
	FF	1,081,352,440	1,125,536,549	8,244,251	1,133,780,800	1,174,155,636	0	1,174,155,636	0	1,174,155,636	0
(2) Medical Services Premiums	Total	1,996,264,308	2,057,801,212	9,074,543	2,066,875,755	2,147,858,908	0	2,147,858,908	0	2,147,858,908	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	614,561,650	631,536,899	1,840,815	633,377,714	652,421,500	0	652,421,500	0	652,421,500	0
	GFE	361,644,803	343,100,000	0	343,100,000	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	23,713,210	52,330,509	0	52,330,509	76,001,368	0	76,001,368	0	76,001,368	0
	FF	996,344,645	1,030,795,458	7,233,728	1,038,029,186	1,075,497,784	0	1,075,497,784	0	1,075,497,784	0
(3) Medical Mental Health Community Programs (A) Mental Health Capitation Payments	Total	164,839,222	183,141,013	2,225,047	185,366,060	196,303,651	0	196,303,651	0	196,303,651	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	82,328,858	88,358,589	1,474,141	89,832,730	91,315,646	0	91,315,646	0	91,315,646	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	85,498	3,206,518	0	3,206,518	6,829,511	0	6,829,511	0	6,829,511	0
	FF	82,424,866	91,575,906	750,906	92,326,812	98,158,494	0	98,158,494	0	98,158,494	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 06-07** ☑	**Budget Request Amendment FY 08-09** ☐
Request Title:	Request for FY 06-07 Medicaid Programs Overexpenditure			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-5	**OSPB Approval:**		**Date:**

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base (Column 5) FY 08-19
(6) DHS Medicaid-Funded Programs (E) Mental Health and Alcohol and Drug Abuse Services, High Risk Pregnant Women Program	Total	943,703	983,958	125,489	1,109,447	998,717	0	998,717	0	998,717	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	471,852	491,979	62,745	554,724	499,359	0	499,359	0	499,359	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	471,851	491,979	62,744	554,723	499,358	0	499,358	0	499,358	0
(6) DHS Medicaid-Funded Programs Services for Children and Families - Medicaid Funding	Total	4,222,157	5,346,267	436,158	5,782,425	0	0	0	0	0	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,049,014	2,297,076	239,285	2,536,361	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	62,065	375,985	0	375,985	0	0	0	0	0	0
	FF	2,111,078	2,673,206	196,873	2,870,079	0	0	0	0	0	0

Letternote revised text:			
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX		
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-5
Change Request Title:	Request for FY 06-07 Medicaid Programs Overexpenditure

SELECT ONE (click on box):

☐ Decision Item FY 08-09
☐ Base Reduction Item FY 08-09
☒ Supplemental Request FY 06-07
☐ 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:

This Change Request increases funding for the Department's FY 06-07 appropriations for several line items in the amount of the total General Fund and federal funds overexpenditure in those Long Bill groups, $11,861,237, of which $3,616,986 is General Fund. Because of the overexpenditure in FY 06-07, the Department's FY 07-08 appropriations have been restricted by the same amount.

Background and Appropriation History:

In FY 06-07, the Department of Health Care Policy and Financing exceeded its appropriations for Medical Services Premiums, Medicaid Mental Health Community Programs, and Department of Human Services – Medicaid Funded Programs by a total of $3,616,986 General Fund, and $8,244,251 federal funds. Pursuant to 24-75-109 (3) C.R.S. (2007), the State Controller is required to restrict the Department's FY 07-08 appropriation by the same amount. In order for the State Controller to release the restriction, 24-75-109 (4), C.R.S. (2007) requires that the Department receive a supplemental appropriation for the fiscal year in which the overexpenditure occurred.

General Description of Request: The Department requests an appropriation of $11,861,237 total funds, $3,616,986 General Fund for FY 06-07 in order to release the restriction for the overexpenditure on the Medical Services Premiums and Medicaid Mental Health Community Program line items. Table 1 shows the total overexpenditure by line item, and the total restriction on the FY 07-08 appropriation. Underexpenditure for an individual fund source (such as Cash Funds Exempt for Medical Services Premiums) does not offset the overexpenditure restriction.

Table 1
Total FY 06-07 Overexpenditure and Restriction by Line Item

Medical Services Premiums	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Overexpenditure	$7,536,372	$1,840,815	($38,256)	($1,499,915)	$7,233,728
Total Overexpenditure Restriction	**$9,074,543**	**$1,840,815**	**$0**	**$0**	**$7,233,728**
Mental Health Capitation Payments	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Overexpenditure	$1,499,555	$1,474,141	$0	($725,492)	$750,906
Total Overexpenditure Restriction	**$2,225,047**	**$1,474,141**	**$0**	**$0**	**$750,906**
Department of Human Services High Risk Pregnant Women	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Overexpenditure	$125,489	$62,745	$0	$0	$62,744
Total Overexpenditure Restriction	**$125,489**	**$62,745**	**$0**	**$0**	**$62,744**
Department of Human Services Services for Children and Families - Medicaid Funding	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Overexpenditure	$330,313	$239,285	$0	($105,845)	$196,873
Total Overexpenditure Restriction	**$436,158**	**$239,285**	**$0**	**$0**	**$196,873**
Total	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Overexpenditure	$9,491,729	$3,616,986	($38,256)	($2,331,252)	$8,244,251
Total Overexpenditure Restriction	**$11,861,237**	**$3,616,986**	**$0**	**$0**	**$8,244,251**

Consequences if Not Funded: If not funded, the Departments' FY 07-08 appropriations for these Medicaid programs will continue to be restricted. The Departments' will not have enough funding to provide these services to Medicaid clients. Because the State Controller is permitted to allow overexpenditure for Medicaid programs, the Departments will likely have an overexpenditure again in FY 07-08 and the FY 08-09 appropriations will similarly be restricted.

Calculations for Request:

Summary of Request FY 06-07 Matches Schedule 13 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request (column 3)	**$11,861,237**	**$3,616,986**	**$8,244,251**
(2) Medical Services Premiums	$9,074,543	$1,840,815	$7,233,728
(3) Medicaid Mental Health Community Programs (A) Mental Health Capitation Payments	$2,225,047	$1,474,141	$750,906
(6) Department of Human Services - Medicaid Funded Programs (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	$125,489	$62,745	$62,744
(6) Department of Human Services - Medicaid Funded Programs (G) Services for People with Developmental Disabilities - Medicaid Funding Services for Children and Families - Medicaid Funding	$436,158	$239,285	$196,873

Assumptions for Calculations: The Department has verified the total overexpenditure through the Colorado Financial Reporting System (COFRS) and with the State Controller's Office.

Impact on Other Government Agencies: This request will require a corresponding increase in the Department of Human Services' budget.

Cost Benefit Analysis: Not applicable.

Statutory and Federal Authority: 24-75-109, C.R.S. (2007). Controller may allow expenditures in excess of appropriations - limitations - appropriations for subsequent fiscal year restricted - repeal.

(1) For the purpose of closing the state's books, and subject to the provisions of this section, the controller may, on or after May 1 of any fiscal year and before the forty-fifth day after the close thereof, upon approval of the governor, allow any department, institution, or agency of the state, including any institution of higher education, to make an expenditure in excess of the amount authorized by an item of appropriation for such fiscal year if:
(a) The overexpenditure is for medicaid programs; or

(3) For any overexpenditure, whether or not allowed by the controller in accordance with subsection (1) of this section, the controller shall restrict, in an amount equal to said overexpenditure, the corresponding item or items of appropriation that are made in the general appropriation act for the fiscal year following the fiscal year for which the overexpenditure that is allowed occurs. For the purposes of determining such corresponding item or items of appropriation, the controller shall consider, in order of importance, the fund from which the overexpenditure was allowed, the department, institution, or agency that was allowed to make the overexpenditure, and the purpose for which the overexpenditure was allowed. The department, institution, or agency shall not be allowed to expend any amount restricted pursuant to this subsection (3) unless such restriction is released in accordance with subsection (4) of this section.

(4) (a) The department, institution, or agency whose appropriation is restricted may request a supplemental appropriation for the fiscal year in which the overexpenditure occurred for the amount of any overexpenditure allowed pursuant to this section. If a supplemental appropriation is enacted for the overexpenditure or some portion thereof, the restriction on the succeeding fiscal year's appropriation shall be released in the amount of the supplemental appropriation enacted.

Performance Measures:

This Change Request affects the following Performance Measures:

- Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services.

The Department anticipates that by removing the restriction due to the overexpenditure that it will be better able to budget for FY 07-08.

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:	Health Care Policy and Financing Medical Director Consortium			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-6, BA-1	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	15,260,951	16,715,590	80,000	16,795,590	18,860,743	0	18,860,743	200,000	19,060,743	200,000
	FTE	0.00	245.30	0.00	245.30	0.00	0.00	0.00	0.00	0.00	0.00
	GF	6,054,845	7,261,822	10,000	7,271,822	7,768,653	0	7,768,653	40,000	7,808,653	40,000
	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	70,000	8,790,787	8,758,214	0	8,758,214	160,000	8,918,214	160,000
(1) Executive Director's Office - Personal Services	**Total**	15,260,951	16,715,590	80,000	16,795,590	18,860,743	0	18,860,743	200,000	19,060,743	200,000
	FTE	0.00	245.30	0.00	245.30	0.00	0.00	0.00	0.00	0.00	0.00
	GF	6,054,845	7,261,822	10,000	7,271,822	7,768,653	0	7,768,653	40,000	7,808,653	40,000
	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	70,000	8,790,787	8,758,214	0	8,758,214	160,000	8,918,214	160,000

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-6, BA-1
Change Request Title:	Health Care Policy and Financing Medical Director Consortium

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:

This request is for $80,000 total funds in FY 07-08, with annualization to $200,000 in FY 08-09 and beyond, to hire a consortium of medical professionals from University Physicians Incorporated. By using the services of University Physicians Incorporated, the Department would be able to leverage a wide range of expertise provided by a variety of specialties, including pediatrics, internal medicine, geriatrics, obstetrics, and gynecology, resulting in a greater dissemination of best practices to the Medicaid community. The Department believes a consortium of diverse medical professionals will provide more clinical expertise than a single Chief Medical Officer.

Background and Appropriation History:

Since the Department's inception it has never employed a Medical Doctor as a Chief Medical Officer or as the State's Medicaid Director. Lacking such a position, the Department has employed non-clinical staff to research and determine departmental policy positions on complicated medical subject matter.

Additionally, advocacy groups recommend, almost daily, that the Department fund alternative therapies for Medicaid clients that they profess will save the State money.

However, in the past the Department, by not having a Chief Medical Officer or other medical professional on staff, could not clinically corroborate the validity of these claims. As a result the Department has been unable to rigorously evaluate the appropriateness and medical necessity of the numerous treatments recommended by these advocacy groups.

Prior to FY 07-08, the Department had a contract with the Denver Health and Hospital Authority for consulting services one day per week at a cost of approximately $40,000 annually. At the time, the Department allocated funds for this contract from its Personal Services appropriation, using the standard 50% federal funds match. However, the exact amount spent was based on the actual amount of consultative services utilized by the Department. This contract was intended to provide the Department with the types of services that a Chief Medical Officer would provide. However, this program did not perform as well as originally designed. The Department believed that the agreement with the Denver Health and Hospital Authority, as both a consultant and Medicaid provider had a conflict of interest when supplying consultation services to the Department. As a result of the passage of SB 07-211, the Department did not renew the contract when it expired at the end of FY 06-07.

In the six state Centers for Medicare and Medicaid Services Region that includes Colorado, there is only one Medical Doctor employed as a Chief Medical Officer. However, per the Centers for Medicare and Medicaid Services, there are at least 32 Medical Doctors acting as Chief Medical Officers for state Medicaid offices nationwide.

Currently, the Department contracts with the Colorado Foundation for Medical Care to determine the medical necessity of procedures for its Medicaid clients and to approve prior authorization requests. However, if the procedure is considered non-standard or experimental, the Colorado Foundation for Medical Care will defer the decision to the Department for final determination. Without a Chief Medical Officer, the Department does not have sufficient knowledge and expertise to make truly informed decisions regarding the medical necessity and appropriateness of these types of medical procedures.

In September 2007 the Department's Executive Director conducted a survey with various medical organizations to determine whether the Department needed a Medical Director at all, or if it could access the expertise of other state agencies that already employ physicians on staff. The overwhelming response was that the Department would benefit from having its own full-time clinical consultation.

Based on the Executive Director's guidance, in early October, Department staff began surveying other state Medicaid agencies to gather information regarding roles and responsibilities, reporting relationships, salaries and other pertinent information to determine the best solution for the State of Colorado to obtain this essential clinical guidance. After this information was gathered, the Executive Director met with the Chief Medical Officer at the Department of Public Health and Environment and the Dean of the School of Medicine at the University of Colorado Health Sciences Center to conclude the informal survey. After these meetings were held and information was gathered, it was decided to pursue a relationship with University Physicians Incorporated, the administrative services unit for the School of Medicine at the University of Colorado Health Sciences Center. This was based on feedback that was obtained that suggested that while there may be some advantages to having an FTE on staff, the needs of the Department are so varied that perhaps a different model would be more beneficial. Department staff would require assistance in a variety of specialties such as pediatrics, family medicine, internal medicine, pharmacology, geriatrics, obstetrics and gynecology, and psychiatry.

In mid-October the Dean of the School of Medicine at the University of Colorado Health Sciences Center offered to contact all the Deans of the sections to get input on how they could assist the Department, and to identify physicians from each of the specialties listed above that would be willing to provide these consultative services. Due to the schedules of those solicited, it took more than two weeks to gather the necessary information back from all the schools, contact interested physicians, interview them and then fine tune how this model would be expected to work.

University Physicians Incorporated was then contacted in late October regarding developing the mechanisms available to the Department and an estimate of the cost. It was too late to incorporate into the Department's November 1, 2007 Budget Request. The information gained from the informal survey and internal and external research has identified the benefit to the State of funding this in FY 07-08.

General Description of Request:

This Request is for $80,000 total funds, $10,000 in General Fund in FY 07-08, with annualization to $200,000 total funds, $40,000 General Fund, in FY 08-09 to enter into a contract with University Physicians Incorporated to provide clinical expertise to the Department in multiple fields of medicine. Based on the permissive language contained in SB 07-211, the Department conducted an assessment of its need for a Chief Medical Officer and determined that it cannot manage a $3.5 billion budget, with a diverse and demanding range of medical services, effectively with a single Chief Medical Officer. The Department believes it would operate more efficiently if a consortium of medical professionals with expertise in multiple medical disciplines were engaged instead.

The Department's five largest expenditures involve reimbursements for services pertaining to nursing facilities, in-patient hospital expenses, prescription drugs, assisted care for in-home Medicaid clients, and physician office visits. Contracting with University Physicians Incorporated will provide expertise and services in the following fields of medicine: pediatrics, internal medicine, geriatrics, obstetrics, and gynecology. These areas are where the Department incurs the vast majority of its expenses. The Department believes that by using a physician group with expertise in various fields, it will receive more knowledgeable and focused feedback on a client's condition and recommended treatment protocol. Therefore, the Department would be better able to serve the needs of the Medicaid community at large.

The alternative of a consortium of medical professionals rather than a single Chief Medical Officer, allows the Department to utilize medical professionals with specific and up-to-date expertise in areas related to the recommended pilot programs. Additionally, when unusual cases arise, there would be more thorough diagnoses of the patient's condition

provided by a consortium of multiple medical specialists, with diverse expertise, reviewing the facts and circumstances of the case.

The Department expects University Physicians Incorporated to be available during regular business hours, five days a week, and to provide a lead doctor. The lead doctor's responsibilities will be coordination and distribution of Departmental requests and to provide timely feedback from the various specialists listed above when necessary.

Finally, by having a consortium of doctors available during the legislative season, the Department would be able to draw on their expertise when developing fiscal impact statements for the proposed legislation, as they would be using true clinical standards as the basis for determining costs to the State.

The Department will be asking University Physicians Incorporated to provide the following services for its Medicaid clients.

The Physicians will provide clinical and policy consultation and technical assistance to the Colorado Department of Health Care Policy and Financing with a concentration in the following areas, pediatrics, internal medicine, geriatrics, obstetrics, and gynecology. They will do this by:

- Researching new and best standards of practice and synthesizing that information for use by the Department in the design of new benefits packages. Specifically, these physicians will develop standards of care that will meet the criteria for reimbursement for pediatrics, internal medicine, geriatrics, obstetrics, and gynecology, and provide second opinions regarding medical necessity and appropriateness of requested procedures.

- Advising the Department on policies and protocols related to adding new treatments or procedures as a benefit. For example, when legislation or new policies are proposed which impact the functions of the Department, having a group of professionals with medical expertise to provide clinical analyses on the consequences

of the proposed legislation or policy will greatly improve the operations of the Department. This consortium of professionals can also provide input and feedback regarding other potential areas of impact for items that may have been overlooked and will enhance the Department's ability to develop and defend its position on proposed legislation or policies. Finally, they will review newly developed treatments and determine whether these treatments should qualify for Medicaid coverage.

- Assisting in the design and evaluation of quality improvement programs.

- Assisting in the evaluation and improvement of prior authorization programs and procedures.

- Reviewing proposed legislation and advising the Department on the potential impact to clinical services, health outcomes, and providers' ability to implement new policy.

- Participating in standing medical and clinical advisory committees. The Physician group will assist the Department's Medical Policy Committee, among others, when it is reviewing requests for benefit coverage. The Physician group will be able to apply current medical standards as the basis for recommended new policies.

- Testifying on behalf of the Department at Administrative Law Judge hearings when necessary and to boards, committees, the legislature and at other hearings or meetings where clinical expertise is needed.

- With regards to pregnancy, labor and delivery, the Physician group will define minimum standards of care, develop and recommend standardized billing procedures, and provide opinions regarding medical necessity and appropriateness of competing treatment options.

Each physician covered under this contract is expected to be available for consultation up to 10% of the time on a monthly basis. Consultation may be provided by telephone, email, or regularly scheduled meetings with Health Care Policy and Financing personnel.

An annual contract for these services is estimated at $240,000 total funds, or $20,000 per month.

The Department currently plans to enter into a four month contract with University Physicians Incorporated beginning January 1, 2008 and continuing through April 30, 2008, using its existing $40,000, ($20,000 General Fund) allocation that has qualified for a 50% federal match. However, the Department is requesting an enhanced federal match for this expenditure as it will now qualify for a 75% federal match. This will allow the Department to leverage its current $20,000 General Fund allocation to obtain an additional $40,000 (above the $20,000 it already receives) in federal funds (see Table A).

The Department is also requesting new funding to continue this contract through May and June 2008. The additional amount required to continue the contract through the fiscal year end will be $40,000 total funds, however due to the enhanced federal match mentioned above, only $10,000 in additional General Fund appropriation will be required (see Table B).

To summarize, the total amount of new funding the Department will require in FY 07-08 is $80,000 but only an additional $10,000 General Fund appropriation to enter into the agreement with University Physicians Incorporated.

For FY 08-09, the Department will require an additional appropriation of $40,000 General Fund. Again, the reason for this is that the contract with University Physicians Incorporated qualifies for an enhanced federal match, and the previously allocated $20,000 General Fund that assumed 50% federal funds match will now qualify for an enhanced match (See Table C). This contract qualifies for the enhanced match because parts of the Physicians' duties are directly related to policy development and the administration of the Medicaid program.

Consequences if Not Funded:

The Department anticipates its request for enhanced federal match will be approved as there is no General Fund impact associated with this portion of the Request. If the

additional funding is not approved, the Department would not extend the contract for the additional two months and would renegotiate for less robust services in FY 08-09 using the existing allocation of its Personal Services appropriation.

The lack of a Medical Director puts the Department at risk in a number of ways such as being vulnerable to challenges from clients regarding the quality of care they received, being open to litigation regarding the denial of services, and paying for services that are experimental and provide no value to a client. It is not satisfactory to be without dedicated, expert, medical consultation when serving almost 400,000 individuals and paying out $2.5 billion in medical claims.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund	Federal Funds	FTE
Total Request	$80,000	$10,000	$70,000	0.0
(1) Executive Director's Office: Personal Services	$80,000	$10,000	$70,000	0.0

Summary of Request FY 08-09	Total Funds	General Fund	Federal Funds	FTE
Total Request	$200,000	$40,000	$160,000	0.0
(1) Executive Director's Office: Personal Services	$200,000	$40,000	$160,000	0.0

Table A

	Calculation of Enhanced Match for 4 Month Contract Using Current Funding Allocation FY 07-08; January - April	Total Funds	General Fund	Federal Funds	Description
A	Current Funding	$40,000	$20,000	$20,000	Previously allocated funds using the current 50%-50% match rate
B	Total Needed Fund with Enhanced Fund Splits	$80,000	$20,000	$60,000	Total cost of four month contract with proper fund splits
C	Incremental Funding Needed	$40,000	$0	$40,000	Net need by fund split (Row B- Row A)

Table B					
	Calculation of Fund Splits for Additional 2 Month Contract Being Requested for FY 07-08; May - June	**Total Funds**	**General Fund**	**Federal Funds**	**Description**
A	Current Funding	$0	$0	$0	
B	Total Needed Funds using Enhanced Fund Splits	$40,000	$10,000	$30,000	Total cost of two month contract with enhanced fund splits
C	Incremental Funding Needed	$40,000	$10,000	$30,000	Net need by fund split (Row B- Row A)

Table C					
	Calculation of Fund Splits for Contract Request for FY 08-09	**Total Funds**	**General Fund**	**Federal Funds**	**Description**
A	Current Funding	$40,000	$20,000	$20,000	Previously allocated funds using the current 50%-50% match rate
B	Total Needed Fund with Enhanced Fund Splits	$240,000	$60,000	$180,000	Total cost of annual contract with proper fund splits
C	FY 08-09 Annual Need	$200,000	$40,000	$160,000	Net need by fund split (Row B- Row A)

Assumptions for Calculations: The amount of the request is based on a pending contract with University Physicians Incorporated. The funds splits are due to the enhanced federal match for the services performed by medical professionals.

Impact on Other Government Agencies: None

Cost Benefit Analysis:

Cost	Benefits
FY 07-08: $80,000 FY 08-09: $200,000	By using a consortium of medical professionals with expertise in various fields rather than a single Chief Medical Officer, Medicaid recipients will receive expert knowledge and focused treatment for their condition using the most appropriate course of treatment. Additionally, by having medical professionals available, the Department will be better able to evaluate the claims made by advocacy groups regarding alternative methods of treatment.
$0	None. Without a Chief Medical Officer or a consortium of medical professionals to consult with, Medicaid recipients could get delayed care, insufficient care or care that is inappropriate for their condition. The Department would also lack the ability to clinically evaluate the claims made by advocacy groups and other assertions that may be contained in proposed legislation.

Implementation Schedule:

Task	Month/Year
SB 07-211 Signed by the Governor - Becomes Law	May 31, 2007
Internal Research/Planning Period	May 2007
Contract Written	November 2007
Contract Awarded/Signed	December 2007
Start-Up Date	January 1, 2008

Statutory and Federal Authority:

25.5-1-105.5. C.R.S. (2007) Chief medical officer - qualifications. *(1) The executive director may appoint a chief medical officer who shall: (a) Have a degree of doctor of medicine or doctor of osteopathy and be licensed to practice medicine in the state of Colorado; (b) Have at least two years of postgraduate experience in primary care; and (c) Have at least two years of experience in an administrative capacity in a health care organization. (2) The chief medical officer shall, with the assistance of advisory committees of the state department, provide medical judgment and advice regarding all medical issues involving programs administered by the state department.*

42 CFR 432.50 § 432.50 FFP: Staffing and training costs. *(a) Availability of FFP. FFP is available in expenditures for salary or other compensation, fringe benefits, travel, per diem, and training, at rates determined on the basis of the individual's position, as specified in paragraph (b) of this section.(b) Rates of FFP. (1) For skilled professional medical personnel and directly supporting staff of the Medicaid agency or of other public agencies (as defined in § 432.2), the rate is 75 percent.(2) For personnel engaged directly in the operation of mechanized claims processing and information retrieval systems, the rate is 75 percent...(2) Staff of other public agencies. The rate of 75 percent FFP is available for staff of other public agencies if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met. (e) Limitations on FFP rates for staff in mechanized claims processing and information retrieval systems. The special matching rates for persons working on mechanized claims processing and information retrieval systems (paragraphs (b)(2) and (3) of this section) are applicable only if the design, development and installation, or the operation, have been approved by the Administrator in accordance with part 433, subchapter C, of this chapter.*

42 CFR 432.20 *§* 432.2 Definitions. *As used in this part--Community service aides means subprofessional staff, employed in a variety of positions, whose duties are an integral part of the agency's responsibility for planning, administration, and for delivery of health services....Staff of other public agencies means skilled professional medical personnel and directly supporting staff who are employed in State or local agencies other than the Medicaid agency who perform duties that directly relate to the administration of the Medicaid program...*

Performance Measures:

This Request will help provide more resources in order to support nearly all of the Department's Performance Measures, including those that are aligned with the Governor's *The Colorado Promise*:

- 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.
- Increase number of managed care options for clients enrolling in Medicaid.
- Increase the number of clients enrolled in viable managed care options.
- Improve access to and the quality of Medicaid health care as demonstrated through improvements in Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.

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:	Funding for Additional Leased Space			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-7, BA-2	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	16,623,864	18,027,373	146,484	18,173,857	20,157,001	286,534	20,443,535	6,634	20,450,169	293,168
	FTE	225.36	245.30	0.00	245.30	259.50	0.00	259.50	0.00	259.50	0.00
	GF	6,719,252	7,886,710	73,242	7,959,952	8,385,654	143,267	8,528,921	3,317	8,532,238	146,584
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	154,890	0	154,890	216,481	0	216,481	0	216,481	0
	CFE	412,657	612,532	0	612,532	2,153,788	0	2,153,788	0	2,153,788	0
	FF	9,491,955	9,373,241	73,242	9,446,483	9,401,078	143,267	9,544,345	3,317	9,547,662	146,584
(1) Executive Director's Office - Personal Services	**Total**	15,260,951	16,715,590	10,500	16,726,090	18,860,743	10,500	18,871,243	(10,500)	18,860,743	0
	FTE	225.36	245.30	0.00	245.30	259.50	0.00	259.50	0.00	259.50	0.00
	GF	6,054,845	7,261,822	5,250	7,267,072	7,768,653	5,250	7,773,903	(5,250)	7,768,653	0
	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	5,250	8,726,037	8,758,214	5,250	8,763,464	(5,250)	8,758,214	0
(1) Executive Director's Office - Operating Expenses	**Total**	1,196,014	1,039,465	145,531	1,184,996	1,023,940	212,013	1,235,953	(40,763)	1,195,190	171,250
	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	72,766	566,995	486,342	106,006	592,348	(20,382)	571,966	85,625
	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	72,765	589,060	506,705	106,007	612,712	(20,381)	592,331	85,625

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:	Funding for Additional Leased Space									
Department:	Health Care Policy and Financing			**Dept. Approval by:**		John Bartholomew		**Date:**	January 2, 2008	
Priority Number:	S-7, BA-2			**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 - Leased Space	**Total**	166,899	272,318	(9,547)	262,771	272,318	64,021	336,339	57,897	394,236	121,918
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	77,950	130,659	(4,774)	125,885	130,659	32,011	162,670	28,949	191,619	60,959
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	5,500	5,500	0	5,500	5,500	0	5,500	0	5,500	0
	FF	83,449	136,159	(4,773)	131,386	136,159	32,010	168,169	28,948	197,117	60,959
Letternote revised text:											
Cash Fund name/number, Federal Fund Grant name:				FF: Title XIX							
IT Request: ☐ **Yes** ☑ **No**											
Request Affects Other Departments: ☐ **Yes** ☑ **No**				**If Yes, List Other Departments Here:**							

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S -7, BA - 2
Change Request Title:	Funding for Additional Leased Space

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: This Request is to amend a previously submitted Decision Item (DI - 10 Funding for Additional Leased Space, November 1, 2007) for the Department of Health Care Policy and Financing to increase funding for Leased Space. This request is for total funding of $146,484 for FY 07-08 so the Department may finalize a pending lease at 225 E. 16th Avenue.

Background and Appropriation History: The Department of Health Care Policy and Financing is the second largest General Fund/General Fund Exempt budget in State government and one of the smallest Executive branch departments in terms of staff size. With the Department's ever-growing caseload, expenditures and programs, staffing levels have been increasing, but the space that the Department has appropriated to house these staff has not grown to the same degree.

In May 2003, the Department moved to its current location at 1570 Grant Street. When the Department moved to 1570 Grant in 2003, it was apparent that the Department would not be able to accommodate much growth. From the time of this move up to the present, the programs for which the Department is responsible have grown both in size

and complexity, resulting in additional FTE appropriations. For FY 07-08, the Department was appropriated $391,072 through Common Policies for space at 1570 Grant Street. This space currently houses 230 positions. Additionally, in FY 06-07 the Department began leasing two floors at 225 E. 16th Avenue that contain an additional 56 spaces to house staff that the Grant Street building could not accommodate, providing a total of 286 spaces for employees to work.

The table below shows the historical FTE count for each fiscal year since the Department moved to its current location at 1570 Grant Street in May 2003. This table indicates that FTE appropriations have increased a total of 32% since the Department moved to its current location.

Year	Long Bill FTE Appropriation	Special Bill FTE Appropriations	Total FTE
FY 02-03	193.3	1.2	194.5
FY 03-04	196.6	3.8	200.4
FY 04-05	196.1	6.7	202.8
FY 05-06	207.1	7.3	214.4
FY 06-07	222.7	8.0	230.7
FY 07-08	238.0	19.5*	257.5

* Includes June 20, 2007 1331 Emergency Supplemental for the Office of Colorado Benefits Management System staff of 12 FTE transferred to the Department on July 1, 2007.

The table above shows the number of approved FTE, not the number of positions. The Department had 274 positions (though not all filled) as of June 30, 2007, not including contractors, temporary staff, interns, or auditors. The Department employs a number of temporary staff to comply with legislation and to complete special projects. For example, as of June 2007, the Department had employed roughly 35 different temporary staff, interns and contractors throughout FY 06-07.

The Department's space issues are not new, for FY 05-06 the Department received one time funding of $36,278 total funds to house 15 temporary employees charged with the implementation of the Medicare Modernization Act. Additionally, HB 05-1262 (the

Tobacco Tax bill) and two 1331 Emergency supplementals (one for an emergency call center for cases that exceed processing guidelines and another to cover tasks inadvertently left out of HB 05-1262) were approved providing an additional $38,903 to house employees authorized through those legislative initiatives, for a total FY 05-06 appropriation of $75,181.

For FY 06-07 the one time funding for the Medicare Modernization Act was removed. However, the Department requested supplemental funding to acquire additional leased space at 225 E. 16th Avenue to alleviate overcrowding at 1570 Grant Street. Funding for FY 06-07 was approved for $218,950 (annualized) to lease an additional 13,056 square feet of office space to accommodate the increased staff from other FTE appropriations. This space provided the Department with critically needed room to place staff and provide two conference rooms for staff and the Medical Services Board to meet. Additionally, this allowed the Department to relieve overcrowded conditions at 1570 Grant Street.

General Description of Request:

When the Department submitted its Decision Item (DI - 10) in November 2007 it did not yet have definitive lease information. Therefore, it used the cost of its previously negotiated lease agreement as the basis of its request, and the Department of Personnel and Administration - Division of Finance and Procurement's standard for an efficient use of space, which provides 200 square feet of space per employee. At that time the Department requested to lease 7000 square feet at an estimated rate of $16.77 per square foot to house 35 employees. Since DI -10 was submitted, the Department has been able to locate 8,347 square feet of leased space at a rate of $21.00 per square foot that the Department plans to begin leasing on April 1, 2008. The Department was able to locate two contiguous offices on the 6th floor of 225 E. 16th Avenue. One office consists of 3,151 square feet and the other, next door, is 5,196 square feet. The Department decided to pursue these spaces as they were in the same building that it currently leases space, they are both on the same floor, facilitating easy interaction among staff located there. By requesting the two full suites, the Department will avoid additional expenditures required to modify the space that would otherwise be required if the Department only pursued the 7,000 total square feet as was previously requested in DI -10. This would provide each employee with approximately 238 square feet of office space.

Due to timing issues associated with the Department's FY 07-08 Decision Item (DI-5) submitted on November 1, 2006 and the Department's FY 06-07 Supplemental (S-8) submitted on January 4, 2007 for Leased Space, $53,369 was inadvertently left in the Department's Leased Space appropriation for FY 07-08 and beyond. This request, therefore, will revert $9,547 of its FY 07-08 Leased Space appropriation. It will increase the Department's need for Leased Space in FY 08-09 and beyond by a total of $175,287 total funds, with a net increase to the Department's Leased Space Appropriation of $121,918.

The Department's DI - 10 request; Funding for Additional Leased Space submitted on November 1, 2007 will provide $64,021 of this $121,918 need and this Supplemental Request is seeking the remaining $57,897 required. In order to have adequate funding to pay for this Leased Space the Department requires approval of both DI - 10, and this Supplemental Request (See Table A).

Additionally, due to the ability to move into the new Leased Space in FY 07-08 versus FY 08-09, the Department will need to move funding into FY 07-08 to build out the space to make it useful. The Office of State Planning and Budget's Common Policies currently provides $2,225 for office equipment. However, this amount is inadequate to purchase and install modular office equipment that is the norm for buildings with open floor plans. The Office of State Planning and Budget's Common Policies provide funding for a stand alone desk, an office chair, a side chair, a computer tray, a file cabinet and a bookcase. The Department does not use stand alone desks for its employees; it provides modular office furniture (cubicles) instead. As a result, this Common Policy does not provide sufficient funding for the Department to purchase and install suitable work stations for its employees. The Common Policy also does not address nor does it fund, any ancillary issues such as office layout design, and required infrastructure such as electrical connections, phone lines and cubicle walls.

The Department is requesting incremental funding to acquire cubicles of the same style of those previously purchased to furnish its current lease space on the second floor at 225 E.

16th Avenue. The reason the Department is requesting funding in this amount is to provide flexibility and interchangeability when office reconfigurations are required. If the Department is not allowed to purchase like style cubicles, it will not have the ability to make inexpensive adjustments to cubicle configurations when office layouts are changed. The Department has received quotes from the State's designated furniture provider (Colorado Correctional Industries, DBA Juniper Valley Products). Juniper Valley Products has provided updated quotes of modular office furniture of $4,401 per cubicle. However, this quote does not include the necessary employee chair that the Department will be required to purchase at an additional cost of $419 each.

The Department's original Request (DI - 10) also contained an error, the number of unfunded cubicles requested in DI - 10 should have been 19 not 12 as requested in DI -10. The Department received partial funding for 16 FTE referenced in DI - 10. The Department regrets this error, and would like to correct it now to insure the correct amount of funding is provided for its employees' workstations. Additionally, as stated earlier, the Common Policies associated with office equipment is inadequate to purchase the modular office equipment required by the Department, therefore the Department is now also requesting incremental funding for those positions previously appropriated or contained in other submitted Decision Items.

The Department will also require one-time funding for personal services and operating expenses to build out the acquired space with cubicles, chairs, telecommunications and information technology equipment, wiring and associated data transmission equipment for the space. The Department projects these costs will total $156,031 (See Table B).

Consequences if Not Funded:

In order to have adequate funding to pay for this space the Department requires approval of both DI - 10, and this Supplemental Request. If this Supplemental Budget Request Amendment is not funded, the Department would not have adequate funding to pay its anticipated leased space expenses for FY 08-09 and beyond. Therefore, it would have no space to house employees that were authorized by special bills passed during the 2007 legislative session, and would not be prepared to take on staff to support the implementation of any proposed health care reform. Additionally, the Department would

be forced to perform a hiring freeze due to a lack of physical space and only hire positions as space becomes available for a seating location. The consequences of this action would likely include delays in implementing the Governor's Health Care Initiatives, non-compliance with federal and State requirements and increased turnover as the work environment becomes increasingly less tolerable.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
Total Request	$146,484	$73,242	$0	$73,242
(1) Executive Director's Office - Personal Services (Column 3)	$10,500	$5,250	$0	$5,250
(1) Executive Director's Office - Operating Expenses (Column 3)	$145,531	$72,766	$0	$72,765
(1) Executive Director's Office - Leased Space (Column 3)	($9,547)	($4,774)	$0	($4,773)

Summary of Request FY 08-09	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
Total Request	$6,634	$3,317	$0	$3,317
(1) Executive Director's Office - Personal Services (Column 8)	($10,500)	($5,250)	$0	($5,250)
(1) Executive Director's Office - Operating Expenses (Column 8)	($40,763)	($20,382)	$0	($20,381)
(1) Executive Director's Office - Leased Space (Column 8)	$57,897	$28,949	$0	$28,948

Table A - Leased Space Cost				
Square Feet Per Employee	**Number of Employees/Spaces**	**Total Square Feet Required**	**Cost per Square Foot**	**Total Leased Space Cost**
238	35	8,347*	$21.00	$175,287
Appropriated Leased Space Funding that is not Currently Needed				($53,369)
Net Total Annual Need				**$121,918**
Funding Provided through DI - 10				($64,021)
Net Additional Leased Space Need				**$57,897**

Table B – FY 07-08 Build-Out Costs	
(1) Executive Director's Office, Personal Services	
Contract for Movers	$6,500
Electrical Installation	$4,000
Subtotal Personal Services	**$10,500**
(1) Executive Director's Office, Operating Expenses	
Purchase and Installation of 19 Cubicles at an average rate of $4,401 per Cubicle	$83,619
Incremental Purchase and Installation of 16 Cubicles at an average rate of $4,401 per Cubicle due to inadequate funding provided in the authorizing legislation, which provided $2,225 (=$2,176 * 16)	$34,816
35 Additional Chairs at $419 per Chair	$14,665
Printers and Fax Machines	$4,795
Telephone Installation and Equipment	$2,100
Wiring for Data Equipment	$2,350
Data Equipment – Ethernet Switch and Panel Patch	$3,186
Subtotal Operating Expenses	**$145,531**
Total for Personal Services and Operating Expenses	**$156,031**

* Amount does not match due to rounding.

Assumptions for Calculations: The Department's total need for Leased Space is $175,287, based on the pending agreement between the Department and the building management company, for two suites on the 6th floor of 225 E. 16th Avenue.

As stated previously in the Department's Decision Item (DI - 10), due to timing issues associated with the Department's FY 07-08 Decision Item (DI-5) submitted on November 1, 2006 and the Department's FY 06-07 Supplemental (S-8) submitted on January 4, 2007 for Leased Space, $53,369 was inadvertently left in the Department's Leased Space appropriation for FY 07-08 and beyond. Therefore, that appropriation offsets a portion of the total need, reducing the Department's net increase in costs to $121,918 annually (see Table A).

As this request is an amendment of the Department's previously submitted Decision Item (DI - 10), it is anticipated that DI - 10 has already received legislative approval, therefore the funding requested in DI - 10 needs to be factored into this request. DI - 10 requested funding of $64,021, so factoring this amount into the Request results in a net additional need of $57,897 for leased space.

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

Cost	Benefits
$146,484 in FY 07-08, $6,634 in FY 08-09	The Department would be able to lease, build out and furnish 8,347 square feet of additional office space for staff use. Increasing the Department's ability to meet the ever growing demands placed upon it.
$0	If funding is not approved, the Department would be forced to stop hiring and possibly lay off staff, jeopardizing the completion of required projects. The Department would most likely experience greater turnover as the work environment become less tolerable.

Implementation Schedule:

Task	Month/Year
Lease Awarded/Signed	February 2008
Build Out and Tenant Preparation Begins	March 1, 2008
Build Out and Tenant Preparation Complete	March 31, 2008
Move Date	April 1, 2008

Statutory and Federal Authority:

24-1-107, C.R.S. (2007). Internal organization of department - allocation and reallocation of powers, duties, and functions - limitations. *In order to promote economic and efficient administration and operation of a principal department and notwithstanding any other provisions of law, except as provided in section 24-1-105, the head of a principal department, with the approval of the governor, may establish, combine, or abolish divisions, sections, and units other than those specifically created by law and may allocate and reallocate powers, duties, and functions to divisions, sections, and units under the principal department, but no substantive function vested by law in any officer, department, institution, or other agency within the principal department shall be removed from the jurisdiction of such officer, department, institution, or other agency under the provisions of this section.*

25.5-1-104 (2) (4), C.R.S. (2007). Department of health care policy and financing created - executive director - powers, duties, and functions…*(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director … (4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in part 2 of this article.*

Performance Measures:

This Request will help provide more administrative resources in order to support nearly all of the Department's Performance Measures, including those that are aligned with the Governor's *The Colorado Promise*:

- 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.
- Increase number of managed care options for clients enrolling in Medicaid.
- Increase the number of clients enrolled in viable managed care options.
- Improve access to and the quality of Medicaid health care as demonstrated through improvements in Medicaid Health plan scores on Health Plan Employer Data Information Set (HEDIS) measures.

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:	Additional Financing for the Implementation of SB 07-211			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-8	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	7,532,758	8,716,030	17,879	8,733,909	7,975,468	0	7,975,468	0	7,975,468	0
	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	0	4,021,332	3,677,330	0	3,677,330	0	3,677,330	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	516,953	580,621	0	580,621	532,547	0	532,547	0	532,547	0
	FF	3,557,691	4,114,077	17,879	4,131,956	3,765,591	0	3,765,591	0	3,765,591	0
(6) DHS Medicaid Funded Programs - (B) Office of Information Technology Services - Colorado Benefits Management System	Total	7,532,758	8,716,030	17,879	8,733,909	7,975,468	0	7,975,468	0	7,975,468	0
	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	0	4,021,332	3,677,330	0	3,677,330	0	3,677,330	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	516,953	580,621	0	580,621	532,547	0	532,547	0	532,547	0
	FF	3,557,691	4,114,077	17,879	4,131,956	3,765,591	0	3,765,591	0	3,765,591	0

Letternote revised text: See corresponding Schedule 13 from the Department of Human Services for other funding sources besides federal funds.

Cash Fund name/number, Federal Fund Grant name: Federal Funds: 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-8
Change Request Title:	Additional Financing for the Implementation of SB 07-211

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: This request seeks to re-allocate $244,604 in total funding to implement the Colorado Benefits Management System changes required to process presumptive eligibility applications as required by SB 07-211. Of the total funding, $135,400, which was appropriated in FY 06-07, will come from the Deficit Reduction Act and HB 06S-1023 roll-forward. The remaining $109,204 will be financed through the Colorado Benefits Management System Calculator and includes the State's portion of $45,929, taken from the Colorado Cares Prescription Drug Program roll-forward, and $63,275 in federal funds. Most of the requested funding would be reallocated from previous funding. The only new funding needed is $17,879 in federal funds.

Background and Appropriation History: The Colorado Benefits Management System (CBMS) is an automated system that supports application, eligibility determination, and benefits for thirty-six of Colorado's medical, food, and public assistance programs. Development of the Colorado Benefits Management System began in FY 99-00 and was designed to provide a uniform, all-encompassing eligibility determination system for the thirty-six public assistance programs under the direction of the Department of Health Care Policy and Financing and the

Department of Human Services. The Colorado Benefits Management System was also designed to facilitate the transfer of information between county administrators that collect and enter data into the system and State departments that administer these public assistance programs.

During the 2007 legislative session, the Colorado Legislature passed SB 07-211, which required the Department to modify the Colorado Benefits Management System so that it could handle presumptive eligibility for Medicaid and Children's Basic Health Plan clients. During the legislative process, the Department was required to submit a fiscal note detailing the cost of implementing SB 07-211, which included the anticipated costs of the Colorado Benefits Management System changes. At that time, the Department estimated that the changes to the Colorado Benefits Management System would cost $59,600, based upon previous experience.

Unfortunately, the Department was not able to receive an estimate from the Colorado Benefits Management System's operations vendor, Electronic Data Systems (EDS), before the fiscal note was due to the legislature. However, after the passage of SB 07-211, Electronic Data Systems submitted an estimate that detailed the work required to complete the changes. That estimate is for $304,204 and is substantially greater than the amount of funding the Department requested for the necessary changes. Therefore, the Department does not currently have the funding required to pay Electronic Data Systems for the changes necessary to implement SB 07-211.

Further complicating the need for funding is the requirement to comply with cyber security and firewall protections mandated by the new security rules promulgated by the Governor's Office of Information Technology in the Spring of 2007 after the fiscal note was written. Because the presumptive eligibility will be established for clients by personnel at special presumptive eligibility and medical assistance sites, extra procedures will be implemented to protect the Colorado Benefits Management System from cyber security threats.

General Description of Request:

If approved, this request would allow the Department to reallocate $181,329 in unspent funding appropriated in FY 06-07 from the Colorado Cares Prescription Drug and Deficit Reduction Act roll-forwards to pay for the system changes the Colorado Benefits Management System requires to implement presumptive eligibility. The remaining $122,875 would be comprised of the $59,600 that was originally appropriated for SB 07-211 changes and an additional $63,275 in federal funding drawn as a result of using SB 07-001 Colorado Cares Prescription Drug Program funds as the State's portion of Colorado Benefits Management System costs.

The Department is requesting permission to reallocate $135,400 in total funding from the Deficit Reduction Act and HB 06S-1023 roll-forward. Originally, the Department had expected to fully expend this roll-forward for the changes required by HB 06S-1023, however, the Department was able to realize considerable savings as described below.

In the original bill, HB 06S-1023 required the Department to upgrade decision tables for the Children's Basic Health Plan and Old Age Pension State Medical Programs to deny eligibility if an affidavit or proper identification for the potential applicant was not entered. In addition, the Department anticipated decision table upgrades to determine whether or not the documents the applicants provided were an acceptable form of documentation. However, due to subsequent legislation, the Department was no longer required to modify the decision tables for the Children's Basic Health Plan, and the Department was able to absorb the cost of document verification with existing Colorado Benefits Management System staff and resources.

The HB 06S-1023 roll-forward also included funds to allow the Department to upgrade the Colorado Benefits Management System to automatically send notices to clients placed in a pending status, and automatically trigger a review of the documentation for clients that owe enrollment fees. While funding for these changes was provided in the HB 06S-1023, the projects were paid out of the funding provided as a result of the Governor's Emergency Supplemental to Address Top County Concerns.

The Department is requesting that $45,929 of the $66,000 from the Colorado Cares Prescription Drug Program (Colorado Cares) roll-forward be used to fund the unanticipated costs for system development to accommodate changes required to implement SB 07-211 Presumptive Eligibility for Children. Colorado Cares Prescription Drug Program, which was created by SB 07-001, charged the Department with creating a mechanism by which uninsured or underinsured Coloradans can purchase lower-cost generic and non-patented prescription drugs. Original plans for the implementation of SB 07-001 included the use of the Colorado Benefits Management System. However, the Department encountered issues during the system development process that caused the Department to review and revise the original implementation plans. It was determined that some issues were too great to overcome in the short timeframe allocated for implementation and other issues would have added a level of complexity to Colorado Cares or Colorado Benefits Management System that would be too costly or time consuming.

Currently, the Department is pursuing an implementation plan that will use an outside vendor to administer the program. This option will involve using the vendor's systems to track and monitor participation in Colorado Cares Prescription Drug Program. With this new plan for implementation, the Department will not be utilizing Colorado Benefits Management System for the implementation of Colorado Cares Prescription Drug Program.

The statute that authorizes the Colorado Cares Prescription Drug Program states that the Department is expected to use registration fees collected from program participants to reimburse the State for any expenditures incurred to develop the program. However, since this request seeks to use this funding to implement SB 07-211 Presumptive Eligibility for Children, for which no revenues will be generated as a result of the changes, the Department requests it be granted the use of a portion of the $66,000 in General Fund Exempt without the requirement to pay it back. In total, the Department is requesting $45,929 in General Funds Exempt from this roll-forward to pay for the Department’s and the Department of Human Services’ portion of State costs associated with these changes. The Department is, however, requesting additional federal funds in the Colorado Benefits

Management System appropriation. This is because the Department is requesting that the portion of funding from SB 07-001, which was State-only funding when it was appropriated initially, receive the federal match as calculated by the Colorado Benefits Management System calculator. The tables in the "Calculations for Request" show how the Department anticipates funding these changes.

The Department is only requesting to use a portion of the Colorado Cares Prescription Drug Program roll-forward because of the way the Colorado Benefits Management System is financed. Currently, the Department of Human Services and the Department use the federally approved Colorado Benefits Management System calculator to allocate costs for the Colorado Benefits Management System. The calculator computes the State General Fund and Cash Funds Exempt portion of all costs for both departments, as well as the amount of federal funds that can be drawn down.

Due to the fact that the State's portion of funding is coming from roll-forwards that were already appropriated in FY 06-07, the Department cannot reflect the movement of those funds from an appropriation within the budget. This is due to the fact that roll-forward expenditures are recorded in the fiscal year after they were appropriated in an off-budget line item. Therefore, the Schedule 13 does not reflect the removal of funding from the Colorado Cares Prescription Drug Program – Colorado Benefits Management System Contract line item, which is where the $66,000 was originally appropriated. The situation with the roll-forwards has been discussed with the State Controller's Office.

Consequences if Not Funded:

If this request is not funded, the Department will not be able to pay for the changes required by SB 07-211 and will need to seek additional funding sources. In addition, the Department will not be able to meet the January 1, 2008 deadline for presumptive eligibility for children implementation set forth by SB 07-211.

Calculations for Request:

	Table 1: Funding Sources for Presumptive Eligibility Changes	
		Total Funds FY 07-08
A	**Estimated Cost**	**$304,204**
B	Current Appropriation for Presumptive Eligibility Changes	$59,600
C	**Funding Shortage and Total Need (A - B)**	**$244,604**
D	Funding Available from the Deficit Reduction Act and HB 06S-1023 Roll-Forward	$135,400
E	**Total Financed Through the Colorado Benefits Management System Calculator (C - D)**	**$109,204**

	Table 2: Colorado Benefits Management System Calculator Split of Total Need	
		Total Funds FY 07-08
F	**Department of Human Services Portion (G + H + I)**	**$71,300**
G	General Fund	$17,140
H	Cash Funds	$8,764
I	Federal Funds	$45,396
J	**Department of Health Care Policy and Financing Portion (K + L + M)**	**$37,904**
K	General Fund	$17,757
L	Cash Funds Exempt	$2,268
M	Federal Funds (Only amount of new funding requested for HCPF)	$17,879
N	**Total Estimated Need (F + J)**	**$109,204**
O	General Funds Exempt* (G + H + K + L)	$45,929
P	Federal Funds** (I + M)	$63,275

* From the Colorado Cares Prescription Drug Program roll-forward because the funding is available and otherwise unused. The unused General fund from the Colorado Cares Prescription Drug Program will be sufficient to the needed General Fund, Cash Funds, and Cash Funds Exempt usually identified as needed through the Colorado Benefits Management System calculator.

** The Department needs to request additional federal funding because the initial Colorado Cares Prescription Drug Program appropriation was State-only.

Assumptions for Calculations:

Table 1: The Department has assumed the estimate provided by Electronic Data Systems represents the final cost the Department should expect to pay for the Colorado Benefits Management System changes required to implement presumptive eligibility for children.

Table 2: The Department has used the Colorado Benefits Management System calculator to calculate the fund splits between the Department and the Department of Human Services. However, due to the nature of this request, the Department has taken the sum of all State-portion funds (General Fund, Cash Funds, and Cash Funds Exempt) and assumed that their source of funding will be General Funds Exempt from the Colorado Cares Prescription Drug Program roll-forward.

The Department has not provided a break-out of the funds from the Deficit Reduction Act and HB 06S-1023 roll-forward because the appropriation is already financed through the Colorado Benefits Management System calculator.

Impact on Other Government Agencies:

This request does have an impact on the Department of Human Services, as the request funds their portion of the associated costs with money already appropriated to the Department.

Cost Benefit Analysis:

Additional Financing for SB 07-211 Changes	
Cost	**Benefit**
$0 General Fund,	This request would allow the Department to implement presumptive eligibility for children in the Colorado Benefits Management System, as mandated by SB 07-211. In addition, the Department would be able to serve its potential Medicaid clients with greater speed and efficacy.

Implementation Schedule:

Task	**Month/Year**
Requirements Analysis and Design	June 1, 2007
Program Development	September 27, 2007
Testing	December 12, 2007
Presumptive Eligibility User ID Setup	December 28, 2007
Presumptive Eligibility in Colorado Benefits Management System Implementation	January 18, 2007

Statutory and Federal Authority: 25.5-4-205. C.R.S (2007) Application - verification of eligibility - demonstration project - rules - repeal.

(1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a

hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f), C.R.S., and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. When the state department determines that it is necessary to designate an additional medical assistance site, the state department shall notify the county in which the medical assistance site is located that an additional medical assistance site has been designated. Any person who is determined to be eligible pursuant to the requirements of this article and articles 5 and 6 of this title shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefor. Separate determination of eligibility and formal application for benefits under this article and articles 5 and 6 of this title for persons eligible as provided in sections 25.5-5-101 and 25.5-5-201 shall be made in accordance with the rules of the state department.

Performance Measures: Improve access to health care, increase health outcomes and provide more cost effective services using information technology.

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:	Implement Preferred Drug List			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-9, BA-3	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	2,078,238,408	2,166,131,395	422,556	2,166,553,951	2,168,136,894	(793,091)	2,167,343,803	(50,579)	2,167,293,224	(1,660,782)
	FTE	225.36	245.30	0.00	245.30	259.50	0.00	259.50	1.00	260.50	1.00
	GF	640,133,131	660,343,757	287,314	660,631,071	659,986,498	(320,510)	659,665,988	(90,043)	659,575,945	(775,939)
	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	193,146	0	193,146	216,481	0	216,481	0	216,481	0
	CFE	49,269,455	76,615,475	0	76,615,475	78,958,391	0	78,958,391	0	78,958,391	0
	FF	1,045,735,822	1,085,079,017	135,242	1,085,214,259	1,085,037,268	(472,581)	1,084,564,687	39,464	1,084,604,151	(884,843)
(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	35,114	18,895,857	38,497
	FTE	225.4	245.3	0.0	245.3	259.5	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	17,557	7,786,210	19,249
	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	17,557	8,775,771	19,248
(1) Executive Director's Office SB 04-257 Amortization Equalization Disbursement	**Total**	93,197	178,339	0	178,339	243,206	0	243,206	51	243,257	56
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	41,256	76,448	0	76,448	108,110	0	108,110	26	108,136	28
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	2,092	5,855	0	5,855	12,070	0	12,070	0	12,070	0
	FF	49,849	96,036	0	96,036	123,026	0	123,026	25	123,051	28

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:	Implement Preferred Drug List			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-9, BA-3	**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 Supplemental Amortization Equalization Disbursement	Total	0	34,950	0	34,950	77,872	0	77,872	236	78,108	193
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	13,722	0	13,722	34,615	0	34,615	118	34,733	97
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	1,220	0	1,220	3,866	0	3,866	0	3,866	0
	FF	0	20,008	0	20,008	39,391	0	39,391	118	39,509	96
(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	4,365	1,028,305	950
	FTE	0.0	0.0	0.0	0.0	0.0	0.00	0.00	0.00	0.00	0.00
	GF	586,457	494,229	0	494,229	486,342	0	486,342	2,183	488,525	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	2,182	508,887	475
(1) Executive Director's Office Drug Utilization Review	Total	291,438	304,143	(61,000)	243,143	304,143	0	304,143	79,020	383,163	(93,660)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	72,859	76,036	45,536	121,572	76,036	76,036	152,072	(25,245)	126,827	7,621
	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	218,579	228,107	(106,536)	121,571	228,107	(76,036)	152,071	104,265	256,336	(101,281)

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:	Implement Preferred Drug List									
Department:	Health Care Policy and Financing			**Dept. Approval by:**		John Bartholomew		**Date:**	January 2, 2008	
Priority Number:	S-9, BA-3			**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	483,556	2,148,342,464	2,147,626,990	(793,091)	2,146,833,899	(169,365)	2,146,664,534	(1,606,818)
	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	241,778	652,663,278	651,512,742	(396,546)	651,116,196	(84,682)	651,031,514	(803,409)
	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	0	0	0	0	0	0
	CFE	48,860,206	76,001,368	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	241,778	1,075,739,562	1,075,381,825	(396,545)	1,074,985,280	(84,683)	1,074,900,597	(803,409)
Letternote revised text:											
Cash Fund name/number, Federal Fund Grant name:				FF: Title XIX							
IT Request: ☐ **Yes** ☑ **No**											
Request Affects Other Departments: ☐ **Yes** ☑ **No**				**If Yes, List Other Departments Here:**							

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-9, BA-3
Change Request Title:	Implement Preferred Drug List

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:

This FY 07-08 supplemental request is for $422,556 total funds to correct the federal match rate for the Executive Director's Office, Drug Utilization Review line and to restate the savings estimate for prescription drug expenditures in the Medical Services Premiums line. This correction would adjust the line from a 75% federal match rate to a 50% federal match rate for all administrative services. In addition, the Department would like to make a budget amendment to the FY 08-09 base reduction request and replace the preferred drug list contract with the Drug Effectiveness Review Project and 1.0 FTE Program Assistant I. This would cause an incremental decrease of $50,579 total funds and a reduction of $90,043 in General Fund from the Base Reduction Item located in the FY 08-09 Budget Request, November 1, 2007. The net result would be a reduction of $843,670.

Background and Appropriation History:

In January 2007, Governor Ritter signed Executive Order D 004 07 establishing a preferred drug list for Colorado's Medicaid program. The purpose of this program is to provide needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This Executive Order gives the Department the authority to implement a

preferred drug list after evaluating various methods of implementation and determining the best option for Colorado. In addition, the Department is responsible for forming a Pharmacy and Therapeutics Committee responsible for evaluating clinical data and evidence on all drugs under consideration for inclusion in the preferred drug list. The Department will also evaluate and pursue supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.

As proposed under SB 05-022, a 15-member Pharmacy and Therapeutics Committee would have been created to "use an evidence-based research approach to review and recommend drugs for inclusion on a preferred drug list for Medicaid recipients and specifies the factors the committee should use in reviewing and recommending drugs for the PDL" (Legislative Council Fiscal Note for SB 05-022, May 3, 2005, page 1). The fiscal note assumed that the Department would be able to obtain evidenced-based research from other states at no additional cost.

Description of Current Preferred Drug List Resources Appropriated:

In FY 07-08, the Department was appropriated funds for 3.0 FTE and $194,877 for Personal Services and Operating Expenses. This appropriation was obtained by the JBC staff from the Legislative Council's May 3, 2005 fiscal note for SB 05-022. The justification for these positions was "…to provide the professional expertise required to create the [preferred drug list]… and to provide general support to the committee" (Figure Setting, February 14, 2007, page 14). While this bill failed during the second House reading, it provided the basis for the JBC action related to the Executive Order. In addition, $340,880 was appropriated for Medicaid Management Information System changes, (Figure Setting, March 8, 2007, page 105), and $670,376 was removed from the Department's appropriation for Medical Services Premiums to reflect six months of expected savings in drug costs for FY 07-08 (Figure Setting, March 8, 2007, page 52).

FTE

The Department received $48,720 for 3.0 FTE for one quarter of a year beginning in FY 06-07. In FY 07-08, the Department received $194,877 for 3.0 FTE. The appropriated FTE includes a Pharmacist III, a General Professional III and a Statistical Analyst III. These FTE would remain within the Department to run the program, manage the preferred drug list contract and to implement supplemental rebates. As a result of the adjustments to the scope of work, the Department changed the classification for these FTE. The FTE include a General Professional V, a Pharmacist II and a Rate and Financial Analyst II. The Department will retain many of the responsibilities of administering the preferred drug list. Specific duties for the 3.0 FTE are provided below.

The Preferred Drug List Coordinator (General Professional V) would be responsible for:

- Completing the procurement process, selecting the preferred drug list contractor, and managing and overseeing performance of the contract;
- Overseeing implementation of the Medicaid rules for the preferred drug list and the Pharmacy and Therapeutic Committee;
- Submitting the State Plan amendment to the Centers for Medicare and Medicaid Services and monitoring the preferred drug list program to assure compliance with federal regulations;
- Reviewing contractor analysis of Medicaid drug utilization data, average daily drug costs and methodologies for determining the cost effectiveness of drug classes;
- Overseeing the supplemental rebate process including solicitation of bids from drug manufacturers and negotiating and managing the supplemental rebate contracts, and;
- Assisting with the selection and appointment of Pharmacy and Therapeutic Committee members.

The Preferred Drug List Pharmacist (Pharmacist II) would be responsible for:

- Acting as point of contact for all clinical questions/issues for providers, drug manufacturers, advocacy groups, Medicaid stakeholders, and Pharmacy and Therapeutic Committee members;

- Reviewing quality of analysis provided by the preferred drug list contractor before making recommendations on which drugs should be considered for inclusion on the preferred drug list;
- Attending Pharmacy and Therapeutic Committee meetings;
- Reviewing systems requirements for program implementation including the Prescription Drug Card System, customer service requests and prior authorization criteria, and;
- Performing provider outreach and education, draft related documents.

The Preferred Drug List Rate and Financial Analyst II would be responsible for:

- Performing pharmaeconomic analysis of drug classes and categories;
- Developing decision support methodologies for determining the cost-effectiveness of drugs;
- Performing post-implementation analysis of the cost-effectiveness of the preferred drug class implementation;
- Analyzing and making recommendations on current pharmacy rates and reimbursement methodologies, and;
- Performing cost savings analysis related to prior authorizations.

Medicaid Management Information System

The Department received $340,880 for preferred drug list costs related to the Medicaid Management Information System in FY 07-08. This includes $290,000 for processing prior authorizations and $50,880 for ongoing maintenance costs. Prior authorizations will be required for all clients requiring non-preferred drugs. In FY 07-08, drug prior authorizations became part of the fixed price contract and as a result, the contractor, ACS, is obligated to handle all prior authorizations up to the cap set by the contract. Significant increases will cause the non-preferred drug list prior authorizations to exceed the cap. Until the fixed price contract can be renegotiated, the Department will be required to pay a per unit cost between $10 and $12. As a result, the Department expects to spend the entire $290,000 appropriated for this purpose. In addition, system revisions will be necessary as additional drug classes are added to the preferred drug list. As a result of

these updates, the Department will fully expend the $50,880 appropriated for Medicaid Management Information System maintenance.

Further, $170,371 in one-time system costs funding was added in FY 06-07 to make Medicaid Management Information System development changes. These include changes to the formulary, plan file, and edit changes needed for all drugs affected by this implementation. System changes were not implemented by the close of FY 06-07 and the Department has received rollforward authority to spend these moneys in FY 07-08.

Documented Quote, Preferred Drug List Contractor FY 07-08

Implementation of the Executive Order in a timely manner required a documented quote[1] in FY 07-08. This allowed the Department to move forward with the implementation process with a temporary contractor. The temporary contractor also allowed the Department to research long term implementation options. This contract will begin in October 2007 and will end in June 2008; the total cost is $119,000. The Department will fund the FY 07-08 preferred drug list contractor through the Drug Utilization Review line item.

The Department ended a contract with the Business Research Division of the Leeds School of Business at the University of Colorado for drug utilization review at the end of FY 06-07 and used the $180,000 in funding for the preferred drug list contractor. Many of these same services would be required of the contractor to implement a preferred drug list in addition to providing evidence based research for clinical data which the Business Research Division was unable to provide. Rather than pay two separate drug utilization review contractors to provide duplicative services, this alternative would utilize the existing funding to provide a broader range of services.

[1] A documented quote is an abbreviated procurement process for soliciting bids for contracts between $25,000 and $150,000. The documented quote is required to be posted for a minimum of 3 working days rather than the 30 days required for an RFP. Documented quotes and RFPs both have a one year limit with the option to renew up to 4 additional years. The $150,000 limit for a documented quote applies to the full duration of the contract including renewals.

Implementation of the preferred drug list requires the contractor to have access to a comprehensive clinical database providing information including: peer reviewed medical literature, established clinical practice guidelines and Medicaid drug utilization data. Further, the contractor must be able to use flexible evaluation criteria in order to evaluate different scenarios under a preferred drug list. Implementation also requires the ability to analyze the clinical data and Medicaid drug utilization data using a decision support system. The Department does not currently have the resources in place to provide these services and would not be able to implement the preferred drug list in a timely fashion without the expertise of a contractor.

In addition, the contractor is responsible for analyzing claims data from the Medicaid Management Information System to provide utilization reporting specific to Colorado. This requires a support system to store monthly claims data provided by the Department and historical claims data starting 18 months prior to the start of the program. With an April 1, 2008 start date, this will require the contractor to maintain claims data from October 1, 2006.

The contractor is responsible for planning and management of committee meetings. The Department would require the contractor to retain a dedicated clinical manager that is either a Registered Pharmacist or a Doctor of Pharmacy and is licensed in the State of Colorado. The contractor is responsible for attending all committee meetings, planning meeting logistics, developing an agenda, compiling informational packets on clinical and Medicaid utilization data, distributing necessary materials, and drafting meeting minutes.

The contractor is implementing the first six drug classes including three drug classes to be added April 1, 2008 and three drug classes to be added July 1, 2008. The Department is working on three drug classes for implementation on April 1, 2008 including proton pump inhibitors (PPIs); sedatives and hypnotics; and statins. Proton pump inhibitors are prescribed for stomach problems and include drugs such as Nexium, Prevacid and Prilosec. Sedatives and hypnotics include drugs such as Lunesta, Ambien CR and Sonata. The statins drug class includes drugs that lower the level of cholesterol in the blood and include drugs such as Lipitor, Crestor and Zocor. The Department is still looking into the

third drug class for implementation on April 1, 2008. The Department will determine additional drug classes to add to the preferred drug list on July 1, 2008, after receiving recommendations from the Pharmacy and Therapeutics Committee and the preferred drug list contractor.

General Description of Request: This supplemental request is for $422,556 total funds in FY 06-07 for the Department to correct fund splits for the Executive Director's Office, Drug Utilization Review line and update the savings estimate for the program. In addition, the total FY 08-09 Department request is a reduction in total funds of $843,670 to replace the preferred drug list contractor with clinical data from the Drug Effectiveness Review Project (DERP) and 1.0 FTE Program Assistant I. This is an incremental decrease of $50,579 total funds from the Base Reduction Item located in the FY 08-09 Budget Request, November 1, 2007.

Drug Utilization Review Line Item, FY 07-08 Supplemental Request

Currently, the Executive Director's Office, Drug Utilization Review line item assumes a federal match rate of 75%. During the implementation of the preferred drug list, the Department determined that drug utilization review should receive a federal match rate of 50% for all administrative services. Under 42 CFR 456.719, it states that, "[Federal Funds Participation] is available…for the Statewide adoption of a [Drug Utilization Review] program...for funds expended by the State after December 31, 1993, at the rate of 50 percent." Services for clinical review in the Executive Director's Office, Drug Utilization Review line would retain a match rate of 75%. This is based on 42 CFR Section 432.50(d)(2) which states that funding for clinical services "The rate of 75 percent FFP is available for staff [skilled professional medical personnel and directly supporting staff] of other public agencies if the requirements specified in paragraph (d)(1)[2] of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met."

Based on these federal citations, the Department would require an additional $45,536 in General Fund to offset the change from the 75% federal match rate to the 50% federal

[2] Requirements specified in 42 CRR Section 432.50(d)(1) can be found in the section "Statute and Federal Authority".

match rate. This would include all four programs to be paid out of the line including the new preferred drug list contractor, the drug utilization review contract with Health Information Design, Inc., the Thomson Micromedex contract and a new pharmacist incentive payment. The pharmacist incentive payment is a new appropriation to the Executive Director's Office, Drug Utilization Review line beginning in FY 07-08. Calculations for this adjustment are available in Table 3 in the Calculations for Request section of this request.

Savings Estimate, FY 07-08 Supplemental Request

The Department originally estimated savings of $670,376 for 6 months and $1,340,752 for 12 months from FY 03-04 pharmaceutical data for Legislative Council's May 3, 2005 fiscal note for SB 05-022. This estimate was used to calculate the appropriation received by the Department during Figure Setting for FY 07-08 (Figure Setting, February 14, 2007, pages 14-15). This estimate was updated using FY 06-07 data due to legislative changes impacting pharmacy expenditures including the impact of the Medicare Modernization Act of 2003. The Department will implement 3 to 4 drug classes quarterly, for a total of 14 drug classes by the end of FY 08-09. Further, the savings estimate was revised to account for the staggered drug class implementation dates and inflation due to the anticipated increase in drug utilization across fiscal years. As a result, the Department estimates a total potential savings of $2,490,956 in FY 07-08. This calculation is available in Table 8 in the Calculations for Request section.

The total potential savings is then discounted based on the number of drug classes implemented and total number of months of implementation. As a result, the Department estimates a total drug savings of $186,820 in FY 07-08. This is $483,556 less than the savings applied to the Medical Services Premiums line during the February 14, 2007 Figure Setting.

The Drug Effectiveness Review Project (DERP) Benefits, FY 08-09 Budget Amendment

In FY 08-09, the Department requests an incremental decrease of $50,579 in total funds and a decrease of $90,043 in General Fund, to purchase clinical data from the Drug Effectiveness Review Project and correct the fund splits for all other contracts in the Executive Director's Office, Drug Utilization Review line. Participating in the Drug Effectiveness Review Project would allow the Department to obtain a 75% federal match rate for these services. This would replace the preferred drug list contractor services obtained in FY 07-08 to collect and provide reports on clinical data receiving a 50% federal match rate. Currently, the Department's FY 08-09 Budget Request, November 1, 2007 has $180,000 total funds, $45,000 General Fund, for preferred drug list contractor services prior to correcting for the 50% federal match (Please see Table 5).

The Drug Effectiveness Review Project is a collaboration of organizations, including 13 states, which compile the best available clinical evidence on prescription drug effectiveness and safety by drug class. Clinical reports on drug classes go through a rigorous process using a series of comprehensive, up-to-date and unbiased reviews conducted by evidence based practice centers (EPCs). The results of this research are used to make informed decisions in public policy. Participating entities provide equal financing to the project and participate in the operation through a self-governing process. In addition, the Drug Effectiveness Review Project provides technical assistance within the review process, ensures that timelines are met and manages communications with pharmaceutical companies.

The Drug Effectiveness Review Project is based on a three year program. The project is in the second year of the program in FY 07-08. Starting in FY 08-09 the project will begin the third year of the program. The Department would join the project in the last year but would have to pay the full three year cost of $259,020. The Department would not receive a prorated fee as it would still receive all proprietary reports created by the project over the course of the first and second phase in addition to all newly created

documents. This includes a total of 36 original reports, 70 updated reports, 11 journal articles and 13 pharmacy and therapeutic committee reports. This would allow the Department to provide a more comprehensive list of drug classes to the Pharmacy and Therapeutics Committee when deciding which drug classes to pursue. Beginning July 1, 2009 the Department would pay approximately the same membership fee for the following three years, through June 30, 2012. This would annualize to $86,340 total funds and $21,585 General Fund per year. (Please see Table 6.)

The Drug Effectiveness Review Project provides several benefits over the Department's current preferred drug list contractor. The Department currently receives summary reports collected from existing information and studies. These reports are produced at the request of the Department and are not immediately available for review. The Drug Effectiveness Review Project works directly with evidence based practice centers and pharmaceutical companies and has a large body of already published work that would be available to the Department upon joining. The Department received a sample report for a drug class currently under consideration. The Department pharmacist performed a comparison of this report and the report provided by the current preferred drug list contractor and determined that the Drug Effectiveness Review Project provided more comprehensive and scientifically rigorous clinical reports.

The project produces reports that are well known and widely accepted by policy makers to make decisions on drug classes to add to preferred drug lists. In addition, due to the self-governing process, the Department would directly participate in the development of criteria to guide the drug class reviews, help in the development of key questions, participate in the selection of the drug classes for study and provide feedback on draft reports.

Based on the structure of the Drug Effectiveness Review Project, the Department would receive a 75% federal match rate for these clinical services. This is based on 42 CFR Section 432.50(d) which states "Staff of other public agencies means skilled professional medical personnel and directly supporting staff who are employed in State or local

agencies other than the Medicaid agency who perform duties that directly relate to the administration of the Medicaid program."

Preferred Drug List Program Assistant I FTE Responsibilities, FY 08-09 Budget Amendment

Under this alternative, the Department would hire a Program Assistant I to provide support services to the Pharmacy and Therapeutics Committee beginning in FY 08-09 for 11 months. This would require $39,766 in total funds for FY 08-09; $35,114 for the Executive Director's Office, Personal Services line; $51 for the Executive Director's Office, SB 04-257 Amortization Equalization Disbursement; $236 for the Executive Director's Office, Supplemental Amortization Equalization Disbursement and $4,365 for the Executive Director's Office, Operating Expenses line. The 1.0 FTE would replace services currently provided by the preferred drug list contractor related to planning and management of the Pharmacy and Therapeutics Committee meetings. The total cost of maintaining an administrative contract would require significantly more resources then providing these duties within the Department. Responsibilities would include attending all committee meetings, planning meeting logistics, developing an agenda, compiling informational packets on clinical and Medicaid utilization data, distributing necessary materials, and drafting meeting minutes. In addition, the Program Assistant I would support to the pharmacy section to provide clerical, administrative and office assistance.

The combination of the Drug Effectiveness Review Project and the 1.0 FTE would provide a higher quality product at a lower cost starting in FY 09-10. The preferred drug list contractor would annualize to $158,667 in total funds and $79,333 in General Fund. In comparison, the Drug Effectiveness Review Project and FTE would annualize to $125,940 in total funds and 41,385 in General Fund. This is $32,727 less in total funds and $37,948 in General Fund for the Drug Effectiveness Review Project and 1.0 FTE for a more comprehensive and higher quality product. (Please refer to Table 7 for calculations.)

Savings Estimate, FY 08-09 Budget Amendment

The Department assumes that the Drug Effectiveness Review Project (DERP) would impact the savings estimate as a result of additional implementation and cost efficiencies related to this product. Utilization of this product would allow the Department to add an additional two drug classes for a total of 14 drug classes and increase the number of drug classes implemented in FY 08-09 from 9 to 11. The source of this change would be 36 original reports and 70 updated reports that the Department would receive after enrollment with the Drug Effectiveness Review Project (DERP). As a result, the Department estimates a total potential savings of $2,709,661 in FY 08-09 (Please see Table 8.)

The total potential savings is then discounted based on the number of drug classes implemented and total number of months of implementation. As a result, the Department estimates a total drug savings of $2,303,208 in FY 08-09. This is $962,456 more than the savings applied to the Medical Services Premiums line during the February 14, 2007 Figure Setting and $169,365 more than the FY 08-09 Budget Request, November 1, 2007 Base Reduction Item 2. Calculations are available in Table 9 of the Calculations of Request section.

Consequences if Not Funded:

If the Department did not receive funding for the FY 07-08 supplemental request, the Executive Director's Office, Drug Utilization Review line would continue to operate at the 75% federal match rate. This would be non-compliant with federal regulation and would be susceptible to federal audits and disallowance of funding. In addition the savings estimate would remain at $670,376 which is $483,556 higher than the revised savings estimate of $186,820 based on implementation dates of drug classes.

If the Department did not receive funding for the FY 08-09 budget amendment, clinical data would continue to come from a preferred drug list contractor. The Department assumes that drug classes and savings estimates would remain the same but that lower

quality and greater limitations in the data would be used to provide drug classes results to the Pharmacy and Therapeutics Committee for review. Using a less established and trusted data source could open the Department up to litigation, particularly for potentially contentious drug classes.

In addition, the Department would implement fewer drug classes with the preferred drug list contractor than the Drug Effectiveness Review Project (DERP) in FY 08-09; 12 drug classes would be implemented rather than 14 drug classes. This would decrease the savings by $169,365 in FY 08-09 and $294,777 FY 09-10.

Calculations for Request:

Table 1: Summary of Request FY 07-08

Summary of Request FY 07-08	Total Funds	General Fund	Federal Funds
Total Request	**$422,556**	**$287,314**	**$135,242**
FY 08-09 Executive Director's Office, Drug Utilization Review Request (Column 3)	($61,000)	$45,536	($106,536)
FY 08-09 Medical Services Premiums (Column 3)	$483,556	$241,778	$241,778

Table 2: Summary of Request FY 08-09

Summary of Request FY 08-09	Total Funds	General Fund	Federal Funds
Total Request	**($50,579)**	**($90,043)**	**$39,464**
(1) Executive Director's Office, Personal Services (Column 8)	$35,114	$17,557	$17,557
(1) Executive Director's Office, SB 04-257 Amortization Equalization Disbursement (Column 8)	$51	$26	$25
(1) Executive Director's Office, Supplemental Amortization Equalization Disbursement (Column 8)	$236	$118	$118
(1) Executive Director's Office, Operating Expenses (Column 8)	$4,365	$2,183	$2,182
(1) Executive Director's Office, Drug Utilization Review Request (Column 8)	$79,020	($25,245)	$104,265
(2) Medical Services Premiums (Column 8)	($169,365)	($84,682)	($84,683)

Table 3: Summary of Request FY 09-10

Summary of Request FY 09-10	Total Funds	General Fund	Federal Funds
Total Request	**($1,660,782)**	**($775,939)**	**($884,843)**
(1) Executive Director's Office, Personal Services (Column 10)	$38,497	$19,249	$19,248
(1) Executive Director's Office, SB 04-257 Amortization Equalization Disbursement (Column 10)	$56	$28	$28
(1) Executive Director's Office, Supplemental Amortization Equalization Disbursement (Column 10)	$193	$97	$96
(1) Executive Director's Office, Operating Expenses (Column 10)	$950	$475	$475
(1) Executive Director's Office, Drug Utilization Review Request (Column 10)	($93,660)	$7,621	($101,281)
(2) Medical Services Premiums (Column 10)	($1,606,818)	($803,409)	($803,409)

Table 4: Summary of Changes to the Executive Director's Office, Drug Utilization Review Line FY 07-08

Row	Summary of Request FY 07-08, Executive Director's Office, Drug Utilization Review Line	Total Funds	General Fund	Federal Funds	Description
A	FY 07-08 Business Research Division of the University of Colorado at Boulder	$180,000	$45,000	$135,000	Previous contract amount for drug utilization review services provided by the Business Research Division of the University of Colorado at Boulder
B	FY 07-08 Health Information Design Contract	$99,840	$24,960	$74,880	Current Health Information Design drug utilization contract
C	FY 07-08 Thomson Micromedex Contract	$7,353	$1,838	$5,515	Current Micromedex contract
D	FY 07-08 Pharmacist Incentive Payment	$16,950	$4,238	$12,712	HB 07-1021
E	**FY 07-08 Executive Director's Office, Drug Utilization Review**	**$304,143**	**$76,036**	**$228,107**	**Row A + Row B + Row C + Row D (FY 07-08 Appropriation, SB 07-239, Long Bill and HB 07-1021)**
F	FY 07-08 Health Information Design Contract	$107,193	$53,597	$53,596	Adjusted Health Information Design drug utilization contract
G	FY 07-08 Pharmacist Incentive Payment	$16,950	$8,475	$8,475	Adjusted Federal Match Rate from HB 07-1021
H	FY 07-08 Preferred Drug List Contract	$119,000	$59,500	$59,500	Requested preferred drug list contract
I	**Estimated FY 07-08 Executive Director's Office, Drug Utilization Review**	**$243,143**	**$121,572**	**$121,571**	**Row F + Row G + Row H**
J	**FY 07-08 Fiscal Impact**	**($61,000)**	**$45,536**	**($106,536)**	**Row I - Row E**

Table 5: Summary of Changes to the Executive Director's Office, Drug Utilization Review Line FY 08-09

Row	Summary of Request FY 08-09	Total Funds	General Fund	Federal Funds	Description
A	FY 07-08 Business Research Division of the University of Colorado at Boulder	$180,000	$45,000	$135,000	Previous contract amount for drug utilization review services provided by the Business Research Division of the University of Colorado at Boulder
B	FY 07-08 Health Information Design Contract	$99,840	$24,960	$74,880	Current Health Information Design drug utilization contract
C	FY 07-08 Thomson Micromedex Contract	$7,353	$1,838	$5,515	Current Micromedex contract
D	FY 07-08 Pharmacist Incentive Payment	$16,950	$4,238	$12,712	HB 07-1021
E	**FY 07-08 Executive Director's Office, Drug Utilization Review**	**$304,143**	**$76,036**	**$228,107**	**Row A + Row B + Row C + Row D (FY 07-08 Appropriation, SB 07-239, Long Bill and HB 07-1021)**
F	FY 08-09 Health Information Design Contract	$99,840	$49,920	$49,920	Adjusted Health Information Design drug utilization contract
G	FY 07-08 Thomson Micromedex Contract	$7,353	$3,677	$3,676	Current Micromedex contract
H	FY 08-09 Pharmacist Incentive Payment	$16,950	$8,475	$8,475	Adjusted Federal Match Rate from HB 07-1021
I	FY 08-09 Drug Effectiveness Review Project (DERP)	$259,020	$64,755	$194,265	Requested preferred drug list contract
J	**Estimated FY 08-09 Executive Director's Office, Drug Utilization Review**	**$383,163**	**$126,827**	**$256,336**	**Row F + Row G + Row H + Row I**
K	**Difference Between the FY 07-08 Drug Utilization Review Funding and the FY 08-09 Funding**	**$79,020**	**$50,791**	**$28,229**	**Row J - Row E**

Table 6: Summary of Changes to the Executive Director's Office, Drug Utilization Review Line FY 09-10

Row	Summary of FY 09-10	Total Funds	General Fund	Federal Funds	Description
A	**FY 07-08 Executive Director's Office, Drug Utilization Review**	**$304,143**	**$76,036**	**$228,107**	Table 5, Row E
B	FY 07-08 Health Information Design Contract	$99,840	$49,920	$49,920	Adjusted Health Information Design drug utilization contract
C	FY 07-08 Thomson Micromedex Contract	$7,353	$3,677	$3,676	Current Micromedex contract
D	FY 08-09 Pharmacist Incentive Payment	$16,950	$8,475	$8,475	Adjusted Federal Match Rate from HB 07-1021
E	Evidence Based Policy Research (DERP), Phase III Estimated 3 Year Cost	$259,020	$64,755	$194,265	Phase II Evidence Based Policy Research (DERP) Contract
F	Number of Years in Evidence Based Policy Research (DERP) Contract	3	3	3	Phase II Evidence Based Policy Research (DERP) Contract
G	FY 09-10 Evidence Based Policy Research (DERP), Phase III Estimated Annual Appropriation	$86,340	$21,585	$64,755	Row E / Row F
H	**Estimated FY 09-10 Executive Director's Office, Drug Utilization Review line**	**$210,483**	**$83,657**	**$126,826**	**Row B + Row C + Row D + Row G**
I	**Difference Between the FY 07-08 Drug Utilization Review Funding and the Annualized FY 09-10 Funding**	**($93,660)**	**$7,621**	**($101,281)**	**Row H - Row A**

Table 7: Comparison of the Drug Effectiveness Review Project and the Preferred Drug List Contractor FY 09-10

Row	Summary of FY 09-10	Total Funds	General Fund	Federal Funds	Description
A	FY 09-10 Drug Effectiveness Review Project (DERP)	$86,340	$21,585	$64,755	Row E / Row F
B	Program Assistant, 1.0 FTE Executive Director's Office, Personal Services	$38,497	$19,249	$19,248	Budget Amendment Request
B.1	Program Assistant, 1.0 FTE Executive Director's Office, SB 04-257 Amortization Equalization Disbursement	$56	$28	$28	Budget Amendment Request
B.2	Program Assistant, 1.0 FTE Executive Director's Office, Supplemental Amortization Equalization Disbursement	$193	$97	$96	Budget Amendment Request
C	Program Assistant, 1.0 FTE Executive Director's Office, Operating Expenses	$950	$475	$475	Budget Amendment Request
D	**Total Cost of the Drug Effectiveness Review Project and 1.0 FTE**	**$126,036**	**$41,434**	**$84,602**	**Row A + Row B + Row C**
E	FY 07-08 Preferred Drug List Contractor Costs	$119,000	$59,500	$59,500	Phase II Evidence Based Policy Research (DERP) Contract
F	Number of Months in Preferred Drug List Contractor FY 07-08 Contract	9	9	9	Preferred Drug List Contract
G	Number of Months in Preferred Drug List Contractor FY 08-09 Contract	12	12	12	Annual Preferred Drug List Contract
H	**Total Cost of the Preferred Drug List Contract FY 09-10**	**$158,667**	**$79,333**	**$79,333**	**Row E / Row F * Row G**
I	**Difference Between the Drug Effectiveness Review Project with 1.0 FTE and the Preferred Drug List Contract**	**($32,631)**	**($37,899)**	**$5,269**	**Row D - Row H**

Table 8: Medical Services Premiums, Estimated Drug Savings

Row	Item	Total Funds	Description
A	Total Drug Expenditures FY 06-07	$190,166,972	Cash based actual expenditures for FY 06-07
B	Excluded Drug Class Expenditures FY 06-07	$52,730,213	Cash based actual expenditures for FY 06-07
C	Estimated Drug Rebates	($55,000,908)	Three quarters of actual FY 06-07 rebates plus one quarter of estimated rebates
D	Total Fee-For-Service Expenditures	$82,435,851	Row A - Row B + Row C
E	Estimated Savings	2.78%	Based on Michigan actual preferred drug list savings FY 03-04 (Rounded to two decimal places)
F	**Potential Savings Estimate FY 06-07**	**$2,289,903**	**Round(Row D x Row E,0)**
G	Estimated Drug Savings Inflator	8.78%	Assumptions for Calculations
H	**Potential Savings Estimate FY 07-08**	**$2,490,956**	**Round(Row F x (1 + Row G),0)**
I	**Potential Savings Estimate FY 08-09**	**$2,709,662**	**Round(Row H x (1 + Row G),0)**
J	**Potential Savings Estimate FY 09-10**	**$2,947,570**	**Round(Row I x (1 + Row G),0)**

Table 9: Medical Services Premiums, Estimated Drug Savings, Drug Class Savings by Implementation Date

Row	Item	FY 07-08	FY 08-09	FY 09-10	Description
A	Savings from Drug Classes Implemented April 1, 2008	$186,820	$812,893	$884,264	See Appendix 2
B	Savings from Drug Classes Implemented July 1, 2008	$0	$812,893	$884,264	See Appendix 3
C	Savings from Drug Classes Implemented October 1, 2008	$0	$406,454	$589,521	See Appendix 4
D	Savings from Drug Classes Implemented January 1, 2009	$0	$270,969	$589,521	See Appendix 5
E	**Total Estimated Drug Savings**	**$186,820**	**$2,303,208**	**$2,947,570**	Row A + Row B + Row C + Row D
F	2007 Figure Setting Savings	$670,376	$1,340,752	$1,340,752	Figure Setting, February 14, 2007, page 14-15 and 12 Month Annualization
G	**Additional Estimated Drug Savings**	**($483,556)**	**$962,456**	**$1,606,818**	**Row E - Row F**

Table 10: Incremental Change in the Savings Estimate as a Result of Using the Drug Effectiveness Review Project (DERP)

Row	Item	FY 07-08	FY 08-09	FY 09-10	Description
A	Additional Estimated Drug Savings with the Drug Effectiveness Review Project (DERP) Contract	($483,556)	$962,456	$1,606,818	Table 9, Row G
B	Additional Estimated Drug Savings with Preferred Drug List Contractor	($483,556)	$793,091	$1,312,041	FY 08-09 Budget Request, November 1, 2007; Tab 17 BRI-2
C	**Incremental Increase to Drug Savings with the Drug Effectiveness Review Project (DERP) Contract**	**$0**	**$169,365**	**$294,777**	**Row A - Row B**

Table 11: 1.0 FTE Calculations for FY 08-09 and FY 09-10

FTE and Operating Costs				***GRAND TOTAL***	
Fiscal Year(s) of Request		**FY 08-09**	**FY 09-10**	**FY 08-09**	**FY 09-10**
PERSONAL SERVICES	**Title:**	**Program Assistant I**			
Number of PERSONS / class title		1	1		
Number of months working in FY 07-08, FY 08-09 and FY 09-10		12	12		
Number months paid in FY 07-08, FY 08-09 and FY 09-10*		11	12		
Calculated FTE per classification		**0.92**	**1.00**	0.92	1.00
Annual base salary		**34,284**	**34,284**		
Salary		$31,427	$34,284	$31,427	$34,284
PERA	**10.15%**	$3,190	$3,480	$3,190	$3,480
Medicare	**1.45%**	$497	$497	$497	$497
Prior Year SAED	**N/A**	$0	$236	$0	$236
Subtotal Personal Services at Division Level		**$35,114**	**$38,497**	**$35,114**	**$38,497**
Subtotal AED at EDO Long Bill Group Level	**Varies**	**$51**	**$56**	**$51**	**$56**
Subtotal SAED at EDO Long Bill Group Level	**Varies**	**$236**	**$193**	**$236**	**$193**
OPERATING EXPENSES					
Supplies @ $500/$500***	**$500**	$460	$500	$460	$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		**$4,365**	**$950**	**$4,365**	**$950**
GRAND TOTAL ALL COSTS		**$39,766**	**$39,696**	**$39,766**	**$39,696**

Table 12: Comparison of the FY 08-09 Decision Item and the FY 08-09 Budget Amendment

Row	Item	Total Funds	General Fund	Federal Funds	Description
A	FY 08-09 Total Change, Personal Services	$35,114	$17,557	$17,557	Table 10, Subtotal Personal Services, Grand Total FY 08-09
B	FY 08-09 Total Change, SB 04-257 Amortization Equalization Disbursement	$51	$26	$25	Table 10, SB 04-257 Amortization Equalization Disbursement, Grand Total FY 08-09
B.1	FY 08-09 Total Change, Supplemental Amortization Equalization Disbursement	$236	$118	$118	Table 10, Subtotal Supplemental Amortization Equalization Disbursement, Grand Total FY 08-09
B.2	FY 08-09 Total Change, Operating Expenses	$4,365	$2,183	$2,182	Table 10, Subtotal Operating Expenses, Grand Total FY 08-09
C	FY 08-09 Total Change, Drug Utilization Review Request	$79,020	$50,791	$28,229	Table 5, Row K
D	FY 08-09 Total Change, Estimated Drug Savings	$962,456	$481,228	$481,228	Table 9, Row G FY 08-09
E	**FY 08-09 Total Change, Total Request**	**($843,670)**	**($410,553)**	**($433,117)**	**Row A + Row B + Row C - Row D**
F	Base Reduction Item, Drug Utilization Review Request	$0	$76,036	($76,036)	FY 08-09 Budget Request, November 1, 2007; Tab 17 page G-1.
G	Base Reduction Item, Estimated Drug Savings	$793,091	$396,546	$396,545	FY 08-09 Budget Request, November 1, 2007; Tab 17 page G-1.
H	**Base Reduction Item, Total Request**	**($793,091)**	**($472,582)**	**($320,509)**	**(Row F + Row G) * -1**
I	Incremental Change, Personal Services	$35,114	$17,557	$17,557	Row A
J	Incremental Change, SB 04-257 Amortization Equalization Disbursement	$51	$26	$25	Row B
K	Incremental Change, Supplemental Amortization Equalization Disbursement	$236	$118	$118	Row B.1
L	Incremental Change, Operating Expenses	$4,365	$2,183	$2,182	Row B.2
M	Incremental Change, Drug Utilization Review Request	$79,020	($25,245)	$104,265	Row C - Row F
N	Incremental Change, Estimated Drug Savings	$169,365	$84,682	$84,683	Row D - Row G
O	**Incremental Change, Total Request**	**($50,579)**	**($90,043)**	**$39,464**	**Row I + Row J + Row K - Row L**

Assumptions for Calculations:

Please note that for all tables rounding is used for reporting purposes. As a result, some numbers may very slightly due to unreported decimal places.

Table 4: Summary of Changes to the Executive Director's Office, Drug Utilization Review Line FY 07-08

The Department is not renewing the drug utilization review contract with the Business Research Division of the Leeds School of Business at the University of Colorado at Boulder beginning in FY 07-08. The total contract amount was $180,000 for FY 07-08 and was funded with a 75% federal match rate. The Department assumes that it will use these funds to pay the preferred drug list contractor in the Executive Director's Office, Drug Utilization Review line. Based on information received from the Centers for Medicare and Medicaid Services, the Drug Utilization Review line should receive a 50% federal match rate. As a result, the new preferred drug list contract would receive a 50% federal match rate. In addition, the Department's remaining drug utilization review contract with Health Information Design, Inc. and incentive payments to pharmacists would be adjusted to receive a 50% federal match rate.

Table 5: Summary of Changes to the Executive Director's Office, Drug Utilization Review Line FY 08-09

The Department assumes that it will use the funds used to pay the preferred drug list contractor in FY07-08 to pay the Drug Effectiveness Review Project in the Executive Director's Office, Drug Utilization Review line. Based on information received from the Centers for Medicare and Medicaid Services, the Drug Utilization Review line should receive a 50% federal match rate except for the Drug Effectiveness Review Project which would receive a 75% match rate. In addition, for the first year of the project the Department would have to pay the full three year contract price for the phase ending June 30, 2009.

Table 6: Summary of Changes to the Executive Director's Office, Drug Utilization Review Line FY 09-10

Beginning in FY 09-10 the Department would pay annually on a three-year phase agreement with the Drug Effectiveness Review Project for Phase III. As a result the cost would be approximately one-third the cost for FY 08-09 that was $259,020.

Table 7: Medical Services Premiums, Estimated Drug Savings FY 08-09

The Department originally estimated savings of $670,376 for 6 months and $1,260,752 for Legislative Council's May 3, 2005 fiscal note for SB 05-022. These savings were based on 12 months from the total FY 03-04 expenditures, less FY 03-04 drug rebates, less excluded drug therapeutic classes[3], times an estimated 2% cost savings. The estimate provided for SB 05-022 was used to calculate the appropriation received by the Department during figure setting for FY 07-08 (Figure Setting, February 14, 2007, pages 14-15).

The estimate used to calculate savings for FY 08-09 was updated with FY 06-07 data as a result of legislative changes impacting pharmacy expenditures including the Medicare Modernization Act of 2003. The updated savings projection is based on total FY 06-07 expenditures, less FY 06-07 estimated drug rebates, less excluded drug therapeutic classes[4], times an estimated 2.78% cost savings in the FY 08-09 Budget Request, November 1, 2007. The cost savings increased to 2.78% for the FY 08-09 budget amendment to reflect the implementation and cost efficiencies resulting from the participation in the Drug Effectiveness Review Project (DERP). This 2.78% savings results from two additional drug classes at an annual drug savings of $124,547 per class.

[3] Excluded drug classes in FY 06-07 include: atypical antipsychotics, typical antipsychotics, anti-cancer, immunosuppressants, anticonvulsants, hemophilia drugs and HIV/AIDS drugs. These classes are expected to be excluded to protect the most vulnerable Medicaid populations. Both programs have a small number of drug classes and do not necessarily incorporate all of the drug classes currently being considered for the Colorado preferred drug list.

[4] Excluded drug classes in FY 03-04 include: atypical antipsychotics, typical antipsychotics, anti-cancer, immunosuppressants, biologics, and HIV/AIDS drugs. These classes are expected to be excluded to protect the most vulnerable Medicaid populations.

Savings, which would be a part of the Medical Services Premiums line, are estimated based on the similarity to the program developed and implemented by Michigan. Michigan uses a state-based panel of doctors and pharmacists to determine cost effective yet clinically safe and effective drugs for their clients. It is not known whether the implementation of Colorado's program will result in the same outcomes as Michigan, so this will need to be closely monitored.

In Michigan, the impact of pooling, negotiations, and supplemental rebates on drugs resulted in a 4% budget reduction (Michigan had savings of $42 million within its $1 billion Medicaid pharmacy budget). Michigan is pooling with another state and Colorado will not be pooling with another state at this time. With other differences, Michigan uses a contracted service in their model, a pharmacy benefits administrator, and disease management programs. Therefore, the Department assumes a more conservative savings estimate of 2.78%.

Based on the updates and changes addressed above, the Department estimates a total potential cost savings of $2,289,903 for FY 06-07 for 12 drug classes. Cost savings are expected to increase over time and as a result, the Department estimated an 8.78% drug savings inflator. This inflator is based on the change in monthly drug expenditures between December 2006 and June 2007. Fluctuations in expenditures due to the number of weeks in a month were adjusted using a three-month moving average. The three-month moving average was averaged for the seven calculated months resulting in a 0.732% average monthly percent change. Multiplying 0.732% by 12 months provides the annual estimated savings inflator of 8.78%. Applying this percentage across fiscal years, the Department estimates that the potential savings is $2,490,956 in FY 07-08, $2,709,662 in FY 08-09 and $2,947,570 in FY 09-10. The Department plans a staggered implementation, adding three drug classes per quarter. As a result, the Department will not realize the potential savings estimates. Further calculations are available in Table 8 to discount the potential savings based on the implementation dates of the drug classes.

Table 8: Medical Services Premiums, Estimated Drug Savings, Drug Class Savings by Implementation Date

This base estimate assumes that all drug classes are part of the preferred drug list as of July 1, 2008. The current implementation plan has staggered implementation dates for adding drug classes and not all drug classes will be included by July 1, 2008. As a result, savings are discounted depending on the drug class start date.

For the purposes of the savings estimate, the Department assumes that drug classes will be implemented based on the potential savings per drug class. Drug classes with the highest potential savings will be implemented before classes with lower potential savings. This assumption is based on limited drug savings information provided for Arkansas and Indiana[5]. The Department is working with the preferred drug list contractor to determine the highest potential savings by class based on utilization data for Colorado but a full list and order for the preferred drug list is not yet available. The Department estimates that three-fifths of drug savings will occur in the first six drug classes and two-fifths of the drug savings will occur with the implementation of the remaining eight drug classes. For FY 07-08, $2,490,956 in total potential savings is multiplied by three-fifths to obtain $1,494,562 in drug savings for the first six drug classes.

The total dollar amount for the first drug classes did not change between the FY 08-09 Budget Request, November 1, 2007 and the current budget amendment. The Department is assuming that the total savings estimate will increase from 2.50% to 2.78% based on the inclusion of the two additional drug classes implemented in FY 08-09. This also changes the ratio of savings to set of drug classes. In Base Reduction Item 2 the first six drug classes comprised two-thirds of the total drug savings. With the inclusion of two additional drug classes, this ratio fell to three-fifths or 60.00% of the total drug savings. The remaining $747,281 in potential savings comes from the remaining six drug classes.

[5] The Department reviewed data provided in "Arkansas Medicaid Evidence-Based Prescription Drug Program (EBRx). Quarterly Report – First Quarter 2006" and the "Evaluation of the Indiana Medicaid Preferred Drug List (PDL) Program", 6/30/2005.

The yearly savings estimates are divided by either six or eight for the number of drug classes, and twelve for the total number of potential savings months. The Department estimates savings of $20,758 and $10,379 per drug class per month. These monthly savings estimates are updated by fiscal year using the 8.78% savings inflator. The per drug class per month savings estimate was multiplied by the number of months for each drug class to obtain the total savings by fiscal year and implementation date. Totals are available in Row B through Row D. These underlying calculations to Table 8 are available in Appendix 1 through Appendix 6. Although not shown for the purposes of this report, calculations are rounded to two decimal points. This may cause some differences in rounding if manually calculating the estimates.

Table 9: Medical Services Premiums, Estimated Drug Savings, Drug Class Savings by Implementation Date

Table 9 summarizes the savings estimates by implementation date as summarized in Appendices 2 through 5. In addition, this table compares the revised estimates to the savings removed from the Medical Services Premiums during the February 14, 2007 Figure Setting.

Table 10: Incremental Change in the Savings Estimate as a Result of Using the Drug Effectiveness Review Project (DERP)

Table 10 summarizes the differences in the savings estimate as a result of utilizing the Drug Effectiveness Review Project (DERP). This difference is based on the implementation of two additional drug classes due to increased implementation and cost efficiencies; this increases the total number of drug classes implemented from 12 to 14. The Department also assumes that the increased implementation efficiencies will increase the total number of drug classes per quarter. Starting with the October 2008 implementations, this would increase the drugs implemented from three drug classes to four drug classes.

Table 11: 1.0 FTE Calculations for FY 08-09 and FY 09-10

This table demonstrates the calculations used to determine the cost of 1.0 FTE Program Assistant I to take over the administrative responsibilities related to the Pharmacy and Therapeutics Committee.

Table 12: Comparison of the FY 08-09 Decision Item and the FY 08-09 Budget Amendment

This table demonstrates the calculation of the incremental change between the Budget Reduction Item submitted November 1, 2007 and the Budget Amendment.

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

FY 07-08 Cost Benefit Analysis	Costs	Benefits
Request	The cost of the request includes $422,556 total fund to fix the Drug Utilization Review fund splits and hire a preferred drug list contractor and update the preferred drug list savings estimates to reflect the Department's implementation plan.	The request would allow the Department to implement the preferred drug list per the Executive Order of Governor Ritter by January 1, 2008. This alternative would provide greater efficiency in implementing the drug categories and ultimately decreasing prescription drug expenditures. The Department would realize total estimated cost savings of $186,820 in FY 07-08 and $2,303,208 in FY 08-09. This request will also fix the federal fund splits to be in compliance with federal regulation.
Consequences if not Funded	The Department would be out of compliance with federal regulations including 42 CFR 456.719 which states that the Drug Utilization Review line should be 50%.	There are no benefits.

FY 08-09 Cost Benefit Analysis	Costs	Benefits
Request	The request would show a reduction in expenditures of $843,670 total funds to fix the Drug Utilization Review fund splits, buy into the Drug Effectiveness Review Program, hire 1.0 FTE update the preferred drug list savings estimates to reflect the Department's implementation plan. This is an incremental decrease of $50,579 total funds and $90,043 General Fund.	The request would allow the Department to implement the preferred drug list per the Executive Order of Governor Ritter by January 1, 2008. This alternative would provide greater efficiency in implementing the drug categories and ultimately decreasing prescription drug expenditures. The Department would realize total estimated cost savings of $186,820 in FY 07-08 and $2,303,208 in FY 08-09. This request will also fix the federal fund splits to be in compliance with federal regulation.
Consequences if not Funded	The Department would receive a lower match rate for clinical services and have higher long term costs. After the initial one time payment, the cost of staying in the Drug Effectiveness Review Program drops to one-third of the initial cost. In addition, The Department would be providing the Pharmacy and Therapeutics Committee with lower quality clinical data and analysis. This would increase the likelihood of implementation problems as a result of potential contentious drug classes.	There are no benefits.

Implementation Schedule:

Task	Month/Year
Governor Signed Executive Order D 004 07 to Create the Preferred Drug List	January 2007
Internal Research/Planning Period	January 2007
Documented Quote Posted for the Temporary Preferred Drug List Contractor	July 2007
Preferred Drug List Committee Rules Presented to the Medical Services Board and Withdrawn	July 2007
Documented Quote Bids Reviewed, Contract Negotiated and Approved	August 2007
Preferred Drug List Committee Rules Represented to the Medical Services Board	September 2007
Preferred Drug List and Committee Rules Became Effective	October 2007
Committee Members Appointed by the Executive Director of the Department	October 2007
Preferred Drug List Contractor Began Performance of Contract	October 2007
First Committee Meeting	December 2007
First 3 Drug Classes Added to the Preferred Drug List	April 2008
Post Position for FTE	April 2008
Hire 1.0 FTE Program Assistant	July 2008
Join the Drug Effectiveness Review Project (DERP)	July 2008
3 Additional Drug Classes Added to the Preferred Drug List	July 2008
4 Additional Drug Classes Added to the Preferred Drug List	October 2008
4 Additional Drug Classes Added to the Preferred Drug List (for 14 Total Drug Classes)	January 2009
Evaluation of the Preferred Drug List Drug Classes and the Consideration of Additional Classes	January 2009

Statutory and Federal Authority: 25.5-5-506, C.R.S. (2007). Prescribed drugs - utilization review.

(1) The state department shall develop and implement a drug utilization review process to assure the appropriate utilization of drugs by patients receiving medical assistance in the fee-for-service and primary care physician programs. The review process shall include the monitoring of prescription information and shall address at a minimum underutilization and overutilization of benefit drugs. Periodic reports of findings and recommendations shall be forwarded to the state department.

(2) It is the general assembly's intent that the implementation of a drug utilization review process for the fee-for-service and primary care physician programs will produce savings within the state's Medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the development and implementation of a drug utilization review process for these programs, as required by subsection (1) of this section. The state department may contract on a contingency basis for the development or implementation of the review process required by subsection (1) of this section.

(3) (a) The state department shall implement drug utilization mechanisms, including, but not limited to, prior authorization, to control costs in the medical assistance program associated with prescribed drugs. The state board shall promulgate a rule that outlines a process in which any interested party may be notified of and comment on the implementation of any prior authorization for a class of prescribed drugs before the class is prior authorized.

(b) The state department shall report to the health and human services committees for the house of representatives and the senate, or any successor committees, and the joint budget committee no later than December 1, 2003, and each December 1 thereafter, on plan utilization mechanisms that have been implemented or that will be implemented by the state department, the time frames for implementation, the expected savings associated with each utilization mechanism, and any other information deemed appropriate by the health and human services committees, or any successor committees, or the joint budget committee.

42 CFR 456.719 - Funding for DUR program.

FFP is available for the sums that the Secretary determines are attributable to the Statewide adoption of a DUR program as described in the subpart, and payment is made under procedures established in part 433 of this chapter as follows:

(a) For funds expended by the State during calendar years 1991 through 1993, at the rate of 74 percent.

(b) For funds expended by the State after December 31, 1993, at the rate of 50 percent.

42 CFR 432.50 - FFP: Staffing and training costs

(b) Rates of FFP. (1) For skilled professional medical personnel and directly supporting staff of the Medicaid agency or of other public agencies (as defined in Sec. 432.2), the rate is 75 percent.

(d) Other limitations for FFP rate for skilled professional medical personnel and directly supporting staff--(1) Medicaid agency personnel and staff. The rate of 75 percent FFP is available for skilled professional medical personnel and directly supporting staff of the Medicaid agency…

(i) The expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance;

(ii) The skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. ``Professional education and training'' means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.

(iii) The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills.

(iv) A State-documented employer-employee relationship exists between the Medicaid agency and the skilled professional medical personnel and directly supporting staff; and

(v) The directly supporting staff are secretarial…who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

Performance Measures:

This Supplemental and Budget Amendment request affects the following Performance Measure:

- Decrease Medicaid pharmaceutical costs for therapeutic classes on the Preferred Drug List.

The Department believes that a preferred drug list will provide the high quality prescription medications required by clients. Implementing the preferred drug list program will allow the state to increase the cost efficiency of pharmaceutical purchases through manufacture agreements and supplemental rebates.

Appendix 1: FY 07-08 Baseline

Row	Item	Drug Classes 1-6	Drug Classes 7-14	Total	Description
A	Maximum Potential Savings (FY 07-08)	$1,494,562	$996,394	$2,490,956	FY 06-07 Drug Expenditures * 2.78% * 8.78%. See Narrative
B	Savings Per Drug Class	$249,094	$124,549		Row A / 6 for Drug Classes 1-6 and Row A / 8 for Drug Classes 7-14, Rounded to 2 Decimal Places
C	Savings Per Drug Class Per Month	$20,758	$10,379		Row B / 12, Rounded to 2 Decimal Places

Appendix 2: Estimated Savings for Drug Classes Implemented April 1, 2008

Row		Drug Classes 1-6	Drug Classes 7-14	Total	Description
A	Number of Drug Classes Implemented	3	0		Preferred Drug List Implementation Plan
B	Savings Per Drug Class Per Month	$20,758	$10,379		Appendix 1, Row C
C	Effective Number of Months in Fiscal Year	3	3		Preferred Drug List Implementation Plan
D	**Total Savings FY 07-08**	**$186,820**	**$0**	**$186,820**	Row A * Row B * Row C
E	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
F	Estimated Savings Per Drug Class Per Month (FY 08-09)	$22,580	$11,290		Row B * (1+ Row E), Rounded to 2 Decimal Places
G	Effective Number of Months in Fiscal Year	12	12		Preferred Drug List Implementation Plan
H	**Total Savings FY 08-09**	**$812,893**	**$0**	**$812,893**	Row A * Row F * Row G
I	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
J	Estimated Savings Per Drug Class Per Month (FY 09-10)	$24,563	$12,282		Row F * (1 + Row I), Rounded to 2 Decimal Places
K	Effective Number of Months in Fiscal Year	12	12		Preferred Drug List Implementation Plan
L	**Total Savings FY 09-10**	**$884,264**	**$0**	**$884,264**	Row A * Row J * Row K

Appendix 3: Estimated Savings for Drug Classes Implemented July 1, 2008

Row		Drug Classes 1-6	Drug Classes 7-14	Total	Description
A	Number of Drug Classes Implemented	3	0		Preferred Drug List Implementation Plan
B	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
C	Estimated Savings Per Drug Class Per Month (FY 08-09)	$22,580	$11,290		Appendix 1, Row C * Row B, Rounded to 2 Decimal Places
D	Effective Number of Months in Fiscal Year	12	12		Preferred Drug List Implementation Plan
E	**Total Savings FY 08-09**	**$812,893**	**$0**	**$812,893**	Row A * Row C * Row D
F	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
G	Estimated Savings Per Drug Class Per Month (FY 09-10)	$24,563	$12,282		Row C * (1 + Row B), Rounded to 2 Decimal Places
H	Effective Number of Months in Fiscal Year	12	12		Preferred Drug List Implementation Plan
I	**Total Savings FY 09-10**	**$884,264**	**$0**	**$884,264**	Row A * Row G * Row H

Appendix 4: Estimated Savings for Drug Classes Implemented October 1, 2008

Row		Drug Classes 1-6	Drug Classes 7-14	Total	Description
A	Number of Drug Classes Implemented	0	4		Preferred Drug List Implementation Plan
B	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
C	Estimated Savings Per Drug Class Per Month (FY 08-09)	$22,580	$11,290		Appendix 1, Row C * Row B, , Rounded to 2 Decimal Places
D	Effective Number of Months in Fiscal Year	9	9		Preferred Drug List Implementation Plan
E	**Total Savings FY 08-09**	**$0**	**$406,454**	**$406,454**	Row A * Row C * Row D
F	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
G	Estimated Savings Per Drug Class Per Month (FY 09-10)	$24,563	$12,282		Row C * (1 + Row B), Rounded to 2 Decimal Places
H	Effective Number of Months in Fiscal Year	12	12		Preferred Drug List Implementation Plan
I	**Total Savings FY 09-10**	**$0**	**$589,521**	**$589,521**	Row A * Row G * Row H

Appendix 5: Estimated Savings for Drug Classes Implemented January 1, 2009

Row		Drug Classes 1-6	Drug Classes 7-12	Total	Description
A	Number of Drug Classes Implemented	0	4		Preferred Drug List Implementation Plan
B	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
C	Estimated Savings Per Drug Class Per Month (FY 08-09)	$22,580	$11,290		Appendix 1, Row C * Row B, Rounded to 2 Decimal Places
D	Effective Number of Months in Fiscal Year	6	6		Preferred Drug List Implementation Plan
E	**Total Savings FY 08-09**	**$0**	**$270,969**	**$270,969**	Row A * Row C * Row D
F	Estimated Growth in Drugs			8.78%	Average Growth Rate December 2006-June 2007
G	Estimated Savings Per Drug Class Per Month (FY 09-10)	$24,563	$12,282		Row C * (1 + Row B), Rounded to 2 Decimal Places
H	Effective Number of Months in Fiscal Year	12	12		Preferred Drug List Implementation Plan
I	**Total Savings FY 09-10**	**$0**	**$589,521**	**$589,521**	Row A * Row G * Row H

Appendix 6: Calculating Total Savings by Fiscal Year

Fiscal Year	Month	Drug Class														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total Savings
FY 07-08	Apr-08	$20,758	$20,758	$20,758												$62,273
	May-08	$20,758	$20,758	$20,758												$62,273
	Jun-08	$20,758	$20,758	$20,758												$62,273
	Savings	**$62,273**	**$62,273**	**$62,273**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$186,820**
FY 08-09	Jul-08	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580									$135,482
	Aug-08	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580									$135,482
	Sep-08	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580									$135,482
	Oct-08	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290					$180,644
	Nov-08	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290					$180,644
	Dec-08	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290					$180,644
	Jan-09	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$225,805
	Feb-09	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$225,805
	Mar-09	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$225,805
	Apr-09	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$225,805
	May-09	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$225,805
	Jun-09	$22,580	$22,580	$22,580	$22,580	$22,580	$22,580	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$11,290	$225,805
	Savings	**$270,964**	**$270,964**	**$270,964**	**$270,964**	**$270,964**	**$270,964**	**$101,613**	**$101,613**	**$101,613**	**$101,613**	**$67,742**	**$67,742**	**$67,742**	**$67,742**	**$2,303,208**
FY 09-10	Jul-08	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Aug-08	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Sep-08	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Oct-08	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Nov-08	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Dec-08	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Jan-09	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Feb-09	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Mar-09	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Apr-09	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	May-09	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Jun-09	$24,563	$24,563	$24,563	$24,563	$24,563	$24,563	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$12,282	$245,631
	Savings	**$294,755**	**$294,755**	**$294,755**	**$294,755**	**$294,755**	**$294,755**	**$147,380**	**$147,380**	**$147,380**	**$147,380**	**$147,380**	**$147,380**	**$147,380**	**$147,380**	**$2,947,570**

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:	Increased Funding for Non-Emergency Transportation Services			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-10	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	7,583,761	7,299,302	144,963	7,444,265	7,299,302	0	7,299,302	0	7,299,302	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	3,791,881	3,649,651	72,482	3,722,133	3,649,651	0	3,649,651	0	3,649,651	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	3,791,880	3,649,651	72,481	3,722,132	3,649,651	0	3,649,651	0	3,649,651	0
(1) Executive Director's Office, Non-Emergency Transportation Services	**Total**	7,583,761	7,299,302	144,963	7,444,265	7,299,302	0	7,299,302	0	7,299,302	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	3,791,881	3,649,651	72,482	3,722,133	3,649,651	0	3,649,651	0	3,649,651	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	3,791,880	3,649,651	72,481	3,722,132	3,649,651	0	3,649,651	0	3,649,651	0

Letternote revised text:
Cash Fund name/number, Federal Fund Grant name: FF: Title XIX
IT Request: ☐ Yes ☑ No
Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-10
Change Request Title:	Increased Funding for Non-Emergency Transportation Services

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: This Request seeks additional funding in the amount of $144,963 total funds to restore FY 07-08 funding that was used to pay for an unexpectedly higher amount of FY 06-07 claims from the 56 non-metro counties within the Executive Director's Office, Non-Emergency Transportation Services line item.

Background and Appropriation History: The Department provides non-emergency transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation throughout all sixty-four counties in Colorado. Section 25.5-5-202 (1) (s) (2), C.R.S. (2007) and 42 CFR §431.53 require the Department to provide non-emergency medical transportation to eligible clients under the State's Medical Assistance Program. The type of transportation authorized is determined by the distance to be traveled, treatment facilities available, and the physical condition of the client. Non-emergency medical transportation services include transportation between the client's home and the site of the Medicaid covered service, and when applicable, the cost of lodging and food when an overnight stay is necessary for an escort. There are also administrative costs related to non-emergency medical transportation including, but not

limited to, the intake of client calls, determining eligibility, and authorizing and arranging transportation.

History

Prior to FY 03-04, non-emergency medical transportation, approximated to be $12,041,460, was contained in the Department's (2) Medical Services Premiums Long Bill group. However, due to difficult economic conditions in FY 02-03, the General Assembly reduced the funding by $7,640,682 in an effort to reduce General Fund expenditures (FY 03-04 Figure Setting, March 11, 2002, pages 110-111).

In FY 03-04, the Department received legislative authority via HB 04-1220 to administer non-emergency medical transportation as an administrative program rather than an optional Medicaid service in an effort to maintain cost savings. This action resulted in $4,400,778 being transferred from the Department's (2) Medical Services Premiums Long Bill group to a newly created line item under the (1) Executive Director's Office Long Bill group titled "Non-Emergency Transportation Services."

The Department employs two mechanisms to provide non-emergency medical transportation needs for Medicaid clients: 1) in the 8 Front Range counties, the Department has a full-risk, fixed-price contract with LogistiCare, Inc. to provide the necessary services and administration, and 2) in the remaining 56 counties, the county departments of social services are responsible for authorizing, billing through the Medicaid Management Information System and arranging the transportation.

Fixed Contract: LogistiCare, Inc.

From October 2002 to September 2004, the Department contracted with Arapahoe County Transportation Services for non-emergency transportation services in the 8 Front Range counties. Due to the closure of Arapahoe County Transportation Services in September 2004, the Department entered into an emergency contract with LogistiCare from October 1, 2004 through June 30, 2005.

On March 22, 2005, the Department issued a request for proposals for broker services in the 8 Front Range counties for FY 05-06. The winning bidder was LogistiCare; however LogistiCare refused to sign the contract citing concerns about unpredictable spikes in caseload, utilization, and inadequate funding. This resulted in a failed reprocurement for FY 05-06 requiring the Department to enter into an emergency nine month contract with LogistiCare from July 1, 2005 through March 31, 2006, until a new request for proposals could be completed.

In January 2006, the revised request for proposals was an open-ended request, meaning no dollar amount was specified. Having prior experience with providing non-emergency medical transportation services in the 8 Front Range counties, LogistiCare was awarded the winning bid for a fixed-price contract beginning June 1, 2006. This fixed-price contract was negotiated for $446,992 per month, or $5,363,904 per fiscal year. On June 20, 2006, the Department requested and subsequently received a 1331 Emergency Supplemental of $1,121,497 to fund the administrative contract increases, funding for the two-month (April to May 2006) contract holdover provision, plus the fixed-price contract amount for June 2006.

In August 2006, the Department received correspondence from LogistiCare concerning unpaid monies for claim lag adjustments in the period from July 2005 through March 2006. With the assistance of the State Attorney General's Office and Governor's Counsel, the Department negotiated a settlement amount of $1,048,608 with LogistiCare. The General Fund need was reduced by $491,431 from an accounts payable line which was used to offset the total need. On January 23, 2007, the Department requested and subsequently received a FY 06-07 late supplemental in the amount of $557,177 for the remaining lawsuit settlement agreement (February 14, 2007, Executive Director's Office Figure Setting, page 78).

Remaining 56 Counties

In the remaining 56 counties, the county departments of social services are responsible for authorizing and arranging transportation. Similar to increasing contract obligations, increased utilization and caseload in the non-metro counties have required a greater

portion of the total appropriation to be allocated for non-contractor costs. Changes in utilization and caseload are assumed to be the result of increased focus on non-emergency medical transportation from the Centers for Medicare and Medicaid Services, individual client complaints, recent training by the Department on State Plan transportation services, and increased awareness by Department of Human Services program administrators.

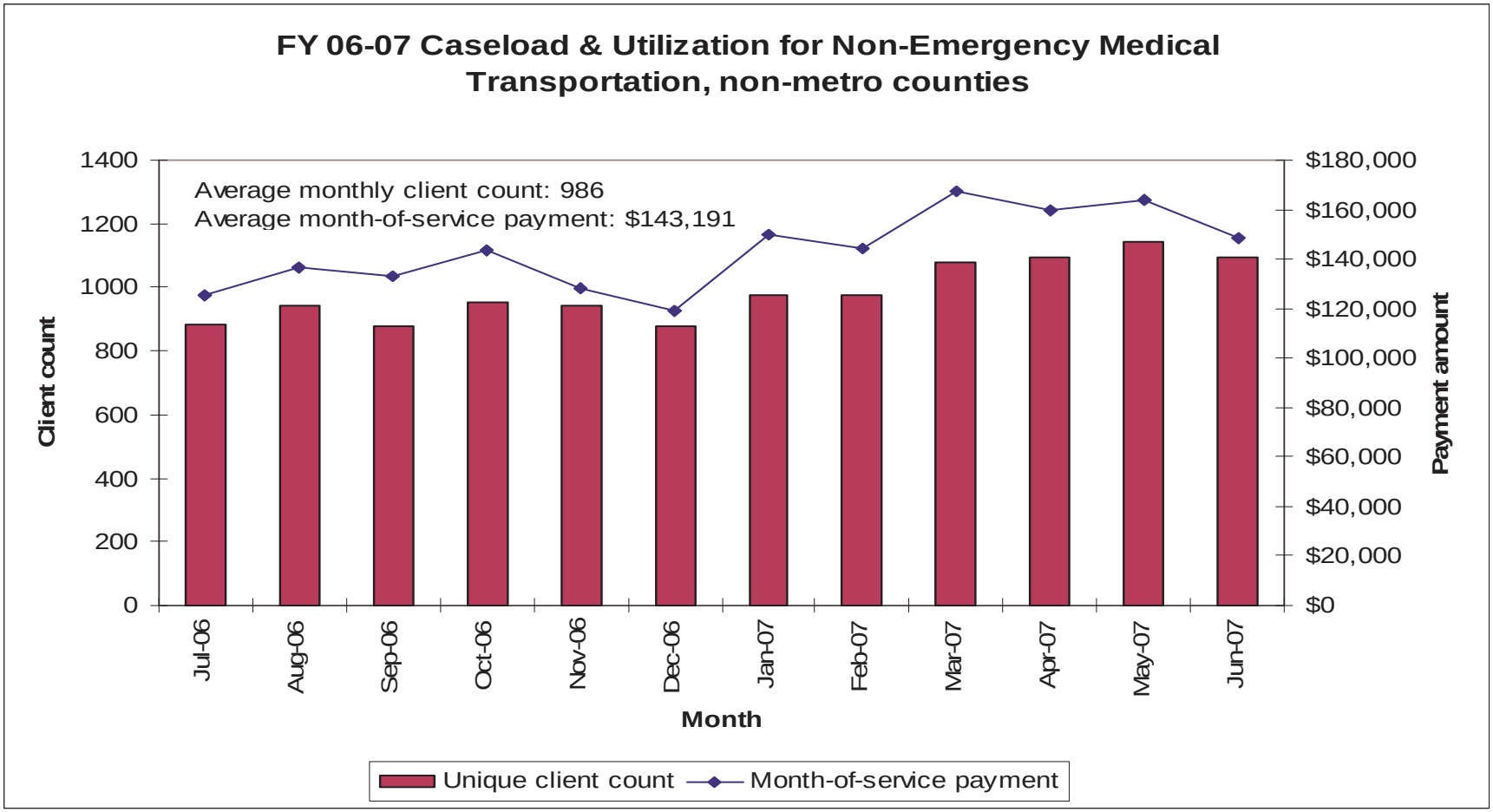
General Description of Request:

This Request seeks additional funding in the amount of $144,963 total funds ($72,482 General Fund and $72,481 federal funds) for Non-Emergency Transportation Services to restore FY 07-08 funding that was used to pay for a FY 06-07 over expenditure. By restoring this funding in FY 07-08, it will prevent an over expenditure at fiscal year end.

In each fiscal year after the passage of HB 04-1220, the Department has seen increased caseload and utilization growth in non-emergency medical transportation services requiring supplemental and emergency supplemental funding. Although the Department has secured a fix-priced contract for the eight Front Range counties, the unpredictable nature of non-emergency medical transportation services in the remaining 56 non-metro counties makes it difficult to estimate an adequate level of funding each fiscal year.

In FY 06-07, the Department experienced higher than estimated non-emergency medical transportation claims in the 56 non-metro counties, which are not included under the fix-priced contract. The higher number of claims caused the Department to over expend its FY 06-07 appropriation in the Non-Emergency Transportation Services line item by $144,963. All of these claims have dates of service in FY 06-07 and were submitted within the required 120 calendar days after fiscal year-end. Having completely spent the FY 06-07 appropriation, the additional claims were paid using the FY 07-08 appropriation. This request will serve to restore the $144,963 in the FY 07-08 appropriation and prevent over expending the line item appropriation at fiscal year end.

Based on data from FY 06-07, the average number of clients per month and average month-of-service payment in the non-metro counties were 986 and $143,191, respectively. See the graph below.



In FY 05-06, the average number of clients per month and average month-of-service payment were 632 and $102,954. Based on these two fiscal years, the average number of clients per month and average month-of-service payment has increased by 56% and 39%, respectively.

In March and September 2007, the Department conducted non-emergency medical transportation training sessions at two separate events to which all Colorado counties were invited. The Department believes the higher caseload and utilization demand in FY 06-07 and FY 07-08 corresponds with the Department's increased training and awareness efforts with county administrators and providers. As such, the Department anticipates increased non-emergency medical transportation claims in the 56 non-metro counties due to these efforts. Moreover, the Department has learned that more non-metro counties are billing in FY 06-07 as compared to FY 05-06 as a result of the Department's awareness efforts. This became known when the Department had to reinstate or reactivate several accounts in the Medicaid Management Information System. (An account is sometimes deactivated due to inactivity and must be reinstated by the Department in order to accept and process provider billing.)

Lastly, in addition to the Department's increased awareness campaign, the Centers for Medicare and Medicaid Services have increased their own focus on non-emergency medical transportation services, which has contributed to increased client utilization in all 64 counties. All these efforts (at both the State and Federal level) have contributed to higher non-emergency medical transportation expenditures in FY 06-07.

Consequences if Not Funded:

If the Department does not restore the FY 07-08 funding used to pay claims with dates of service in FY 06-07, it risks over expending the FY 07-08 non-emergency medical transportation services appropriation. Additionally, the Department estimates that it cannot absorb this unanticipated loss of FY 07-08 funding given recent claims data which shows the July and August 2007 month-of-service payment being $161,454 and $150,978, respectively. These early figures, which include some run-out claims data, are close to the estimated average FY 07-08 monthly expenditure of $161,283 for the 56 non-metro counties. If the remaining month-of-service payments in FY 07-08 exhibit a similar expenditure pattern, then it becomes crucial that the Department restore this funding to ensure continuous non-emergency medical transportation services, prevent an over expenditure at fiscal year end, and possibly avoid a future lawsuit for non-payment of claims.

If restorative funding is denied, the Department will likely seek future emergency supplemental funding should the remaining FY 07-08 funding be insufficient to pay non-emergency medical transportation claims.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund	Federal Funds
Total Request	$144,963	$72,482	$72,481
(1) Executive Director's Office, Non-Emergency Transportation Services (Column 3)	$144,963	$72,482	$72,481

Assumptions for Calculations:

Each of the 56 non-metro counties have 120 calendar days to properly file claims, with additional lag for claims that are in dispute; therefore, the Department must wait for claims run-out to fully capture the entire cost of services attributable to that month. Based on this requirement, the counties have until October 29, 2007 to submit their FY 06-07 claims (assuming there are no disputes involved). In writing this request, the Department captured claims data on November 6, 2007 and believes all FY 06-07 claims have been submitted for payment. Additionally, the Department estimates that any FY 06-07 claims in dispute will be negligible and can be absorbed by the existing FY 07-08 appropriation.

FY 07-08 expenditures

The Department utilized available Medicaid Management Information System data on October 4, 2007 and calculated the month-of-service payment for July and August 2007 to be $161,454 and $150,978, respectively. These two month-of-service payments contain some claims run-out and serve as an estimate for future FY 07-08 monthly expenditures.

Row	Calculation for estimated average monthly expenditure for 56 non-metro counties	Amount
A	FY 07-08 appropriation	$7,299,302
B	FY 07-08 fix-priced contract for 8 metro counties = $446,992 x 12 months	$5,363,904
C	Remaining FY 07-08 appropriation for claims in 56 non-metro counties, row A minus row B	$1,935,398
D	Estimated average monthly expenditure for 56 non-metro counties, row C divided by 12	$161,283

Based on this claims data for FY 07-08, the Department estimates that it cannot absorb the unexpected FY 06-07 claims from its remaining FY 07-08 appropriation given that the most recent month-of-service payments are nearly equal to the estimated FY 07-08 average monthly expenditure of $161,283. If the FY 07-08 expenditures exceed the Department's expenditure estimates for the 56 non-metro counties, then the Department will seek emergency supplemental funding to cover the shortfall.

Impact on Other Government Agencies: No impact on other government agencies.

Cost Benefit Analysis:

Description of Benefits	Cost
The Department would be in compliance with all State and federal citations regarding the delivery of non-emergency medical transportation.	$144,963
The Department will ensure an adequate level of funding for non-emergency medical transportation claims and avoid a possible lawsuit for non-payment of claims.	
The Department would be able to pay all its provider claims associated with the State's eligible Medicaid clients.	

Statutory and Federal Authority: 25.5-5-202, (1) (s) (2), C.R.S. (2007). Basic services for the categorically needy – optional services. *(1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program: (s) (2) In addition to the services described in subsection (1) of this section and*

subject to continued federal financial participation, Colorado has selected to provide transportation services as an administrative cost.

42 C.F.R. § 431.53. Assurance of transportation. *A State Plan must--(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and (b) Describe the methods that the agency will use to meet this requirement. (Sec. 1902(a)(4) of the Act)*

Performance Measures:

Maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services.

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:	Restore Enrollment Broker Contract Funding			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-11	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	2,056,800	1,739,465	159,570	1,899,035	1,723,940	159,570	1,883,510	0	1,883,510	159,570
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	997,942	810,715	79,785	890,500	802,828	79,785	882,613	0	882,613	79,785
	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	27,059	48,060	0	48,060	60,607	0	60,607	0	60,607	0
	FF	1,031,799	866,295	79,785	946,080	856,705	79,785	936,490	0	936,490	79,785
(1) Executive Director's Office SB 97-05 Enrollment Broker	Total	860,786	700,000	257,418	957,418	700,000	257,418	957,418	0	957,418	257,418
	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	128,709	445,195	316,486	128,709	445,195	0	445,195	128,709
	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	128,709	478,709	350,000	128,709	478,709	0	478,709	128,709
(1) Executive Director's Office Operating Expenses	Total	1,196,014	1,039,465	(97,848)	941,617	1,023,940	(97,848)	926,092	0	926,092	(97,848)
	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	(48,924)	445,305	486,342	(48,924)	437,418	0	437,418	(48,924)
	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	(48,924)	467,371	506,705	(48,924)	457,781	0	457,781	(48,924)

Letternote revised text:

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

IT Request: Yes ☑ No ☐

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

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-11
Change Request Title:	Restore Enrollment Broker Contract Funding

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:

This request is to increase the total funds appropriation for the (1) Executive Director's Office, SB 97-05 Enrollment Broker from $700,000 to $957,418 in FY 07-08 - a change of $257,418. This increase is offset by a reduction to the (1) Executive Director's Office, Operating Expenses line item of $97,848. This supplemental is an unforeseen contingency based on funding cuts during JBC figure setting and direction from the Centers for Medicare and Medicaid Services on scope of work required of the enrollment broker.

Background and Appropriation History:

Funding Enrollment Broker Services

The Department funds enrollment broker services through two sources including the (1) Executive Director's Office, SB 97-05 Enrollment Broker and (1) Executive Director's Office, Operating Expenses. In FY 06-07 the Department funded $942,784 from the enrollment broker line item. This included $33,514 in tobacco tax moneys with matching federal funds, $67,028 total, for caseload increases driven by the expansion Medicaid population. In addition, the Department funded $97,848 through the Operating Expenses

line item. As a result, $1,040,632 in funding was available for enrollment broker services. The Department estimated that the expansion Medicaid population would only require $35,030. As a result, the Department contracted with Maximus Inc. for $1,008,634 to provide enrollment broker services and reverted $31,998 to the Health Care Expansion Fund.

The Department primarily funds the enrollment broker through the (1) Executive Director's Office, SB 97-05 Enrollment Broker line item. Under 42 CFR 438.10 the Department is required to undertake various activities to ensure *all* eligible Medicaid clients receive sufficient information to make an informed choice when they decide to enroll in either a managed care or a primary care physician program. The Centers for Medicare and Medicaid Services requires the Department to follow very specific instructions with respect to content, format, and procedures when disseminating information to Medicaid-eligible clients about their options. Under this regulation, the Department must:

- Provide current and **potential enrollees** with enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood (including printing in non-English languages, oral interpretation services, and alternative formats),
- Disseminate information about the availability of various languages, formats, and communication alternatives for receiving information and provide clear instructions regarding how to access these alternatives,
- Tailor details of printed materials to different regions within the State,
- Produce and distribute directories of physicians, specialists, and hospitals, including information on those who speak a non-English language,
- Provide information about where and how to obtain a counseling or referral service.

In fulfilling all of the functions described above, the Department contracts with an enrollment broker with a multilingual staff who produce printed materials; operate a call-center; disseminate mailings; counsel, enroll and disenroll clients; and coordinate with participating physicians, specialists and hospitals.

Although the majority of the enrollment broker expenses are paid through the (1) Executive Director's Office, SB 97-05 Enrollment Broker line item, the Department also funds a portion of the contract through the (1) Executive Director's Office, Operating Expenses line item. The managed care informational packet received by clients includes a managed care report card comparing Health Plan Employer Data Information Set (HEDIS) scores, capitation rates and focus group results for health care plans, primary care physicians and fee-for-service. This report card is mandated through C.R.S. 25.5-5-410 (2007) which states that the Department must provide reports that "…shall include a comparison of the effectiveness of the MCO [Managed Care Organization] program and the primary care physician program based upon common performance standards that shall include but not be limited to recipient satisfaction."

Originally, the Department produced this managed care report card in-house and sent out a separate mailing to clients with this information. In FY 03-04 the Department determined that it would be more cost effective to provide the information to potential managed care clients through the enrollment broker. Also, during an onsite review, there were concerns from the Centers for Medicare and Medicaid Services regarding the formatting and content of the report card. As a result, the enrollment broker took over all printing and mailing responsibilities related to the managed care report card. However, services provided by the enrollment broker for the managed care report card continued to be paid through the (1) Executive Director's Office, Operating Expenses rather than the (1) Executive Director's Office, SB 97-05 Enrollment Broker. The additional information provided through the report card accounts for an additional $97,848 in the enrollment broker contract.

FY 07-08 Figure Setting

During the Department's FY 07-08 Figure Setting on February 14, 2007, JBC staff recommended a reduction of $33,514, to bring the enrollment broker contract back to the FY 05-06 caseload levels. JBC Staff cited declining traditional Medicaid caseload in their justification for this reduction. "Even with the addition of the Expansion Medicaid

caseload, the FY 2007-08 Medicaid caseload is forecasted to be lower than the FY 2005-06 caseload. In addition, as the Committee is aware, the Medicaid caseload that has an option of managed care is decreasing because of Primary Care Physician program does not cover all counties in the State and nor does Denver Health" (page 74). This reduction was consistent with the Department's decision to revert funding in FY 06-07 due to declining caseload estimates.

However, the ultimate action by the Committee was to cut funding to this appropriation by $242,784 rather than the JBC staff's recommendation with the caveat that the Department could request a Comeback if it was concerned. The Department responded with a Comeback to continue funding for FY 07-08 for the amount of $942,784. During the March 16, 2007 Committee meeting, the Department's Comeback received no action.

Beginning FY 07-08, the Department received $797,848 to fund enrollment broker services after the JBC action to cut funding; $700,000 from the SB 97-05 Enrollment Broker line item and $97,848 from the Department's Operating Expenses line item. This funding must cover all mailings to current managed care clients and all new Medicaid clients while meeting state and federal regulations. As a result, the Department signed a 10 month contract with the enrollment broker contractor, Maximus Inc.

Managed Care in the 2007 General Assembly

Concerns about the current options for managed care and decreasing enrollment prompted the legislature to revisit the managed care model. In the 2007 General Assembly regular session, two important managed care bills were passed and signed by the Governor including HB 07-1346 on prepaid inpatient health plans and SB 07-130 on medical homes for children.

In an effort to increase the participation of providers in managed care in Medicaid, the Governor signed HB 07-1346 concerning managed care in the medical assistance program on May 29, 2007. This bill was a JBC sponsored bill that allows the Department to enter into prepaid inpatient health plan (PIHP) agreements, a form of managed care. The

passage of this bill will allow the Department more options with managed care agreements.

On May 31, 2007 the Governor signed SB 07-130 to create medical homes for children. Under this bill, the Department is required to work with the Department of Public Health and Environment (CDPHE) "to develop systems to maximize the number of children in Medicaid and the Children's Basic Health Plan who have a medical home by July 1, 2008" (Legislative Council fiscal note, page 1). This is a form of managed care that would allow qualified medical specialty, developmental, therapeutic or mental health care practices to act as medical homes. The medical home would provide access and coordination of all medically-related services including:

- Health maintenance and preventive care;
- Health education;
- Acute and chronic illness care;
- Coordination of medications, specialists, and therapies;
- Provider participation in hospital care; and
- 24-hour telephone care.

General Description of Request: The purpose of this request is to increase (1) Executive Director's Office, SB 97-05 Enrollment Broker to $957,418. This is a net increase to the enrollment broker contract of $159,570. This increase would restore the enrollment broker to a 12 month contract; address rising postage costs; move $97,848 in enrollment broker expenses out of the (1) Department's Executive Director's Office, Operating Expenses and into the (1) Executive Director's Office, SB 97-05 Enrollment Broker; and fund a full 12 month contract. In addition, the restoration of the enrollment broker contract would fulfill the Department's directive to ensure all Medicaid clients make informed decisions when choosing among available medical assistance programs.

Restoring a Full Year Enrollment Broker Contract

As a result of the reduction in funding during the FY 07-08 Figure Setting from $942,784 to $700,000, the Department worked with the current enrollment broker to create a revised scope of work beginning with the FY 07-08 contract. Although managed care participation has decreased, the Department is still required to send out information through the enrollment broker to every new Medicaid client and yearly to every managed care enrolled client. The primary method of managing to the appropriation included drastically cutting the amount of information provided to clients through a mailing and instead relied on internet resources.

Although this proposed contract was able to manage to the $700,000 appropriation for FY 07-08, direction from the Centers for Medicare and Medicaid Services stated that this contract would not be in compliance with the federal regulation. In an email sent from the Centers for Medicare and Medicaid Services on July 19, 2007, it was stated that mailings directing clients to a website are "not acceptable by the Centers for Medicare and Medicaid Services as a way to provide information to Medicaid clients that are a potential enrollee in Medicaid managed care. CMS requires the State to actually provide all the informational materials to potential enrollees through hard copy mailings. The State may offer the website as an additional place to obtain information, however, the clients need to receive a hard copy of the information materials listed in 42 CFR 438.10." The Department was required to change the FY 07-08 contract back to the former scope of work to ensure compliance and as a result, the enrollment broker is currently funded for ten months in FY 07-08. As such, the Department's contract with the enrollment broker will end on April 30, 2008. This supplemental is an unforeseen contingency based on funding cuts during JBC figure setting and direction from the Centers for Medicare and Medicaid Services on scope of work required of the enrollment broker.

Increasing the contract by $159,606 in funding would allow the Department to provide coverage for a full fiscal year and would also consolidate enrollment broker funding in one line item. This would meet the federal requirements outlined in 42 CFR Section 438.10(e)

which asserts that "The State or its contracted representative must provide the information…to each potential enrollee…at the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs [Managed Care Organizations], PIHPs [Prepaid Inpatient Health Plans], PAHPs [Prepaid Ambulatory Health Plan] or PCCMs [primary care case management]."

Postage Costs

JBC staff initially recommended a reduction of $33,514 to bring the enrollment broker contract back in line with FY 05-06 caseload levels. This recommendation was based on forecasts predicting that caseload would be lower than FY 05-06. Estimates from the FY 08-09 Budget Request, November 1, 2007, predicts total caseload to fall by 5.00%[1] between FY 05-06 and FY 08-09. This decrease in the number of mailings is offset by increases to the cost per mailing. Postage costs have increased by 9.76%[2]. Changes required by the Centers for Medicare and Medicaid Services to the informational material included will increase the printing and mailing costs.

Enrollment Broker and Operating Expenses

Lastly, in addition to restoring the enrollment broker to a 12 month contract, this request also moves $97,848 out of the (1) Executive Director's Office, Operating Expenses and into the (1) Executive Director's Office, SB 97-05 Enrollment Broker. This is the portion of operating that has been added to the enrollment broker contract since FY 05-06 and includes the costs associated with printing and mailing a managed care report card. Moving this funding would allow the Department to manage all enrollment broker costs out of a single line and would improve the transparency in the Department's budget.

[1] Caseload estimates for FY 07-08 were reported as 379,715 whereas FY 05-06 actuals were reported as 399,705.

[2] The United States Postal Service has made two increases since the start of FY 05-06. The first increase occurred in January 2006 and increased the first-class postage rate from $0.37 to $0.39. Postage increased again in May 2007. This increased first-class postage from $0.39 to $0.41. Although enrollment broker packets are mailed at bulk rate, the Department assumes that the total increases are consistent with the change in the first-class rate.

Managed Care and Medicaid

Managed care in Medicaid is an important approach for the State to provide a medical home for the Medicaid clients, to prevent overutilization, and to ensure quality care for clients. The Health Plan Employer Data Information Set (HEDIS) reports show that clients in managed care plans typically receive more primary care services (e.g. immunizations, primary care physician visits) than clients in the fee-for-service program. The Department is in the process of researching ways to expand managed care in the State. The Department currently contracts with various types of managed care organizations, including health maintenance organizations, primary care physicians, and prepaid inpatient health plans. In addition, establishing new relationships with managed care organizations supports the Governor's *The Colorado Promise* to improve access to health care and improve the quality of care provided.

Consequences if Not Funded:

The Department would maintain a 10 month contract with the enrollment broker, ending April 30, 2008. The Department would not be able to contract for enrollment services from May 1, 2008 to June 30, 2008. During this period, the Department would be in violation of federal law and would risk the potential disallowance of the federal match for all Medicaid services.

Calculations for Request:

Table 1: Summary of Request FY 07-08

Summary of Request FY 07-08	Total Funds	General Fund	Federal Funds
Total Request	$159,570	$79,785	$79,785
(1) Executive Director's Office, SB 97-05 Enrollment Broker (Column 3)	$257,418	$128,709	$128,709
(1) Executive Director's Office, Operating Expenses (Column 3)	($97,848)	($48,924)	($48,924)

Table 2: Calculation of 12 Months of Funding

Row	Item	Total	Description
A	(1) Executive Director's Office, SB 97-05 Enrollment Broker	$700,000	SB 07-239
B	(1) Executive Director's Office, Operating Expenses	$97,848	FY 07-08 Enrollment Broker Contract
C	**Total FY 07-08 Enrollment Broker Contract**	**$797,848**	**Row A + Row B**
D	Number of Months in FY 07-08 Contract	10	FY 07-08 Enrollment Broker Contract
E	Monthly Contract Amount for Enrollment Broker Services	$79,785	Row C / Row D
F	**Total Funding Requested for FY 07-08**	**$957,418**	**Row E x 12**
G	**Additional FY 07-08 Funding Requested**	**$159,570**	**Row F - Row C**

Assumptions for Calculations:

Table 2: Calculation of 12 Months of Funding
The Department is requesting $159,570 in total funds to reinstate the enrollment broker contract ending in FY 06-07. This request would be $79,785 General Fund and $79,785 federal funds. This request is the difference between increases in (1) Executive Director's Office, SB 97-05 Enrollment Broker and reductions to the (1) Executive Director's Office, Operating Expenses.

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

FY 07-08 Cost Benefit Analysis	Costs	Benefits
Request	The cost of the request includes $159,570 to reinstate a 12 month enrollment broker contract.	The request would allow the Department to enter into a 12 month contract with the enrollment broker. The Department assumes that the newly designed website would continue as a resource with the restored contract and that the Centers for Medicare and Medicaid Services concerns regarding printed materials would be addressed with the new contract. In addition, all enrollment broker funding would be moved into the (1) Executive Director's Office, SB 97-05 Enrollment Broker. This would increase transparency in the Department's budget.
Consequences if not Funded	The cost of not funding the reinstatement of moneys to the enrollment broker contract would be a partial year contract ending April 30, 2008. Failure to provide enrollment broker services between May 1, 2008 and June 30, 2008 would cause the Department to be noncompliant with federal regulations and the Department would risk losing federal match for all expenditures.	No benefits.

Statutory and Federal Authority:

42 C.F.R. Section 438.10 (a) Terminology - …*Enrollee means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program. Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.*

42 C.F.R. Section 438.10 (b) Basic rules -…*Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. (2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program. (3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.*

42 C.F.R. Section 438.10 (c) Language - …*(1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. ''Prevalent'' means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State. (2) Make available written information in each prevalent non-English language…*

42 C.F.R. Section 438.10 (d) Format - *(i) Use easily understood language and format; and (ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. (2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.*

42 C.F.R. Section 438.10 *(*e) Information for potential enrollees - …*(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program. (ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, or PCCMs. (2) The information for potential enrollees must include…*

42 C.F.R. Section 438.10 (f) General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs. *Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows: (1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period. (2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year…*

Performance Measures:

This supplemental request affects the following Performance Measure:

- Increase the number of clients enrolled in viable managed care options.

The Department believes that restoring the enrollment broker contract will facilitate Medicaid clients in making informed choices about their managed care options. Managed care has been shown to improve health outcomes through the coordination of care and increased participation in preventive health.

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:	Increase Health Maintenance Organization Rates to 99% of Fee-for-Service			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew JB	**Date:** January 2, 2008
Priority Number:	S-12	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	2,061,396,808	2,147,858,908	3,372,648	2,151,231,556	2,147,626,990	0	2,147,626,990	0	2,147,626,990	0
	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	1,686,324	654,107,824	651,512,742	0	651,512,742	0	651,512,742	0
	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	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	1,686,324	1,077,184,108	1,075,381,825	0	1,075,381,825	0	1,075,381,825	0
(2) Medical Services Premiums	**Total**	2,061,396,808	2,147,858,908	3,372,648	2,151,231,556	2,147,626,990	0	2,147,626,990	0	2,147,626,990	0
	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	1,686,324	654,107,824	651,512,742	0	651,512,742	0	651,512,742	0
	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	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	1,686,324	1,077,184,108	1,075,381,825	0	1,075,381,825	0	1,075,381,825	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-12
Change Request Title:	Increase Health Maintenance Organization Rates to 99% of Fee-for-Service

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:

This Change Request increases funding for the Department's Medical Services Premiums Long Bill Group by $3,372,648 total funds to increase capitation rates paid to physical health managed care organizations from 95% of fee-for-service costs to 99% of fee-for-service costs. This funding would enable the Department to retain its sole physical health managed care organization in the Medicaid managed care program.

Background and Appropriation History:

At the beginning of FY 02-03, the Department contracted with five risk-based managed care organizations to provide acute care services to Medicaid clients: Colorado Access, Community Health Plan of the Rockies, Kaiser Foundation Health Plan, Rocky Mountain HMO, and United Health Care. At the time, roughly 50% of Medicaid clients were enrolled in one of these five plans. However, beginning in FY 02-03, the Department's managed care program began to change.

In November 2002, Kaiser Foundation Health Plan and United Health Care exited the program. Community Health Plan of the Rockies ceased providing services in February 2003. In July 2003, Rocky Mountain HMO ended its risk-based contract with the

Department, and entered into a non-risk administrative services contract with the Department for clients on the Western Slope. By the beginning of FY 03-04, approximately 22% of Medicaid clients were enrolled in a risk-based managed care plan.

During that same period, the Department was engaged in litigation and arbitration with four out of five of the managed care plans who had served Medicaid clients during that time, regarding the adequacy of the capitation rates paid to the plans. Between FY 02-03 and FY 04-05, the Department paid an additional $77,810,395 to managed care plans as a result of judgments against the Department (FY 06-07 Joint Budget Committee Hearing, January 5, 2006, page 40). In response to the litigation, the General Assembly passed HB 02-1292, which significantly changed the managed care statute, and required that managed care organizations certify that capitation rates are actuarially sound, and that those rates are sufficient to assure the managed care organization's financial stability. Capitation rates were restricted to "ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado Medicaid population group" [25.5-5-408 (1) (b), C.R.S. (2007)], and therefore did not include any specific allowance for administrative services.

In May 2004, Denver Health formed a managed care organization known as Denver Health Medicaid Choice, and began providing services to Medicaid clients under a risk-based contract. Still, by the beginning of FY 04-05, enrollment in risk-based managed care had shrunk to approximately 15% of Medicaid clients. Enrollment reached a low of approximately 12.5% of Medicaid clients in April 2006.

On May 1, 2006, the Department initiated passive enrollment in Adams, Arapahoe, Denver, and Jefferson counties. Under passive enrollment, newly eligible clients were notified of their option to choose a Medicaid managed care plan or the Medicaid fee-for-service plan. Clients who did not actively make a decision were passively enrolled into either Colorado Access or Denver Health Medicaid Choice. In addition to newly eligible clients, existing fee-for-service clients from these four counties were given the same options, although the Department limited participation to a portion of the clients per

month. Under passive enrollment, enrollment in risk-based managed care plans almost doubled between May and August 2006.

However, on September 1, 2006, Colorado Access ended its participation in the Medicaid physical health managed care program. Now, less than 10% of Medicaid clients are enrolled in a risk-based managed care organization. No new managed care organization has joined the Department since 2004. There is no risk-based managed care option outside the Denver-metro area.

During the 2007 Legislative Session, the General Assembly passed HB 07-1346, which removed the requirement that the Department pay no more than 95% of the direct health care cost of providing the same services on an actuarially equivalent population (HB 07-1346, Section 4, revising 25.5-5-408 (1) (b), C.R.S.). Further, the requirement that managed care organizations submit a proposal at or below the 95% level was modified to require the managed care organization to submit a proposal at or below 100% of the direct health care cost.

The Department did not receive an appropriation to increase rates to the 100% level. The Legislative Council fiscal note for HB 07-1346 stated that "…no state funds will be used to increase capitation rates" (Legislative Council Fiscal Note, HB 07-1346, May 30, 2007, page 3).

In June 2007, the Department was informed by Denver Health Medicaid Choice that unless capitation rates were increased to the 100% level, that it would leave the Medicaid managed care program. In response, the Department submitted a 1331 Emergency Supplemental to the Joint Budget Committee requesting permission and funding to raise rates to the 100% level. The Joint Budget Committee did not approve the Emergency Supplemental, but sent a letter to the Department stating:

> The Joint Budget Committee has reviewed the Department's FY 2007-08 emergency supplemental request to increase health maintenance organization (HMO) rates to 100 percent of the fee-for-service costs for direct health care services. At this time,

> the Committee has not approved a change to the Department's appropriation for the Medical Services Premiums (MSP) line item. The Committee will address all funding changes to the MSP line item, including the funding needed for this issue, during the March 2008 supplemental review. Although a change to the appropriation has not been approved at this time, **the Committee gives a favorable review to the Department's plan to negotiate HMO rates for Denver Health Medicaid Choice up to 100 percent of the fee-for-service costs** pursuant to Section 25.5-5-408 (9), Colorado Revised Statutes, (2007).
>
> The Committee is fully aware that a favorable review of the Department's plan will have an eventual appropriation impact. (**Emphasis** added).[1]

Based on the letter from the Joint Budget Committee, the Department entered into a contract with Denver Health Medicaid Choice effective July 1, 2007 to pay rates at the 99% of fee-for-service level to ensure that Medicaid clients continued to have adequate health care coverage.

General Description of Request: The Department requests $3,372,648 total funds to increase capitation rates from the 95% of fee-for-service level to the 99% level for FY 07-08. The Department is permitted to pay rates up to the 100% of fee-for-service level by HB 07-1346, Section 4, although the Department did not receive any funding to raise capitation rates. Increasing capitation rates to the 99% level is a significant policy change that will increase expenditure. Because the Department cannot implement such a policy change without additional funding, this request seeks an appropriation from the General Assembly for the purpose of raising capitation rates to the 99% level. This request would allow the approximately 36,500 clients enrolled in Denver Health Medicaid Choice, to remain in the same medical home. If Denver Health Medicaid Choice were to exit the Medicaid managed care program, these clients would transition from managed care to fee-for-service.

[1] Letter from the Joint Budget Committee to Joan Henneberry, Executive Director, Department of Health Care Policy and Financing. June 20, 2007.

In September 2006, when Colorado Access ceased providing services as a physical health managed care organization, a significant number of clients were able to select Denver Health Medicaid Choice as their new medical home. This mitigated the impact of Colorado Access leaving the program, as clients were able to choose an alternative pre-existing network of providers. However, because Denver Health Medicaid Choice is the last remaining Medicaid physical health managed care organization, clients currently enrolled in managed care will immediately move to the fee-for-service population. This is a major change for clients who receive services in the managed care program.

The Department does not believe that a significant number of clients will transition to the primary care physician program. When Colorado Access exited the Medicaid managed care program in September 2006, the Department enrollment in the primary care physician program did not increase. Enrollment in the primary care physician program is not only a function of client need, but also of the ability of providers to take on additional caseload. As was seen after Colorado Access left, there does not appear to be either the capacity or the willingness to accept new clients in the program.

The Department does not require any additional administrative resources to implement the change. The Department, in consultation with its actuary, has determined that rates at the 99% level fall within the range required to maintain actuarial soundness for FY 07-08.

Consequences if Not Funded:

If the Department's request is not approved, Denver Health Medicaid Choice would likely exit the Medicaid managed care program. Approximately 36,500 clients would transition from managed care to fee-for-service. The Department may experience increased costs as a result of paying the full fee-for-service rates, as the Department was previously paying 95% of the fee-for-service cost for these clients. The Department anticipates that it would see increases in more expensive emergency services, as clients' access to primary and preventive care would likely be disrupted. Furthermore, with reduced access to primary and preventive care offered through managed care, the quality of care of patient care could deteriorate, resulting in additional costs.

If this request is not approved, the Department would attempt to cease paying rates at the 99% level. It is unknown if the Department could retroactively return rates to the 95% level. If the Department is unable to restore rates to the 95% level, the Department would be at risk for paying rates at the 99% level for the full year. Therefore, the Department may require an additional supplemental appropriation to provide additional funding for the period of time between the beginning of the fiscal year and the time rates can be restored to the 95% level (if possible). Without funding, the Department would be required to absorb the impact of the change in its Medical Services Premiums line item. This has the potential to cause a significant overexpenditure in FY 07-08.

Further, the Department's ability to encourage new risk-based managed care organizations to participate in the Medicaid program will remain at its current low level. Other than Denver Health Medicaid Choice, the Department has not had a new physical health managed care organization enter the program since August 1997.

The Department estimates that the increased cost of these clients transitioning to the fee-for-service population would be equal to or greater than the cost of increasing capitation rates to the 100% level. If the Department experienced increased costs as a result of the transition, the Department would request additional funding as part of the normal Supplemental Budget Request for Medical Services Premiums on February 15, 2008 or the Budget Request for Medical Services Premiums on November 1, 2008.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund	Federal Funds
Total Request (Matches column 3, Schedule 13)	**$3,372,648**	**$1,686,324**	**$1,686,324**
(2) Medical Services Premiums (Matches column 3, Schedule 13)	$3,372,648	$1,686,324	$1,686,324

Source for Summary of Request located in Table 1, on page 11.

Assumptions for Calculations: The Department has calculated the impact of increasing capitation rates to the 99% level using current figures for Denver Health Medicaid Choice enrollment. Enrollment figures have been adjusted to reflect estimated caseload growth, using trend factors from the Department's November 1, 2007 Budget Request for Medical Services Premiums (page EB-1). To the extent that actual enrollment varies from the forecast, the Department may require more or less funding in FY 08-09 and subsequent years. If the Department experiences increased costs as a result of the transition, the Department may request additional funding as part of the normal Supplemental Budget Request for Medical Services Premiums on February 15, 2008.

Impact on Other Government Agencies: None.

Cost Benefit Analysis: Return on Investment Analysis

The Department anticipates that increasing capitation rates will enable the Department to retain Denver Health Medicaid Choice as a physical health managed care organization. This will increase client access to primary and preventive care. Without this access, clients may experience adverse health outcomes from preventable illnesses which would have been avoided if clients had expanded access to primary and preventive care. As clients

experience adverse health outcomes, the Department is required to purchase more expensive treatments, likely increasing state expenditure on these clients by at least 10% above the 100% of fee-for-service level.

Investment:	**Cost Avoidance**
Additional cost of increased capitation rates	Possible higher incidence of preventable illness and adverse health outcome.
	Increased capitation rates due to higher risk accepted by the managed care organization potentially avoided.
$3,372,648 Total FY 07-08 requested funds	**Approximately $3,709,713**
	ROI = 1.10

Implementation Schedule: The Department implemented new capitation rates on July 1, 2007.

Statutory and Federal Authority: 25.5-5-402, C.R.S. (2007). Statewide managed care system.
(1) The state board shall adopt rules to implement a managed care system for Colorado medical assistance clients pursuant to the provisions of this article and articles 4 and 6 of this title. The statewide managed care system shall be implemented to the extent possible.

25.5-5-408, C.R.S. (2007) [as enacted by HB 07-1346]. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients.
(9) The rate-setting process referenced in subsection (6) of this section shall include a time period after the MCOs have received the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407, for each MCO to submit to the state department the MCO's capitation payment proposal, which shall not exceed one hundred percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients

in the primary care physician program provided in section 25.5-5-407. The state department shall provide to the MCOs the MCO's specific adjustments to be included in the calculation of the MCO's proposal. Each MCO's capitation payment proposal shall meet the requirements of section 25.5-5-404 (1) (k) and (1) (l).

Performance Measures:

This Change Request affects the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs.
- 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.
- Survey customer satisfaction with managed care using the Consumer Assessment of Health Plans Survey (CAHPS).

The Department believes that increasing health maintenance organization rates to the 99% of the fee-for-service level will increase overall access to health care, thereby increasing customer satisfaction and quality of health outcomes.

Table 1: Estimate of Increase in Expenditure Due to Increase in Capitation Rates FY 07-08 Impact									
Column		**A**	**B**	**C**	**D**	**E**	**G**	**H**	**I**
Aid Category	**Rate Subcategory**	**FY 07-08 Rate 95% of Fee-for-Service**	**FY 07-08 Rate 99% of Fee-for-Service**	**Difference**	**Estimated FY 06-07 Monthly Enrollment**	**Estimated Trend from FY 06-07 to FY 07-08**	**Estimated FY 07-08 Monthly Enrollment**	**Estimated Increase in FY 07-08 Monthly Expenditure**	**Estimated Increase in FY 07-08 Expenditure**
Categorically Eligible Low-Income Adults (AFDC-A)	Female	$183.71	$191.44	$7.73	4,015	-11.94%	3,535	$27,333	$327,996
Categorically Eligible Low-Income Adults (AFDC-A)	Male	$162.31	$169.15	$6.84	720	-11.94%	634	$4,335	$52,020
Baby Care Program Adults		$180.89	$188.50	$7.61	215	6.44%	229	$1,744	$20,928
Eligible Children (AFDC-C/BC)	Age 1 and Over	$58.08	$60.52	$2.44	19,027	-6.47%	17,796	$43,470	$521,640
Eligible Children (AFDC-C/BC)	Under 1	$191.73	$199.80	$8.07	2,468	-6.47%	2,308	$18,628	$223,536
Foster Care		$213.20	$222.18	$8.98	139	11.01%	154	$1,383	$16,596
Adults 65 and Older (OAP-A)	Non-Institutional	$231.95	$241.72	$9.77	3,369	-1.96%	3,303	$32,271	$387,252
Adults 65 and Older (OAP-A)	Institutional	$214.79	$223.84	$9.05	191	-1.96%	187	$1,691	$20,292
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Medicaid Only	$726.00	$756.56	$30.56	4,234	1.62%	4,303	$131,515	$1,578,180
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Third Party Coverage	$186.45	$194.30	$7.85	1,779	1.62%	1,808	$14,198	$170,376
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Medicaid Only	$1,585.23	$1,651.98	$66.75	63	1.62%	64	$4,272	$51,264
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Third Party Coverage	$181.89	$189.55	$7.66	28	1.62%	28	$214	$2,568
Total					36,248		34,349	$281,054	**$3,372,648**
Formula/Notes		(1)	(1)	B - A	(2)	(3)	D * (1 + E)	C * F	G * 12

(1) FY 07-08 capitation rates taken from the Department's Actuarial Certification letter

(2) Estimated FY 06-07 Monthly Enrollment based on internal Department figures for Denver Health Medicaid Choice enrollment, using the average of January - June 2007

(3) Estimated trend taken from the Department's November 1, 2007 Budget Request, Exhibits for Medical Services Premiums, page EB-1. For the purpose of this analysis, the Department assumes that enrollment trends will reflect overall Medicaid caseload trends by aid category. For the combined Disabled Individuals category, the Department uses the Disabled Individuals to 59 (AND/AB) trend, as those clients represent the large majority of clients served in this rate group.

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:	Adjust Cash Flow for Integrated Care Delivery Model			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-13, BA-4	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	2,061,396,808	2,147,858,908	2,392,954	2,150,251,862	2,147,626,990	0	2,147,626,990	1,404,939	2,149,031,929	0
	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	1,196,477	653,617,977	651,512,742	0	651,512,742	702,470	652,215,212	0
	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	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	1,196,477	1,076,694,261	1,075,381,825	0	1,075,381,825	702,469	1,076,084,294	0
(2) Medical Services Premiums	**Total**	2,061,396,808	2,147,858,908	2,392,954	2,150,251,862	2,147,626,990	0	2,147,626,990	1,404,939	2,149,031,929	0
	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	1,196,477	653,617,977	651,512,742	0	651,512,742	702,470	652,215,212	0
	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	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	1,196,477	1,076,694,261	1,075,381,825	0	1,075,381,825	702,469	1,076,084,294	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-13, BA-4
Change Request Title:	Adjust Cash Flow for Integrated Care Delivery Model

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 $2,392,954 total funds in FY 07-08 and $1,404,939 total funds in FY 08-09 to account for cash flow issues involved in implementing an integrated care delivery model with managed care organizations.

Background and Appropriation History: At the beginning of FY 02-03, the Department contracted with five risk-based managed care organizations to provide acute care services to Medicaid clients: Colorado Access, Community Health Plan of the Rockies, Kaiser Foundation Health Plan, Rocky Mountain HMO, and United Health Care. At the time, roughly 50% of Medicaid clients were enrolled in one of these five plans. However, in FY 02-03, the Department's managed care program began to change.

In November 2002, Kaiser Foundation Health Plan and United Health Care exited the program. Community Health Plan of the Rockies ceased providing services in February 2003. In July 2003, Rocky Mountain HMO ended its risk-based contract with the Department and entered into a non-risk administrative services contract with the

Department for clients on the Western Slope. By the beginning of FY 03-04, approximately 22% of Medicaid clients were enrolled in a risk-based managed care plan.

During that same period, the Department was engaged in litigation and arbitration with four out of five of the managed care plans who had served Medicaid clients during that time regarding the adequacy of the capitation rates paid to the plans. Between FY 02-03 and FY 04-05, the Department paid an additional $77,810,395 to managed care plans as a result of judgments against the Department (FY 06-07 Joint Budget Committee Hearing, January 5, 2006, page 40). In response to the litigation, the General Assembly passed HB 02-1292, which significantly changed the managed care statute and required that managed care organizations certify that capitation rates are actuarially sound and that those rates are sufficient to assure the managed care organization's financial stability. Capitation rates were restricted to "ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado Medicaid population group" [25.5-5-408 (1) (b), C.R.S. (2007)], and therefore did not include any specific allowance for administrative services.

In May 2004, Denver Health formed a managed care organization known as Denver Health Medicaid Choice and began providing services to Medicaid clients under a risk-based contract. Still, by the beginning of FY 04-05, enrollment in risk-based managed care had shrunk to approximately 15% of Medicaid clients. Enrollment reached a low of approximately 12.5% of Medicaid clients in April 2006.

On May 1, 2006, the Department initiated passive enrollment in Adams, Arapahoe, Denver, and Jefferson counties. Under passive enrollment, newly eligible clients were notified of their option to choose a Medicaid managed care plan or the Medicaid fee-for-service plan. Clients who did not actively make a decision were passively enrolled into either Colorado Access or Denver Health Medicaid Choice. In addition to newly eligible clients, existing fee-for-service clients from these four counties were given the same options, although the Department limited participation to a portion of the clients per month. Under passive enrollment, enrollment in risk-based managed care plans almost doubled between May and August 2006.

However, on September 1, 2006, Colorado Access ended its participation in the Medicaid physical health managed care program. Now, less than 10% of Medicaid clients are enrolled in a risk-based managed care organization. No new managed care organization has joined the Department since 2004. There is no risk-based managed care option outside the Denver-metro area.

During the 2007 Legislative Session, the General Assembly passed HB 07-1346 which removed the requirement that the Department pay no more than 95% of the direct health care cost of providing the same services on an actuarially equivalent population (HB 07-1346, Section 4, revising 25.5-5-408 (1) (b), C.R.S.). Further, the requirement that managed care organizations submit a proposal at or below the 95% level was modified to require the managed care organization to submit a proposal at or below 100% of the direct health care cost.

As part of the Colorado Promise, the Department is committed to ensuring that clients receive services as part of an integrated care delivery model, including managed care. Such a model ensures that clients will have access to needed services in a timely and efficient manner, reducing adverse health outcomes and improving overall client satisfaction.

General Description of Request: The Department requests $2,392,954 total funds in FY 07-08 and $1,404,939 total funds in FY 08-09 to account for cash flow issues involved in implementing an integrated care delivery model. 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.

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.

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 5,000 clients will be able to enroll in a managed care plan in April 2008 and an additional 20,000 clients will be able to enroll in a managed care plan in FY 08-09. It is a long-term goal of the Department to enroll most, if not all, Medicaid clients into a managed care program that will improve health outcomes and reduce unnecessary expenditures.

Consequences if Not Funded:

If not funded, the Department may overexpend its appropriation for Medical Services Premiums. Because the Department has overexpenditure authority for Medicaid programs, this may adversely affect the State budget in other areas.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund	Federal Funds
Total Request Matches Schedule 13, Column 3	**$2,392,954**	**$1,196,477**	**$1,196,477**
(2) Medical Services Premiums Plan A - April 1, 2008 Start Date	$2,392,954	$1,196,477	$1,196,477
(2) Medical Services Premiums Plan B - July 1, 2008 Start Date	$0	$0	$0

Summary of Request FY 08-09	Total Funds	General Fund	Federal Funds
Total Request Matches Schedule 13, Column 8	**$1,404,939**	**$702,470**	**$702,469**
(2) Medical Services Premiums Plan A - April 1, 2008 Start Date	$323,614	$161,807	$161,807
(2) Medical Services Premiums Plan B - July 1, 2008 Start Date	$1,081,325	$540,663	$540,662

The calculations for these figures are located in tables 1 through 3 at the end of this Request.

Assumptions for Calculations: The Department has estimated the total impact based on preliminary discussions with two managed care organizations. At this time, however, the Department does not have signed contracts with either entity. The estimated rates, caseload, and timing may change based on a wide variety of factors, including actuarial certification of capitation rates and approval from the federal Centers for Medicare and Medicaid Services (CMS). Further, the managed care organizations may still choose not to contract with the Department.

Expenditure Assumptions

The total budgetary impact of this Request depends on the amount of claims incurred by clients but not yet billed to the Department. This liability is typically known as "incurred but not reported" (IBNR). In Table 1, the Department estimates the average monthly expenditure for services that will be incurred by clients prior to enrolling in managed care. To estimate this cost, the Department uses the current FY 07-08 managed care capitation rates as a benchmark. The current rates are a good estimate for the total amount of claims that these clients will incur because the rates are designed to pay a managed care organization for the full amount of services that a clients are anticipated to incur. Therefore, they should be comparable to the estimated costs the clients will incur in fee-for-service. The rates are multiplied by the estimated caseload for each rate cell to calculate a total average monthly expenditure. For reference, the managed care organization anticipated to serve clients starting in April 2008 is referred to as "Plan A", and the managed care organization anticipated to serve clients starting in July 2008 is "Plan B." For clients enrolling in Plan B, the Department has inflated the rates by the estimated per capita increase by aid category from the November 1, 2007 Budget Request, Section E, Exhibit F, page EF-4, as the FY 07-08 rates will change in FY 08-09.

Caseload Assumptions

The first managed care organization, Plan A, is estimated to be able to enroll clients starting April 1, 2008. This plan will serve exclusively elderly and disabled clients and enrollment is estimated to be approximately 5,000 clients. The Department anticipates that all clients enrolled on April 1 will be existing Medicaid clients, and therefore, enrollment will reach the maximum level in the first month.

The second managed care organization, Plan B, is estimated to be able to enroll clients starting July 1, 2008. This plan will serve all categories of Medicaid clients eligible to be enrolled in managed care, and total enrollment is estimated to be approximately 20,000 clients. The Department anticipates that enrollment will be staggered and that the average monthly caseload in FY 08-09 will be a total of 10,833 clients. Of this total, the Department anticipates that half the total, or 5,417 clients, will come from existing fee-for-

service clients. Existing clients will be enrolled in the first month. The remainder will be new Medicaid clients.

Incurred but not Reported (IBNR) Assumptions
In tables 2 and 3, the Department estimates the outstanding liability. Table 2 estimates the impact of Plan A (April 1 start date), and table 3 estimates the impact of Plan B (July 1 start date). The calculations in both tables are identical, although the assumptions vary between the tables.

For clients enrolling in either plan, there will be some claims which have been incurred in the previous months which will be paid concurrent with the managed care capitation. Based on estimates of incurred but not reported claims used in the FY 07-08 managed care rate setting process, the Department has calculated that claims require as much as 10 months to be submitted. The factors in Column C of table 2 represent the portion of claims incurred in each month of service in Column A that will have been paid through the end of March 2008. For example, for claims incurred in June 2007, the Department estimates that 99.77% of those claims have been paid by the end of March 2008. The difference between the estimated incurred claims (Column B) and the estimated total paid through March 2008 (Column D) is the total claims outstanding (Column E). This is the total liability.

Not all of the total liability will be paid in FY 07-08. For example, claims which were incurred in March 2008 will only be 96.03% paid though the end of the fiscal year (Column F and G). The remainder of the payment will occur in the next fiscal year, FY 08-09. To calculate the amount of incurred by not reported claims paid in FY 07-08, the Department subtracts the total amount expected to be paid in FY 07-08 (Column G) from the total amount paid through March 2008 (Column D). This is the FY 07-08 concurrent paid claims (Column H); specifically, those claims that will be paid concurrently with a managed care capitation. The difference between the total liability (Column E) and the amount paid in FY 07-08 (Column H) is the FY 08-09 concurrent paid claims.

In Table 3, the months of service have shifted because of the later implementation date. However, the factors used to calculate the estimated percent paid remain the same. This is because the factors are dependant on the difference (in months) between when the claims were incurred and when they are expected to be paid. The actual calendar month does not affect the calculation. Additionally, because all existing clients are expected to be enrolled first, the entire liability is incurred in FY 08-09, and does not carry forward in FY 09-10.

Impact on Other Government Agencies: None.

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 enrolling clients in managed care, including:

- Maintaining client access to primary care and emergency health care services;
- Improving client utilization of preventive primary care medicine; 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 enrolling clients in managed care outweigh the costs.

Implementation Schedule:

Task	Month/Year
Plan A contract signed	February 2008
Plan A enrollment notices sent to clients	March 2008
Plan A clients enrolled	April 2008
Plan B contract signed	May 2008
Plan B enrollment notices sent to clients	June 2008
Plan B clients enrolled	July 2008

Statutory and Federal Authority:

25.5-4-201, C.R.S. (2007). Cash system of accounting - financial administration of medical services premiums - medical programs administered by department of human services - federal contributions - rules.
(1) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of any nonadministrative expenditure that qualifies for federal financial participation under Title XIX of the federal "Social Security Act", except for expenditures under the program for the medically indigent, article 3 of this title.

25.5-5-402, C.R.S. (2007). Statewide managed care system.
(1) The state board shall adopt rules to implement a managed care system for Colorado medical assistance clients pursuant to the provisions of this article and articles 4 and 6 of this title. The statewide managed care system shall be implemented to the extent possible.

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.

The Department believes that enhancing its managed care network will increase overall access to health care, thereby increasing customer satisfaction and quality of health outcomes.

Table 1: Estimate of Increase in Expenditure Due to Increase in Capitation Rates								
Column		**A**	**B**	**C**	**D**	**E**	**F**	**G**
Aid Category	**Rate Subcategory**	**Estimated FY 07-08 Rate**	**Estimated Plan A Monthly Enrollment**	**Estimated Plan A Monthly Expenditure**	**FY 08-09 Estimated Increase in Per Capita Cost**	**Estimated FY 08-09 Rate**	**Estimated Plan B Monthly Enrollment**	**Estimated Plan B Monthly Expenditure**
Categorically Eligible Low-Income Adults (AFDC-A)	Female	$191.44	-	$0	2.50%	$196.23	609	$119,504
Categorically Eligible Low-Income Adults (AFDC-A)	Male	$169.15	-	$0	2.50%	$173.38	114	$19,765
Baby Care Program Adults		$188.50	-	$0	6.15%	$200.09	31	$6,203
Eligible Children (AFDC-C/BC)	Age 1 and Over	$60.52	-	$0	4.16%	$63.04	2,892	$182,312
Eligible Children (AFDC-C/BC)	Under 1	$199.80	-	$0	4.16%	$208.11	381	$79,290
Foster Care		$222.18	-	$0	10.02%	$244.44	24	$5,867
Adults 65 and Older (OAP-A)	Non-Institutional	$241.72	1,941	$469,179	2.29%	$247.26	434	$107,311
Adults 65 and Older (OAP-A)	Institutional	$223.84	111	$24,846	2.29%	$228.97	25	$5,724
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Medicaid Only	$756.56	2,906	$2,198,563	3.36%	$781.96	650	$508,274
Disabled Individuals and Adults (OAP-B and AND/AB)	Non-Institutional, Third Party Coverage	$194.30	-	$0	3.36%	$200.82	243	$48,799
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Medicaid Only	$1,651.98	42	$69,383	3.36%	$1,707.43	9	$15,367
Disabled Individuals and Adults (OAP-B and AND/AB)	Institutional, Third Party Coverage	$189.55	-	$0	3.36%	$195.91	5	$980
Total			**5,000**	**$2,761,971**			**5,417**	**$1,099,396**
Formula/Notes		(1)	(2)	A * B	(3)	A * (1 + D)	(2)	E * F

(1) FY 07-08 capitation rates taken from the Department's Actuarial Certification letter

(2) Estimated FY 06-07 Monthly Enrollment based on internal Department figures for current enrollment, using the average of January - June 2007. New plans are assumed to have the same proportion of enrollment by aid category as the current program.

(3) The estimated increase in per capita cost, applied to the FY 07-08 capitation rates, is taken from the Department's November 1, 2007 Budget Request, Section E, Exhibit F

Totals in Columns C and F are carried forward to Tables 2 and 3, respectively.

Table 2
Plan A: April 1, 2008 Implementation

A	B	C	D	E		F	G	H	I
Month of Service	Estimated Incurred Claims	Estimated Percent Paid Through March 2008	Estimated Total Paid Through March 2008	Total Claims Outstanding (Incurred But Not Reported)		Estimated Percent of Claims Paid in FY 07-08 (Total)	Estimated Claims Paid in FY 07-08 (Total)	FY 07-08 Concurrent Paid Claims[3]	FY 08-09 Concurrent Paid Claims[3]
June 2007	$2,761,971	99.77%	$2,755,668	$6,303		100.00%	$2,761,971	$6,303	$0
July 2007	$2,761,971	99.57%	$2,750,227	$11,744		100.00%	$2,761,971	$11,744	$0
August 2007	$2,761,971	99.25%	$2,741,160	$20,811		100.00%	$2,761,971	$20,811	$0
September 2007	$2,761,971	98.73%	$2,726,799	$35,172		99.77%	$2,755,668	$28,869	$6,303
October 2007	$2,761,971	98.04%	$2,707,893	$54,078		99.57%	$2,750,227	$42,334	$11,744
November 2007	$2,761,971	96.89%	$2,676,180	$85,791		99.25%	$2,741,160	$64,980	$20,811
December 2007	$2,761,971	96.03%	$2,652,256	$109,715		98.73%	$2,726,799	$74,543	$35,172
January 2008	$2,761,971	91.36%	$2,523,324	$238,647		98.04%	$2,707,893	$184,569	$54,078
February 2008	$2,761,971	83.00%	$2,292,448	$469,523		96.89%	$2,676,180	$383,732	$85,791
March 2008	$2,761,971	39.00%	$1,077,187	$1,684,784		96.03%	$2,652,256	$1,575,069	$109,715
Total	**$27,619,710**		**$24,903,142**	**$2,716,568**			**$27,296,096**	**$2,392,954**	**$323,614**
	Table 1	(1)	B * C	B - D		(2)	B * F	G - D	E - H

(1) Estimate of Incurred But Not Reported (IBNR) claims used in FY 07-08 managed care rate setting.

(2) Adjusted IBNR factors to account for payments made between April and June 2008.

(3) "Concurrent Paid Claims" means that these are the claims that the Department will be paying for concurrently with a managed care capitation.

Table 3
Plan B: July 1, 2008 Implementation

A	B	C	D	E		F	G	H	I
Month of Service	Estimated Incurred Claims	Estimated Percent Paid Through June 2008	Estimated Total Paid Through June 2008	Claims Outstanding (Incurred But Not Reported)		Estimated Percent of Claims Paid in FY 08-09 (Total)	Estimated Claims Paid in FY 08-09 (Total)	FY 07-08 Concurrent Paid Claims[3]	FY 08-09 Concurrent Paid Claims[3]
September 2007	$1,099,396	99.77%	$1,096,887	$2,509		100.00%	$1,099,396	$2,509	$0
October 2007	$1,099,396	99.57%	$1,094,721	$4,675		100.00%	$1,099,396	$4,675	$0
November 2007	$1,099,396	99.25%	$1,091,112	$8,284		100.00%	$1,099,396	$8,284	$0
December 2007	$1,099,396	98.73%	$1,085,396	$14,000		100.00%	$1,099,396	$14,000	$0
January 2008	$1,099,396	98.04%	$1,077,870	$21,526		100.00%	$1,099,396	$21,526	$0
February 2008	$1,099,396	96.89%	$1,065,247	$34,149		100.00%	$1,099,396	$34,149	$0
March 2008	$1,099,396	96.03%	$1,055,724	$43,672		100.00%	$1,099,396	$43,672	$0
April 2008	$1,099,396	91.36%	$1,004,403	$94,993		100.00%	$1,099,396	$94,993	$0
May 2008	$1,099,396	83.00%	$912,503	$186,893		100.00%	$1,099,396	$186,893	$0
June 2008	$1,099,396	39.00%	$428,772	$670,624		100.00%	$1,099,396	$670,624	$0
Total	**$10,993,960**		**$9,912,635**	**$1,081,325**			**$10,993,960**	**$1,081,325**	**$0**
	Table 1	(1)	B * C	B - D		(4)	B * F	G - D	E - H

(1) Estimate of Incurred But Not Reported (IBNR) claims used in FY 07-08 managed care rate setting.

(3) "Concurrent Paid Claims" means that these are the claims that the Department will be paying for concurrently with a managed care capitation.

(4) All claims are estimated to be paid by the end of FY 08-09.

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: Implement Mental Health Audit Findings
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew **Date:** January 2, 2008
Priority Number: S-14, BA-5 **OSPB Approval:** **Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	15,260,951	16,715,590	125,000	16,840,590	18,860,743	0	18,860,743	250,000	19,110,743	0
	FTE	225.36	245.30	0.00	245.30	259.50	0.00	259.50	0.00	259.50	0.00
	GF	6,054,845	7,261,822	62,500	7,324,322	7,768,653	0	7,768,653	125,000	7,893,653	0
	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	62,500	8,783,287	8,758,214	0	8,758,214	125,000	8,883,214	0
(1) Executive Director's Office Personal Services	**Total**	15,260,951	16,715,590	125,000	16,840,590	18,860,743	0	18,860,743	250,000	19,110,743	0
	FTE	225.36	245.30	0.00	245.30	259.50	0.00	259.50	0.00	259.50	0.00
	GF	6,054,845	7,261,822	62,500	7,324,322	7,768,653	0	7,768,653	125,000	7,893,653	0
	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	62,500	8,783,287	8,758,214	0	8,758,214	125,000	8,883,214	0

Letternote revised text:
Cash Fund name/number, Federal Fund Grant name: FF: Title XIX
IT Request: ☐ Yes ☑ No
Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-14, BA-5
Change Request Title:	Implement Mental Health Audit Findings

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: This Change Request increases funding for the Department's Executive Director's Office Long Bill Group by $125,000 total funds in FY 07-08 and $250,000 total funds in FY 08-09 in order to comply with the Office of the State Auditor's Performance Audit of Medicaid Mental Health Rates. This funding would be used to develop a standardized encounter data reporting manual for use by providers, and to assess and verify the fee-schedule for mental health encounter claims in order to create a standard mental health fee schedule that is reflective of reasonable and appropriate rates.

Background and Appropriation History: In November 2006, the Office of the State Auditor released the results of a performance audit of Medicaid mental health rates. The audit was conducted between June and November 2006 and evaluated the Department's rate setting methodology used to establish rates for services paid in the Department's mental health managed care program; reviewed processes for managing service utilization and quality; assessed the controls in place to ensure that services provided are medically necessary and access to services has not been limited inappropriately; and, that service data reported to the State are accurate

and complete.[1] In particular, this Request deals with those audit findings related to the usage of encounter data in calculating the mental health capitation rates. Findings and recommendations which the Department was or is able to implement without additional funding are not discussed in this Change Request.

The Department contracts with five behavioral health organizations (BHOs) to provide mental health services to Medicaid clients. The Department makes a monthly payment to each BHO for each Medicaid client within the BHO's geographical service area. In return for the capitated payment, each BHO agrees to provide all medically necessary mental health services to any Medicaid member in the service area that needs services.

In 2003, the Centers for Medicare and Medicaid Services (CMS) revised regulations related to payments to managed care organizations. Existing regulations were replaced with requirements that all managed care rates be actuarially sound, 42 CFR 438.6(c) (2007). This removed the requirement that rates be based on historical fee-for-service data and gave states flexibility to use alternative data sources, including service encounters. In the opinion of the State Auditor, limited use of encounter data in the rate setting methodology puts the Department at a future risk of losing federal financial participation. In FY 08-09, the Department's Budget Request for Mental Health Capitation Payments is $208,102,155, of which $104,059,609 is federal matching funds.

The Centers for Medicare and Medicaid Services approved the Department's FY 07-08 rate-setting methodology which incorporated both reported encounter data and historical fee-for-service claims. In the future, the Department anticipates that CMS will require a greater reliance on encounter data. Because there are numerous ways in which encounter data can be used in rate setting, the Department is committed to ensuring that stakeholders continue to have input in the rate setting process. Even though encounter data, as a CMS-preferred data source, will be used to construct a large share of the rate, the Department is open to usage of other sources of data for consideration in rate setting.

[1] The Performance Audit report can be found on the Office of the State Auditor's website at http://www.state.co.us/auditor. The specific audit is "Medicaid Mental Health Rates, Performance Audit, November 2006, Department of Health Care Policy and Financing."

Encounter Data Manual

Under a managed care system, claims incurred by clients are processed and paid by the managed care organization. These claims are not submitted to the Department for processing, and the Department has no claims record of the specific services provided to clients. Because the Department's statewide managed care system has been in place for over 10 years, recent historical fee-for-service data for mental health services are not available. As a result, encounter data should be used during rate setting to assess the actual Medicaid reimbursable services provided to the individuals covered under the managed care program. Therefore, the encounter data reported must be accurate, consistent, and complete to provide a valid basis for determining appropriate capitation rates.

Encounter data reporting varies by the provider. For example, the performance audit found that four out of the five behavioral health organizations (BHOs) did not require their providers to submit encounter data using codes compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Instead, these providers are allowed to report encounters using various self-developed procedure codes. The BHOs then convert these procedure codes to HIPAA compliant codes using individual "crosswalks" they have developed in order for encounter data to be reported to the Department.

As a result, the providers that render the vast majority of the services within the mental health program likely do not report encounter data consistently to the BHOs or to the Department. Consequently, it is difficult to conduct meaningful analysis of service utilization on a statewide basis. Problems described in the performance audit include inconsistent data reporting, incomplete data due to sub-capitation arrangements, and potential miscoding due to the re-coding of provider-specific codes. Such issues can have a material effect on the capitation rate.

As a result, the Office of the State Auditor issued the following recommendation:

Recommendation No. 7:

The Department of Health Care Policy and Financing should develop a standardized encounter reporting manual for the Medicaid Community Mental Health Services Program to ensure all services are coded by the service provider, at the point of service, in accordance with HIPAA-compliant procedure codes and to ensure that accuracy and consistency of encounter data reported. This manual should provide detailed instructions on the submission of encounter data by BHOs, as well as reporting requirements for the BHOs' internal and external network providers. Once the manual is complete, all service providers should be required to report encounters to BHOs using HIPAA-compliant codes. The use of crosswalks by BHOs to recode local CMHC [Colorado Mental Health Clinic] coding should be eliminated. The Department should incorporate these data reporting requirements for BHOs and their providers into its contracts with the BHOs.

Fee-Schedule Cost-Study

When relying on encounter data to set capitation rates, the Department must determine the appropriate fee to attach to each service delivered to estimate the cost of providing services. The intent of the encounter pricing is to assign a reasonable and appropriate fee for each procedure delivered and to use this information to determine an actuarially sound capitation rate. Currently, capitation rates are determined using a variety of sources, including cost reports from Colorado Mental Health Clinics (CMHCs), BHO financial statements and supplemental reports, and current Medicaid fee-schedules for encounters not covered by CMHCs and for inpatient hospital claims.

Such a pricing scheme has contributed to a wide variance among pricing between providers for similar services. For example, each CMHC has its own fee schedule developed by the Department of Human Services. Therefore, each CMHC can have a unique rate for a procedure code. This results in up to 17 different rates for the same type of service across the 17 CMHCs. The State Auditor determined that such a "pricing methodology perpetuates broad rate disparities and possible inefficiencies across the State

of Colorado… Furthermore, these practices potentially finance provider inefficiencies and may distort the underlying costs of providing services."

Because future rate setting methodologies will likely continue to incorporate BHO encounter data, the State Auditor wrote that "…it is critical that encounters be priced on the basis of current fee schedules that represent reasonable and appropriate rates for services that are provided. Such a fee schedule would assign a reasonable fee to each encounter and not necessarily reimburse providers for their full cost of care. This would drive providers to be more efficient and create more equitable financing of mental health care in Colorado."

Therefore, the State Auditor issued the following recommendation:

Recommendation No. 8:

The Department of Health Care Policy and Financing should initiate a cost study to assess and verify the fee schedule used to price encounters in the Medicaid Community Mental Health Services Program. The evaluation should be based on HIPAA-compliant coding to allow for more accurate comparison to other states' fee schedules. If the study incorporates provider cost report data, the Department should analyze additional fee information to ensure the fees reasonably reflect the best value for services. The study should result in a standard mental health fee schedule that is reflective of reasonable and appropriate rates.

The Department should also implement a process to ensure that the fee schedule is updated periodically to reflect changes in the rates over time.

The Department agreed with both recommendations, but in each case stated the Department did not have resources available to implement the recommendations and that compliance would be conditional upon receiving funding from the General Assembly for that purpose.

General Description of Request:

This Change Request increases funding in the Department's Executive Director's Office Long Bill group, Personal Services line item, by $125,000 total funds in FY 07-08 and $250,000 total funds in FY 08-09 to implement the recommendations of the State Auditor with regard to the creation of an encounter data manual and a cost-study to assess and verify the fee-schedule used to price encounter data in rate setting. In the State Auditor's report, the Department agreed that both recommendations should be implemented, although implementation would require an additional appropriation from the General Assembly.

As the Department moves to a rate methodology that relies more heavily on encounter data, it is of critical importance to have encounter data which is consistent across all behavioral health organizations (BHOs) and provider types. The State Auditor's report stated "[the] Department's fee-for-service data dates back to 1995 and can no longer be used as a basis for setting rates or evaluating managed care program costs." The Department anticipates that by creating an encounter data manual and fee-schedule, the Department will be better able to achieve the Audit's recommendation of revising the rate setting methodology to "ensure that the methodology is primarily based on validated encounters, and that rates are reasonable and appropriate."

The Department has been working with the provider community for several years to improve the quality of encounter data reporting, and has made the BHOs aware of the increased reliance that CMS has placed on incorporating recent encounter data in the rate setting process. To date, the Department has worked within existing resources to improve the quality and consistency of encounter data, but has been unable to make the dramatic improvements called for by the State Auditor. The Department does not believe that the comprehensive changes required by the State Auditor can be completed without additional resources.

The Department does not have the expertise necessary to create either an encounter data manual or a new fee-schedule for mental health encounters. With this funding, the Department would attempt to hire a contractor with experience in assisting other states

performing similar tasks. As pointed out by the state auditor, "many other states have gone beyond the development of basic lists of covered services and procedure code definitions and have created comprehensive encounter data reporting manuals. These manuals provide explicit instructions for BHOs and providers on the definition of services covered under the managed care contract and how to report services in HIPAA-compliant coding formats." The Department anticipates contacting these states for further assistance.

The Department anticipates that $125,000 total funds in FY 07-08 and $250,000 total funds in FY 08-09 will be required in total to create an encounter data manual and a fee-schedule. This figure is based on the Department's previous experience in creating actuarially sound capitation rates and hiring outside entities for the purpose of reviewing components of the rate setting process. The actual total of the contracts may be different from this estimate. The Department will release a Request for Proposals to hire a contractor to create the encounter data manual and fee-schedule; the total amount of the contract will depend on the proposals received. The Department believes that it can write the Request for Proposals with existing staff resources.

The Department anticipates that creation of an encounter data manual and fee-schedule would require approximately 3 months to complete and could be performed concurrently.

Consequences if Not Funded:

If this request is not funded, the Department would likely be at risk of the Centers of Medicare and Medicaid Services denying federal financial participation for mental health services. As a point of reference, the Department's Request for Mental Health Capitation Services in FY 08-09 anticipates $104,059,609 in federal funding. Without this funding, the Department would be required to significantly reduce mental health benefits provided to Medicaid clients or end the mental health program entirely.

Calculations for Request:

Summary of Request FY 07-08 Matches Schedule 13 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request	$125,000	$62,500	$62,500
(1) Executive Directors Office Personal Services (column 3)	$125,000	$62,500	$62,500

Summary of Request FY 08-09 Matches Schedule 13 and Recommended Request	**Total Funds**	**General Fund**	**Federal Funds**
Total Request	$250,000	$125,000	$125,000
(1) Executive Directors Office Personal Services (column 8)	$250,000	$125,000	$125,000

Assumptions for Calculations: The Department assumes that the earliest funding would be appropriated would be March 1, 2008, and that the earliest a contractor would be able to start work would be June 1, 2008. Because the Department estimates that the studies can be completed in 3 months, the Department therefore splits the total funds request proportionally (one-third in FY 07-08, two-thirds in FY 08-09).

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

Cost	**Benefit:**
$375,000: Contractor(s) to create an encounter data manual and comprehensive mental health procedure fee-schedule, as recommended by the Office of the State Auditor.	**$104,059,609**: Total estimated federal financial participation for Mental Health Capitation Payments. Without implementing the recommendations of the State Auditor, the Department would be at risk of the Centers for Medicare and Medicaid Services not approving mental health rates, and therefore losing federal financial participation.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	March 2008
RFP Issued	April 2008
Contract Awarded/Signed	June 2008
Start-Up Date	June 2008

Statutory and Federal Authority:

42 CFR § 438.6 (2007) Contract requirements

(c) Payments under risk contracts

(2) Basic requirements. (i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.

(3) Requirements for actuarially sound rates. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

Performance Measures:

This Change Request affects the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs.
- 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.
- Survey customer satisfaction with managed care using the Consumer Assessment of Health Plans Survey (CAHPS).

The Department believes that funding the State Auditors recommendations to create an encounter data manual and a comprehensive fee-schedule for mental health procedures will reduce rate disparities, incentivize providers to provide a better quality of service, and increase overall access to health care, thereby increasing customer satisfaction and quality of health outcomes.

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:	General Fund Request for CMS Disallowances			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-15	**OSPB Approval:**		**Date:** 12/31/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	205,690,153	227,631,464	10,926,331	238,557,795	239,425,103	0	239,425,103	0	239,425,103	0
	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	10,926,331	102,241,977	95,539,317	0	95,539,317	0	95,539,317	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	12,953,226	22,836,532	0	22,836,532	24,510,250	0	24,510,250	0	24,510,250	0
	FF	102,904,197	113,479,286	0	113,479,286	119,375,536	0	119,375,536	0	119,375,536	0
(5) Other Medical Services, SB 97-101 Public School Health Services	Total	21,049,585	31,327,813	10,438,941	41,766,754	31,322,948	0	31,322,948	0	31,322,948	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	10,438,941	10,438,941	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	10,472,200	16,007,021	0	16,007,021	16,007,021	0	16,007,021	0	16,007,021	0
	FF	10,577,385	15,320,792	0	15,320,792	15,315,927	0	15,315,927	0	15,315,927	0
(3) Medicaid Mental Health Community Programs, (A) Mental Health Capitation Payments	Total	184,640,568	196,303,651	487,390	196,791,041	208,102,155	0	208,102,155	0	208,102,155	0
	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	487,390	91,803,036	95,539,317	0	95,539,317	0	95,539,317	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	2,481,026	6,829,511	0	6,829,511	8,503,229	0	8,503,229	0	8,503,229	0
	FF	92,326,812	98,158,494	0	98,158,494	104,059,609	0	104,059,609	0	104,059,609	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 07-08 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-15
Change Request Title:	General Fund Request for CMS Disallowances

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: This Request is for $10,926,331 General Fund to backfill the loss of federal funds by the Centers for Medicare and Medicaid Services for the Public School Health Services Program and Child Placement Agency payments.

Background and Appropriation History:

Child Placement Agencies

The Medicaid Mental Health Community Programs began in 1992 with the passage of HB 92-1306. This bill authorized the Department of Health Care Policy and Financing and Department of Human Services to develop a pilot program to provide comprehensive mental health services to eligible Medicaid clients through a capitated managed care system. In 1993, the Health Care Financing Administration (predecessor to the Centers for Medicare and Medicaid Services) approved the Department's implementation of a managed care mental health program under the waiver authority in section 1915(b) of Title XIX of the Social Security Act.

The pilot program operated until 1995 when SB 95-078 revised the reporting and termination dates of the pilot program and directed the Department of Health Care Policy and Financing and Department of Human Services to implement a statewide mental health managed care program. In the implementation of the Medicaid Mental Health Capitation Program and as part of its Prepaid Inpatient Health Plan, the Department entered into eight contracts with service providers called Mental Health Assessment and Service Agencies. Later in 2005, the number of contracts was reduced from eight to five and renamed the service providers Behavioral Health Organizations.

Each behavioral health organization is responsible for providing or arranging any medically necessary mental health service for Medicaid-eligible clients including foster care children placed in Child Placement Agencies.

Public School Health Services Program

The Public School Health Services program began in 1997 with the passage of SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care programs for low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike other programs, the Public School Health Services program does not use General Fund dollars; but rather the State uses certification of public expenditures. Under the certification process, a public entity incurs costs for providing services to Medicaid clients which are allowable for reimbursement for federal matching funds. As such, the public entity, which in this case is most often a public school district, completes a certification form attesting the amount and accuracy of these costs and submits this certification to the Department. This certification, which shows up in the Department's budget as Cash Funds Exempt, serves as the State's portion of these Medicaid reimbursable expenditures. The State portion is then matched by Title XIX federal dollars, and as the Single State Agency for Medicaid, these funds are drawn down through the Department's budget. The Department then passes this earned revenue back to the providers as reimbursement for

50% (federal funds participation rate) of the expenditures already incurred. As federal funding is a portion of this program's funding, the program is subject to federal oversight by the Centers for Medicare and Medicaid Services.

The responsibility of the program is bifurcated between the Department of Health Care Policy and Financing and Department of Education through an Interagency Agreement. The Department pays for claims processing and administration through appropriations in the Medicaid Management Information System contract and Personal Services line items. The Department of Education provides schools with technical assistance, reviews and receives all local plans, conducts on-site reviews, submits annual reports, and pays for additional personnel. The administrative costs incurred by the two departments are deducted from the federal matching funds before the remainder is paid to school districts.

In 2004, under the auspices of the General Assembly, the Executive Branch undertook the responsibility for a statewide revenue maximization initiative whereby Public Consulting Group, Inc. was invited to review the Medicaid reimbursement rate-setting methodology for the Public School Health Services program (Footnote 24, SB 03-258, page 51). The purpose of this review was to determine if there was any opportunity to increase the reimbursement rates using all allowable costs and according to the method set forth in the Medicaid State Plan.

General Description of Request: This Request is for $10,926,331 General Fund to pay the disallowances by the Centers for Medicare and Medicaid Services for the Public School Health Services Program and Child Placement Agency payments.

Child Placement Agencies

In 1998, the Department incorporated payments for services provided by Child Placement Agencies into the capitation rate for the Medicaid Mental Health Capitation Program. A subset of foster care children placed in Child Placement Agencies received some mental health services. However, the Child Placement Agencies did not provide comprehensive

mental health services, nor did they intend to be the sole source of mental health services for this subset of foster care children.

By incorporating the Child Placement Agency payment for services for foster care children served by Child Placement Agencies within the capitated rate, the Department allocated a fixed amount of funding to pay for all mental health services provided by Child Placement Agencies. The inclusion of these payments into the capitated rate necessitated the Department to project in advance the total number of foster care children enrolled in the program each fiscal year.

By 2001, the total enrollment in the Medicaid Mental Health Capitation Program expanded beyond the Department's projections. Since the overall enrollment increases contributed to a greater-than-projected amount of capitated payments, it caused a faster-than-expected depletion of the fixed funding source for Child Placement Agencies. To remedy the situation and avoid overspending the fixed source of funds, the Department through a verbal agreement with the Mental Health Assessment and Service Agencies, agreed to remove the costs for the Child Placement Agency services from the capitated rate during the fourth quarter of calendar year 2001. The removal of the payment allowed the Department to pay the Mental Health Assessment and Service Agencies exactly the fixed amount for Child Placement Agency services; however this new payment arrangement constituted a supplemental payment to the capitation payment.

During a site visit in April 2004, the Centers for Medicare and Medicaid Services became aware of the removal of the Child Placement Agency payment from the capitated rate thereby creating a supplemental payment to the Mental Health Assessment and Service Agencies. After conducting its site visit, the Centers for Medicare and Medicaid Services sent the Department a Request for Additional Information concerning the fixed funding source for the Child Placement Agencies and supplemental payments to the Mental Health Assessment and Service Agencies.

The Department responded to the Request for Additional Information in a letter dated October 12, 2004. The Department explained that the fund was part of a Memorandum of

Understanding between the City and County of Denver, Department of Human Services, Family and Children Division and Colorado Access. The Memorandum of Understanding was for the provision of mental health services to children that are in the custody of the County Department of Human Services and Child Placement Agencies. The Department also acknowledged that the Child Placement Agency payment was a supplemental payment to the capitation payment and was not included in the actuarially certified rates.

With this acknowledgment from the Department concerning the supplemental payment not being part of the actuarially certified capitated rate, the Centers for Medicare and Medicaid Services notified the Department in a letter dated November 19, 2004 to discontinue the supplemental payment to the Mental Health Assessment and Service Agencies. Upon receipt of notice to discontinue the Child Placement Agency payment, the Department promptly stopped all payments to the Mental Health Assessment and Service Agencies by December 1, 2004.

On April 4, 2005, the Centers for Medicare and Medicaid Services deferred $487,390 federal financial participation that was claimed as a supplemental payment to the Mental Health Assessment and Service Agencies on the quarter ended December 31, 2004 statement of Medicaid expenditures. The Centers for Medicare and Medicaid Services determined the supplemental payments in the period of October through November 2004 were not allowable for federal financial participation which are not part of the actuarially certified capitated rate referenced in 42 CFR §438.6 (c), 447.10, and 438.60.

In a letter dated August 2, 2005, the Department responded to the notice of deferral from the Centers for Medicare and Medicaid Services, which included the following:

1) The Child Placement Agency program services were previously approved and are currently provided in the Medicaid Community Mental Health Services Program but not included in the Prepaid Inpatient Health Plan managed care capitation rate. Thus the Child Placement Agency program services were State Plan services and 42 USC 1396N (b) (3) services.

2) After the Child Placement Agency payments were include in the capitated rate, the Department experienced significant overall enrollment in the Medicaid Community Mental Health Services Program causing the over expenditure of the fund. This prompted the Department to remove the payment from the capitated rate and create a supplemental payment in 2001.
3) The amount of the disallowance may have been much smaller had the Centers for Medicare and Medicaid Services notified the Department soon after its April 2004 site visit to discontinue the supplemental payments.
4) The Department argued, on average, the foster care children receiving Child Placement Agency services cost an estimated $578 per member per month, while foster care children receiving non-Child Placement Agency services cost an estimated $644 per member per month.

After reviewing the Department's response, the Centers for Medicare and Medicaid Services responded on November 17, 2005 issuing a notice of disallowance of $487,390 in federal financial participation claimed by the Department for supplemental payments to the Mental Health Assessment and Service Agencies. On December 14, 2005, in response to the disallowance, the Department sent notice of intent to appeal to the U.S. Department of Health and Human Services' Departmental Appeals Board.

The Departmental Appeals Board delivered its decision on May 23, 2007 upholding the disallowance of $487,390 by the Centers for Medicare and Medicaid Services concluding the Department was in violation of 42 CFR §438.6 (a). This regulation became effective August 13, 2002 and stated the Centers for Medicare and Medicaid Services regional office must review and approve all managed care organization, prepaid inpatient health plan, and prepaid ambulatory health plan contracts. States with health plans were required to come into full compliance within one year of the effective date, which was over a year before this matter came to the attention of the Centers for Medicare and Medicaid Services. Once the Department, whether through verbal agreement or contract, changed the conditions and/or terms of payment it is required to prepare a written supplemental contract or amendment to its existing contract for approval by the Centers for Medicare and Medicaid Services. Having failed to submit a supplemental contract or amendment

with each Mental Health Assessment and Service Agency covering the two-month period at issue caused the Department to be in violation of 42 CFR §438.6 (a).

Public School Health Services Program

In February 2004, Public Consulting Group Inc. was invited to review the current Medicaid reimbursement rate-setting methodology for the School Health Services Program. The purpose of the review was to determine if the current rates fulfill the requirements set forth in the Medicaid State Plan. Public Consulting Group completed the review and found that the reimbursement rates should be updated to reflect the actual cost of providing school health and related services by participating providers. An analysis of the procedures used to calculate the rates revealed a shortfall in the determination of actual school district costs for both FY 02-03 and FY 03-04.

The shortfall, as discovered by Public Consulting Group Inc., in the calculation of the FY 02-03 and FY 03-04 rates pointed to the use of incomplete data, formula calculation errors, and algebraic inconsistencies in the current calculation which led to the omission of certain allowable costs and the subsequent understatement of rates.

With such a thorough review of all factors influencing the rates calculation, Public Consulting Group Inc. made the necessary corrections [to the rate-setting methodology] to allow for the accurate addition of all the allowable costs into their respective cost pools and developed revised rates to fit the parameters of the data available, and within the language of the Medicaid State Plan. Public Consulting Group Inc. determined the resulting changes did not alter the rate methodology in principle but allowed for additional allowable cost to be added and overall compliance to be improved.

Upon completion of the review in July 2004, the Department submitted a retroactive claims correction for FFY 02-03 and FFY 03-04 totaling $11,028,368 in additional Medicaid reimbursement. On October 1, 2004, the Department and the Office of State Planning and Budgeting sent letters to school districts requesting the recertification of certified public expenditures at the rates determined by Public Consulting Group Inc.

Contemporaneously, the Department notified the Centers for Medicare and Medicaid Services of its intent to revise the reimbursement rates.

On November 10, 2004, the Centers for Medicare and Medicaid Services informed the Department, per federal regulations at 42 CFR §447.201 and 430.20, in order to proceed with this revision, the Department needed to submit an amendment to the Medicaid State Plan modifying the current reimbursement methodology for these providers.

The Department questioned the need to submit an amendment to the State Plan, and solicited a legal opinion from the Office of the Attorney General. On December 17, 2004, the Office of the Attorney General, upon review of relevant federal regulations and federal, State and administrative case law, concluded that a State Plan amendment will be required if there is a material change in State law, organization, policy, or in the State's operation of the Medicaid program. Furthermore, while alteration of data used in the reimbursement rate equations probably would not be considered a "material change", alteration of the reimbursement equations themselves would probably be considered a material change requiring a State Plan amendment.

On December 22, 2004, the Department responded to the Centers for Medicare and Medicaid Services' November 10, 2004 letter. The Department wrote that it did not believe a State Plan amendment was necessary as it was not "revising reimbursement rates." Rather, the Department proposed only to correct certain data used in the determination of such rates. Furthermore, the Department did not consider [under the advisement of the Office of Attorney General] the rate changes "material" in nature.

On April 12, 2005, the Centers for Medicare and Medicaid Services informed the Department of its deferral in the amount of $11,028,368 in federal financial participation. The deferred amount represents the unallowable claim for federal financial participation related to the rate adjustment increase of approximately 67%, on a retroactive basis, for the period of December 30, 2002 to December 29, 2004 for School Based Services. The Centers for Medicare and Medicaid Services' regional office reviewed these rate changes and found that the changes constitute a revision in payment methods and standards which

requires inclusion in the State Plan through a State Plan amendment (42 CFR §430.12 (c)).

Pursuant to 42 CFR §430.40, the Department submitted its response within 60 days of the notice of deferral. On June 2, 2005, the Department maintained that correcting certain data and calculation errors does not require an amendment to the Medicaid State Plan for the period in question. The proposed rate changes were necessary in order to fulfill the requirements of the approved State Plan. Additionally, the rate changes served to correct and eliminate errors that resulted in inaccurate calculation of provider cost per unit-of-service. Furthermore, the Department admitted the corrections generated an overall net increase in federal financial participation, but included corrections that resulted in a decrease in federal financial participation of $2,842,505.

On September 2, 2005, the Centers for Medicare and Medicaid Services sent notice of disallowance of $11,028,368 in claims for federal financial participation based on a retroactive change in the methodology for computing rates for School Based Service providers for the period of December 30, 2002 to December 29, 2004. The Centers for Medicare and Medicaid Services concluded that the retroactive claims adjustments are not consistent with the provisions of the approved State Plan, as the State itself interpreted those provisions. The claims at issue were calculated using a different methodology which constituted a significant and substantial change.

Upon notice of disallowance, the Department submitted a letter on September 30, 2005 for notice to appeal the final decision by the Centers for Medicare and Medicaid Services. Within the letter, the Department contended the claims adjustment followed the approved State Plan by correcting errors, determined upon audit, so that the rates paid are actually "based on the costs of providing school health and related services", as explicitly required by the State Plan. The Department reiterated its position that the rate methodology for School Based Services has not changed since it was federally approved on February 13, 1998.

From October 2005 to September 2006, the Department submitted its Appellant's Opening Brief and Reply Brief to the U.S. Department of Health and Human Services' Departmental Appeals Board. Ultimately, the Departmental Appeals Board sustained the Centers for Medicare and Medicaid Services' decision but reduced the $11,028,368 disallowance by $589,427 to $10,438,941 for acknowledged errors in spreadsheet calculations. The Departmental Appeals Board concluded the Department's retroactive claims adjustment was not made in accordance with the provisions of the State Plan, as the Department had historically interpreted and implemented those provisions. Moreover, the Departmental Appeals Board agreed with the Centers for Medicare and Medicaid Services that the Department claimed this federal financial participation pursuant to rates calculated under a revised methodology that "constituted a significant and substantial change" from the methodology that was originally submitted to the Centers for Medicare and Medicaid Services in implementing its State Plan and that it had historically used in administering its State Plan.

Consequences if Not Funded:

The two disallowances netting to $10,926,331 have drawn against the Department's federal account, which represents the federal allotment of funds available to draw against, and have never been refunded by the State. As a result, the Department has nearly run out of money in our federal account during the last two quarters, January through June 2007, which exposes the Department to non-payment of Departmental expenditures. The continuation of this negative draw on the federal account reduces each subsequent quarterly federal request making it difficult for the Department to appropriately and effectively meet its fiduciary obligations. The Department is also unable to make an additional federal request to offset this negative draw or disallowance. Lastly, pursuant to 42 CFR §433.300, the Department is required to refund any overpayment for Medicaid services within 60 days of discovery of overpayment. If the overpayment is not promptly refunded, the Department risks additional federal sanctions.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	General Fund
Total Request	$10,926,331	$10,926,331
(5) Other Medical Services, SB 97-101 Public School Health Services (Column 3)	$10,438,941	$10,438,941
(3) Medicaid Mental Health Community Programs, (A) Mental Health Capitation Payments (Column 3)	$487,390	$487,390

Assumptions for Calculations: All amounts for disallowances were taken from documentation sent by the Departmental Appeals Board: *Departmental Appeals Board, Colorado Department of Health Care Policy and Financing, Docket No. A-06-33, Decision No. 2085, March 23, 2007* (Child Placement Agency payments); *Departmental Appeals Board, Colorado Department of Health Care Policy and Financing, Docket No. A-06-6, Decision No. 2057, December 15, 2006* (Public School Health Services).

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

Benefits	Cost
The General Fund request will allow the Department to offset the negative payment drawn against its federal account and prevent the continuing shortfall in its federal allotment.	$10,926,331
The payment of disallowances prevents any further federal sanctions or loss of federal financial participation for the Department's Medicaid programs.	
The Department will be in compliance with federal regulation 42 CFR §433.300 which provides the State 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made.	

Statutory and Federal Authority:

Sec. 438.6 (c). (2) Basic requirements. *(i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. (3) Requirements for actuarially sound rates. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable. (4) Documentation. The State must provide the following documentation:*

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are--

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

Sec. 438.6 (a). Regional office review. *The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in Sec. 438.806.*

Sec. 447.201 State plan requirements. *(a) A State plan must provide that the requirements in this subpart are met. (b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.*

Sec. 430.20 Effective dates of State plans and plan amendments. *For purposes of FFP, the following rules apply:*

(a) New plans. The effective date of a new plan--

(1) May not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office; and

(2) With respect to expenditures for medical assistance, may not be earlier than the first day on which the plan is in operation on a statewide basis.

(b) Plan amendment. (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the payment amounts for services already included in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section.

(2) For a plan amendment that changes the State's payment method and standards, the rules of Sec. 447.256 of this chapter apply.

(3) For other plan amendments, the effective date may be a date requested by the State if CMS approves it.

Sec. 430.12 (c) Plan amendments. *(1) The plan must provide that it will be amended whenever necessary to reflect--*
(i) Changes in Federal law, regulations, policy interpretations, or court decisions; or

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. For changes related to advance directive requirements, amendments must be submitted as soon as possible, but no later than 60 days from the effective date of the change to State law concerning advance directives.

Sec. 433.51 Public funds as the State share of financial participation. *(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.*

(b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

Sec. 433.300 Basis. *(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.*

(b) Section 1903(d)(2) (C) and (D) of the Act, which provides that a State has 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 60 days, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

(c) Section 1903(d)(3) of the Act, which provides that the Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.

Performance Measures:

This Change Request affects the following Performance Measures:

The Budget Division will maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid Services.

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:	Federal Funds Appropriation for Health Care Services Fund Line Items			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-16 and BA-10	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	21,082,168	21,119,760	16,225,421	37,345,181	21,119,760	0	21,119,760	15,000,000	36,119,760	15,000,000
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	3,059,880	3,059,880	0	3,059,880	3,059,880	0	3,059,880	0	3,059,880	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	14,962,408	15,000,000	0	15,000,000	15,000,000	0	15,000,000	0	15,000,000	0
	FF	3,059,880	3,059,880	16,225,421	19,285,301	3,059,880	0	3,059,880	15,000,000	18,059,880	15,000,000
(4) Indigent Care Program, The Children's Hospital, Clinic Based Indigent Care	**Total**	6,119,760	16,205,760	10,086,000	26,291,760	16,205,760	0	16,205,760	10,086,000	26,291,760	10,086,000
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	3,059,880	3,059,880	0	3,059,880	3,059,880	0	3,059,880	0	3,059,880	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	10,086,000	0	10,086,000	10,086,000	0	10,086,000	0	10,086,000	0
	FF	3,059,880	3,059,880	10,086,000	13,145,880	3,059,880	0	3,059,880	10,086,000	13,145,880	10,086,000
(4) Indigent Care Program, Health Care Services Fund Programs	**Total**	0	4,914,000	6,139,421	11,053,421	4,914,000	0	4,914,000	4,914,000	9,828,000	4,914,000
	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	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	4,914,000	0	4,914,000	4,914,000	0	4,914,000	0	4,914,000	0
	FF	0	0	6,139,421	6,139,421	0	0	0	4,914,000	4,914,000	4,914,000

Letternote revised text:

Cash Fund name/number, Federal Fund Grant name: FF: Title XIX. CFE: Health Care Services Fund (fund 19V)

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-16, BA-10
Change Request Title:	Federal Funds Appropriation for Health Care Services Fund Line Items

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:
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☐ 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 spending authority for federal financial participation that can be earned using the Health Care Services Fund appropriations as the State match for FY 07-08 and the subsequent two fiscal years for which appropriations are expected to be made from the Health Care Services Fund. The federal financial participation for the Health Care Services Fund payments have been approved by the Centers for Medicare and Medicaid Services for most of the payments and approval for the remaining payments are in the final stages of the approval process. Federal financial participation spending authority in the amount of $16,225,421 is requested for FY 07-08 and $15,000,000 is requested for FY 08-09 through FY 09-10.

Background and Appropriation History:

The Health Care Services Fund was established in SB 06-044 and implemented some of the provisions of "Referendum C". This referendum gave Colorado state government a five-year reprieve from the spending limits of the TABOR (Taxpayer Bill of Rights) amendment, from FY 05-06 through FY 09-10. The bill requires General Fund appropriations to be made to the Health Care Services Fund until FY 09-10.

The proceeds of the Health Care Services Fund are appropriated in the Department's annual budget request as Cash Fund Exempt in the following manner: 1) 18% of the moneys are annually appropriated to Denver Health and Hospitals as the community health clinic provider for the City and County of Denver; 2) 82% of the remaining moneys after the first appropriation are appropriated to community health clinics (outside the City and County of Denver) to provide primary care services; and 3) 18% of the remaining moneys after the first appropriation are appropriated to primary care clinics operated by a licensed or certified health care facility to provide primary care services.

In the Department's November 1, 2006 FY 07-08 Budget Request, the Department requested the proceeds from the Health Care Services Fund to be distributed under the following budget line items (November 1, 2006 FY 07-08 Budget Request, Volume 2, pages M-203 to M-205):

FY 07-08 Colorado Health Care Services Fund appropriations	
Line item under Long Bill Group (4) Indigent Care Program:	**Base request (Cash Funds Exempt)**
Colorado Health Care Services Fund – Denver Health	$2,700,000
Colorado Health Care Services Fund – Certified Health Care Providers	$10,086,000
Colorado Health Care Services Fund – Primary Care Clinics	$2,214,000

However, during the Department's Figure Setting on March 8, 2007, Joint Budget Committee action revised the Health Care Services Fund appropriations in an effort to pursue and secure federal financial participation using the Cash Funds Exempt appropriations as the State share beginning FY 07-08 through FY 09-10 (FY 07-08 Figure Setting, March 8, 2007, pages 61 to 64).

Revised FY 07-08 Colorado Health Care Services Fund appropriations	
Line item under Long Bill Group (4) Indigent Care Program:	**Cash Funds Exempt**
The Children's Hospital, Clinic Based Indigent Care	$10,086,000
Health Care Services Fund Programs	$4,914,000

The Joint Budget Committee action transferred the community health clinics appropriation (25.5-3-112 (2)(b)(I) C.R.S. (2007)) to The Children's Hospital, Clinic Based Indigent Care line item but did not record the corresponding increase in federal funds as a result of the Cash Funds Exempt transfer from the Health Care Services Fund. The Joint Budget Committee recommended the Department discuss with The Children's Hospital the possibility of using additional room under The Children's Hospital upper payment limit to draw down additional federal funding for the community health clinics before properly recording the matching federal financial participation in The Children's Hospital, Clinic Based Indigent Care line item (FY 07-08 Figure Setting, March 8, 2007, page 62).

The remaining two appropriations from the Health Care Services Fund (25.5-3-112 (2)(a) and (2)(b)(II) C.R.S. (2007)) were consolidated into one line item with the title "Health Care Services Fund Programs". In other words, the new line item contained funding for Denver Health and Hospitals and primary care clinics operated by a licensed or certified health care facility (FY 07-08 Figure Setting, March 8, 2007, pages 63 to 64). As for recording the matching federal financial participation under the Health Care Services Fund Programs line item, the Joint Budget Committee again recommended that the Department discuss with Denver Health and Hospitals the possibility of drawing down additional federal funds under Denver Health Hospitals' upper payment limit before recording the matching federal funds (FY 07-08 Figure Setting, March 8, 2007, page 64).

Senate Bill 06-044 also directed the Department to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services to request approval for federal financial participation for the payments to primary care clinics operated by hospitals participating in the Colorado Indigent Care Program. House Bill 07-1258, passed during the 2007 legislative session, further directed the Department to pursue available federal financial participation for moneys appropriated to community health clinics. The bill [HB 07-1258] also removed the requirement that services must be provided to low-income adults only.

General Description of Request: The Department requests federal funds spending authority in the amount of $16,225,421 for FY 07-08 and $15,000,000 for FY 08-09. Federal financial participation can be earned

using the Health Care Services Fund appropriations as the State match for FY 07-08 and the subsequent two fiscal years.

During the Department's FY 07-08 Figure Setting on March 8, 2007, the Joint Budget Committee rearranged the line items receiving appropriations from the Health Care Services Fund in an effort to pursue and secure federal financial participation using the Cash Funds Exempt appropriations as the State match.

The Children's Hospital, Clinic Based Indigent Care

The Joint Budget Committee moved the $10,086,000 appropriation for the community health clinics from the Colorado Health Care Services Fund – Certified Health Care Providers line item to The Children's Hospital, Clinic Based Indigent Care line item (FY 07-08 Figure Setting, March 8, 2007, page 62). As The Children's Hospital already administers the Colorado Indigent Care Program payments to the Colorado Indigent Care Program community clinics, the change in line item appropriation to The Children's Hospital, Clinic Based Indigent Care was appropriate. During FY 07-08 Figure Setting, the Joint Budget Committee recommended that the Department discuss with The Children's Hospital the possibility of using any additional room under The Children's Hospital upper payment limit to draw down additional federal funding before recording the matching federal financial participation due to the addition of the $10,086,000 in Cash Funds Exempt from the Health Care Services Fund.

The Department determined that there is sufficient room under The Children's Hospital upper payment limit to draw down additional federal funding using the $10,086,000 in Cash Funds Exempt from the Health Care Services Fund as the State match. The authorization for federal financial participation for the community health clinic payments made by The Children's Hospital is based on the State Plan Amendment (TN 05-015), which was approved by the Centers for Medicare and Medicaid Services on June 1, 2006. The State Plan Amendment authorizes Medicaid payments to hospitals under the upper payment limit for inpatient hospital services using the Pediatric Major Teaching Hospital Payment as described in Colorado's State Plan, Attachment 4.19-A.

Based on the existing State Plan, the Department has secured authorization from the Centers for Medicare and Medicaid Services to receive federal financial participation under The Children's Hospital, Clinic Based Indigent Care line item for the $10,086,000 in Cash Funds Exempt from the Health Care Services Fund.

Health Care Services Fund Programs

During the 2007 Legislative session, the General Assembly passed HB 07-1258 and the Governor signed it into law on April 16, 2007. This bill amends current law regarding the Health Care Services Fund by eliminating the requirement that community health clinics and primary care clinics provide primary care services only to low-income adults under the Colorado Indigent Care Program. Additionally, it requires the Department to seek federal matching funds for moneys appropriated to community health clinics (25.5-3-112 (3)(b) C.R.S. (2007)).

Pursuant to this legislation, the Department submitted State Plan Amendment TN 07-003 to the Centers for Medicare and Medicaid Services to secure federal financial participation effective April 1, 2007 for payments to Denver Health and Hospitals as the community health clinic for the City and County of Denver.

The Centers for Medicare and Medicaid Services approved Colorado's State Plan Amendment TN 07-003 in a letter dated August 15, 2007. It authorizes federal financial participation for the Department's Urban Safety Net Provider Supplemental Medicaid Payment which will provide Denver Health and Hospitals a federal match on the $2,700,000 Cash Funds Exempt appropriation from the Health Care Services Fund.

The Department also submitted State Plan Amendment TN 07-006 to be effective April 1, 2007 seeking federal financial participation for primary care clinics operated by a licensed or certified health care facility. If approved, this State Plan Amendment will authorize federal financial participation for the $2,214,000 Cash Funds Exempt appropriation from the Health Care Services Fund for primary care clinics. The Department anticipates

approval by the third quarter of FY 07-08. Having an effective date of April 1, 2007 for the State Plan Amendment, the Department can seek retroactive federal financial participation effective the first day of the calendar quarter in which the State Plan Amendment was submitted (42 CFR §430.20 and §447.256). Therefore, the Department has included $1,225,421 in retroactive federal financial participation for the fourth quarter of FY 06-07 in the request for FY 07-08.

Consequences if Not Funded: If the request is denied, then the Department will lose the opportunity to draw down additional federal financial participation for Colorado's community and primary care clinics that serve Medicaid clients. If the clinics and hospitals that participate in the Colorado Indigent Care Program do not receive additional reimbursement for uncompensated Medicaid costs, then there may be cost-shifting within the Colorado health care system.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	Federal Funds
Total Request	$16,225,421	$16,225,421
(4) Indigent Care Program, The Children's Hospital Clinic Based Indigent Care (column 3)	$10,086,000	$10,086,000
(4) Indigent Care Program, Health Care Services Fund Programs (column 3)	$6,139,421	$6,139,421

Summary of Request FY 08-09	Total Funds	Federal Funds
Total Request	$15,000,000	$15,000,000
(4) Indigent Care Program, The Children's Hospital Clinic Based Indigent Care (column 8)	$10,086,000	$10,086,000
(4) Indigent Care Program, Health Care Services Fund Programs (column 8)	$4,914,000	$4,914,000

Assumptions for Calculations: The additional federal funds revenue that can be earned using the Health Care Services Fund appropriations as the State match are based on the Medicare Upper Payment Limit funding mechanism for inpatient hospital services. Federal regulations limit total Medicaid reimbursement to an amount that would have been paid under Medicare payment principles. The Department has determined that payments including federal funds will not

exceed the Inpatient Hospital Medicare Upper Payment Limit for FY 07-08 and assumes FY 08-09 payments will also fit under the limit. If, however, the upper payment limit for inpatient hospital services exceeds its limit, then the payments will be reimbursed with federal financial participation at less than a 1:1 ratio.

The Department has included $1,225,421 in retroactive federal financial participation from FY 06-07 in the request for FY 07-08. The retroactive federal funds are included pursuant to 42 CFR §430.20 and §447.256. These federal regulations allow the Department to seek retroactive federal financial participation effective the first day of the calendar quarter in which the State Plan Amendment was submitted.

Line item	FY 06-07 Appropriation	Fourth quarter (April to June 2007) retroactive federal funds; 25% of FY 06-07 appropriation
Colorado Health Care Services Fund – Denver Health	$2,693,233	$673,308
Colorado Health Care Services Fund – Primary Care Clinics	$2,208,452	$552,113
Total retroactive federal financial participation		$1,225,421

The Department assumes the Centers for Medicare and Medicaid Services will approve State Plan Amendment TN 07-006 during the third quarter of FY 07-08.

Cost Benefit Analysis:

Description of Benefits	Cost
This is a zero General Fund request and will use the Health Care Services Fund appropriations as Cash Funds Exempt to draw down federal financial participation for unreimbursed Medicaid costs.	$0
The additional federal funds will help Colorado hospitals with their unreimbursed Medicaid costs and avoid cost shifting within the Colorado health care delivery system.	

Implementation Schedule:

Task	Month/Year
Anticipated approval of State Plan Amendment TN 07-006 by the Centers for Medicare and Medicaid Services.	March 2008
Supplemental funding approved for federal funds spending authority.	April 2008
Make payments to eligible hospitals which include federal financial participation.	April 2008

Statutory and Federal Authority:

25.5-3-112 (1)(a) C.R.S. (2007), Health care services fund – creation – state plan amendment. *There is hereby created in the state treasury the Colorado health care services fund, referred to in this section as the "fund". The fund shall consist of moneys credited thereto pursuant to this section.*

25.5-3-112 (3)(a) C.R.S. (2007), Health care services fund – creation – state plan amendment. *The state department shall submit a state plan amendment for federal financial participation for moneys appropriated to primary care clinics operated by a licensed or certified health care facility. Upon approval of the state plan amendment, the state department is authorized to receive and expend all available federal moneys without a corresponding reduction in cash funds exempt spending authority from the fund.*

25.5-3-112 (3)(b) C.R.S. (2007), Health care services fund – creation – state plan amendment. *To the extent possible under federal law, the state department shall pursue available federal financial participation for moneys appropriated to community health clinics.*

42 CFR §447.272(b), Inpatient services: Application of upper payment limits. *General rules. (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.*

Performance Measures:

The Budget Division will maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services.

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:	Federal Funds Match for Local Government Provider Fees			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-17, BA-11	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	0	0	10,211,350	10,211,350	0	0	0	5,205,696	5,205,696	5,205,696
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	5,105,675	5,105,675	0	0	0	2,602,848	2,602,848	2,602,848
	FF	0	0	5,105,675	5,105,675	0	0	0	2,602,848	2,602,848	2,602,848
(4) Indigent Care Program, SB 06-145 Inpatient Hospital Payments (new line item)	Total	0	0	4,225,858	4,225,858	0	0	0	2,154,322	2,154,322	2,154,322
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	2,112,929	2,112,929	0	0	0	1,077,161	1,077,161	1,077,161
	FF	0	0	2,112,929	2,112,929	0	0	0	1,077,161	1,077,161	1,077,161
(4) Indigent Care Program, SB 06-145 Outpatient Hospital Payments (new line item)	Total	0	0	5,985,492	5,985,492	0	0	0	3,051,374	3,051,374	3,051,374
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	2,992,746	2,992,746	0	0	0	1,525,687	1,525,687	1,525,687
	FF	0	0	2,992,746	2,992,746	0	0	0	1,525,687	1,525,687	1,525,687

Letternote revised text: 1: (new) the Cash Funds Exempt shall be from local government provider fees created in Section 29-28-103 (1), C.R.S.

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

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-17, BA-11
Change Request Title:	Federal Funds Match For Local Government Provider Fees

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: This Request seeks to obtain and record matching federal funds for local government inpatient and outpatient hospital payments. The total funds request consists of cash funds exempt and federal funds totaling $10,211,350 in FY 07-08 and $5,205,696 in FY 08-09. Pursuant to Senate Bill (S.B.) 06-145, local governments may impose a fee on non-government or private hospital providers for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs.

Background and Appropriation History: During the 2006 legislative session, the General Assembly passed S.B. 06-145, which became law on May 5, 2006 without the Governor's signature, allowing a local government to impose a fee on private hospital providers within their jurisdictions that provide inpatient and/or outpatient services for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs.

The Department determined this legislation to have conditional fiscal impact in FY 06-07 and FY 07-08 should local governments elect to impose a fee on private hospital providers within their jurisdictions. Moreover, the Department could not predict what assessment

rate would be applied to inpatient and/or outpatient revenues. Additionally, as the single State agency authorized to distribute federal Medicaid funds, the Department was required to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services authorizing the reimbursement methodology before federal financial participation is drawn down and provider payments issued.

Since the passage of S.B. 06-145, the Department has developed a reimbursement methodology and submitted two State Plan Amendments (TN 06-013 for Inpatient Hospital Services and TN 06-014 for Outpatient Hospital Services) on September 29, 2006 to the Centers for Medicare and Medicaid Services. At the time of writing this request, only one local government entity — City of Brighton — has informed the Department of their imposition of a provider fee on inpatient and outpatient hospital revenues on their sole private hospital provider, Platte Valley Medical Center.

General Description of Request: This request is a zero General Fund request that seeks to draw down $5,105,675 in matching federal funds using $5,105,675 in cash funds exempt in FY 07-08 and $2,602,848 in federal funds and $2,602,848 in cash funds exempt in FY 08-09. The cash funds exempt will be collected by local governments who elect to impose a fee on private hospital providers within their jurisdictions.

In 2006, the General Assembly passed S.B. 06-145 — "*Concerning the Authority of a Local Government to Impose a Fee on Certain Medical Providers for Purposes of Obtaining Federal Financial Participation under Medicaid for Unreimbursed Medicaid Costs"* — which permits local governments to impose fees on revenues of private hospital providers within their jurisdictions. The local government is required, pursuant to 29-28-103 (2) C.R.S. (2007), to distribute the full amount of funds collected from the imposition of the provider fee and federal financial participation received for eligible unreimbursed Medicaid costs.

When a local government elects to impose a fee on private hospital providers for the purposes of obtaining federal financial participation, it must notify the Department by August 1st of each State fiscal year. To adequately demonstrate its authority, the local

government must also submit to the Department copies of by-laws, charters, and/or ordinances or resolutions promulgating the fee. While the participation by local governments is voluntary, the qualified providers within the jurisdiction of a participating local government are required to participate (29-28-103 (1)(a), C.R.S (2007)).

However, according to the definition of a qualified provider at 29-28-102 (3) C.R.S. (2007), public hospitals are exempt from the imposition of the local government provider fee. Therefore, if there are public hospitals within the jurisdiction of a participating local government, then the Department must request a waiver of the broad-based requirements established under 42 CFR §433.68(c)(2) from the Centers for Medicare and Medicaid Services to exclude the public hospitals from being assessed the provider fee. This regulation establishes that "if a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of local government has jurisdiction." Given the legislative restriction in S.B. 06-145, the Department must request a waiver from the Centers for Medicare and Medicaid Services of the broad-based requirement, pursuant to 42 CFR §433.72(b), to exclude state-owned hospitals within the territorial boundaries of a participating local government from the proposed provider fee. Should the Centers for Medicare and Medicaid Services deny the waiver request, then the provider fee could not be assessed on any provider (private or public) residing within the jurisdiction of that local government.

Based on the State Plan Amendments (TN 06-013 and TN 06-014), the Department will calculate the assessment base of each participating entity for the Local Government Provider Fee using inpatient and/or outpatient revenues less Medicare and Medicaid revenues from the provider's most recent audited Medicare/Medicaid cost report (CMS 2552-96). When necessary, the audited cost report will be inflated forward to the State's request fiscal year using the Consumer Price Index — Urban Wage Earners, Medical Care Index — U.S. City Average.

According to Colorado's Medicaid State Plan, Attachments 4.19-A and 4.19-B, the local government may impose a fee not to exceed 5.5% on the assessment base for inpatient

and/or outpatient hospital revenues. Pursuant to federal Medicaid law, the 5.5% fee limit is effective January 1, 2008 through September 30, 2011.

After the provider's assessment base has been determined, the Department must calculate the Local Government Inpatient/Outpatient Hospital Reimbursement Payment, which includes federal financial participation to participating hospitals within a participating local government's jurisdiction. The federal financial participation for the Local Government Inpatient/Outpatient Hospital Reimbursement Payment is limited by the Medicare Upper Payment Limit.

The upper payment limit is a reasonable estimate of the amount that Medicare would have paid for the Medicaid services provided under Medicaid payment principles. To limit the abuses in the application of upper payment limit requirements, the Centers for Medicare and Medicaid Services revised regulations at 42 CFR §447.272. Effective March 2001, the revised regulations require States to calculate three separate upper payment limits, one for each category of provider: 1) state-owned or operated; 2) non-state government owned or operated; and 3) privately owned or operated. Federal regulations at 42 CFR §447.257 state that federal matching funds are not available for state expenditures that exceed the upper payment limit for any provider category.

The Reimbursement Payment is based on the ratio of the hospital's inflated Unreimbursed Inpatient/Outpatient Hospital Medicaid Costs relative to the total inflated Unreimbursed Inpatient/Outpatient Hospital Medicaid Costs of all participating hospitals located within the jurisdiction of the participating local government. The Department will compute the Local Government Inpatient/Outpatient Hospital Reimbursement Payment for each qualified provider by December 15th of each State fiscal year and report the amounts to each hospital and local government.

The tables below provide an example (based on hypothetical figures) of how the Department will calculate the Assessment Base and Reimbursement Payment for each hospital in the program.

Hospital Provider Assessment Base					
Local Government	**Provider Name**	**Assessment Base (Inflated Inpatient Revenues)**	**Local Assessment Rate**	**Provider's Assessment**	**Local Government Total Assessment Collected**
Government A	Provider A1	$10,000,000	5.5%	$550,000	
	Provider A2	$20,000,000		$1,100,000	$1,650,000
Government B	Provider B1	$20,000,000	4.5%	$900,000	
	Provider B2	$30,000,000		$1,350,000	
	Provider B3	$40,000,000		$1,800,000	$4,050,000
				Total Assessments	$5,700,000

Hospital Reimbursement Payment					
Local Government	**Provider Name**	**Reimbursement Base (Inflated Uncompensated costs)**	**Provider Reimbursement Base as Percent of Local Government Total**	**Local Government Funds Available for Redistribution (Assessment plus Federal Financial Participation)**	**Reimbursement Payment**
Government A	Provider A1	$1,000,000	33.3%	$3,300,000	$1,100,000
	Provider A2	$2,000,000	66.7%		$2,200,000
Total Reimbursement Base Government A		$3,000,000	Total Reimbursement Government A		$3,300,000
Government B	Provider B1	$2,000,000	22.2%	$8,100,000	$1,800,000
	Provider B2	$3,000,000	33.3%		$2,700,000
	Provider B3	$4,000,000	44.4%		$3,600,000
Total Reimbursement Base Government B		$9,000,000	Total Reimbursement Government B		$8,100,000

As an example and using the tables above, Provider A1 in Government A's jurisdiction, has an assessment base of $10,000,000. This amount is multiplied by Government A's local assessment rate of 5.5% which equals $550,000 in assessment fees. Using this same process for the calculation of Provider A2's assessment fee, the Department then sums the

total local government assessment for Government A which equals $1,650,000. This amount will be recorded as Cash Funds Exempt and considered the State match to draw down an equal amount in federal financial participation (subject to the upper payment limits for each provider category). Next, the Department calculates the Reimbursement Payment for each provider and local government. Using the provider's most recent audited Medicare/Medicaid cost report (CMS 2552-96), the Department calculates each provider's unreimbursed Medicaid costs and sums the individual reimbursements to get the total. This total amount is divided into the provider's respective unreimbursed Medicaid cost to calculate the percent of the total unreimbursed Medicaid cost for each local government. This percentage is multiplied by the sum total of the assessment and federal financial participation to produce the provider's total reimbursement payment. The example above also shows that Government B has elected an assessment fee less than the federal Medicaid limit of 5.5%, which is permitted, as each local government may determine its own assessment rate independent of other participating local governments.

The Department used the above methodology to calculate both the Inpatient and Outpatient Reimbursement Payment for Platte Valley Medical Center. For FY 07-08, the Inpatient and Outpatient Reimbursement Payment is $4,225,858 and $5,985,492, respectively. These amounts include the retroactive federal financial participation for FY 06-07. Having submitted the State Plan Amendments on September 29, 2006 and pursuant to 42 CFR §430.20 and §447.256, the Department can seek retroactive federal financial participation effective the first day of the calendar quarter in which the State Plan Amendment was submitted.

For the purposes of estimating the total provider Inpatient and Outpatient Reimbursement Payment for FY 08-09, the Department used the FY 07-08 amounts of $2,154,322 and $3,051,374, respectively, or total funds of $5,205,696. Please see table on page 9.

Consequences if Not Funded:

Pursuant to 25.5-4-417 (2) C.R.S. (2007), the Department is required to amend the Medicaid State Plan to allow the imposition and collection of a provider fee by a local government for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs. Moreover, according to 25.5-4-417 (4) and (5) C.R.S (2007), the

Department is required upon notice of the imposition of a fee by a local government to calculate the unreimbursed Medicaid costs for qualified providers within the participating local government's jurisdiction and distribute the federal financial participation received for eligible unreimbursed Medicaid costs to a local government that has certified payment to qualified providers.

If the request is denied, then the Department will be in violation of the aforementioned State statutes. Furthermore, the Department will lose the opportunity to draw down additional federal financial participation for Colorado hospitals that serve Medicaid clients.

Calculations for Request:

Summary of Request FY 07-08	Total Funds	Cash Funds Exempt	Federal Funds
Total Request	$10,211,350	$5,105,675	$5,105,675
(4) Indigent Care Program, SB 06-145 Inpatient Hospital Payments **(new line item)**	$4,225,858	$2,112,929	$2,112,929
(4) Indigent Care Program, SB 06-145 Outpatient Hospital Payments **(new line item)**	$5,985,492	$2,992,746	$2,992,746

Summary of Request FY 08-09	Total Funds	Cash Funds Exempt	Federal Funds
Total Request	$5,205,696	$2,602,848	$2,602,848
(4) Indigent Care Program, SB 06-145 Inpatient Hospital Payments **(new line item)**	$2,154,322	$1,077,161	$1,077,161
(4) Indigent Care Program, SB 06-145 Outpatient Hospital Payments **(new line item)**	$3,051,374	$1,525,687	$1,525,687

Assumptions for Calculations:

The figures used to calculate Platte Valley Medical Center's Inpatient and Outpatient assessment and reimbursement base were taken from the provider's CMS 2552-96 form.

On September 29, 2006, the Department submitted two State Plan Amendments to the Centers for Medicare and Medicaid Services. Having done so allows the Department to seek retroactive federal financial participation effective the first day of the calendar quarter

in which the State Plan Amendment was submitted (42 CFR §430.20 and §447.256). This means that the Department can seek retroactive federal financial participation effective July 1, 2006 based on its State Plan Amendment submission date. Based on these federal Medicaid regulations, the Department can include the FY 06-07 Inpatient and Outpatient provider fees collected in the Department's total funds request for FY 07-08. Please see the table below for the calculation of the FY 06-07 and FY 07-08 Inpatient and Outpatient Hospital Payments.

Calculation of Request Amount for FY 07-08	Total Funds	Cash Funds Exempt	Federal Funds
Total Request	**$10,211,350**	**$5,105,675**	**$5,105,675**
FY 06-07 Inpatient Hospital Payments	$2,071,536	$1,035,768	$1,035,768
FY 06-07 Outpatient Hospital Payments	$2,934,118	$1,467,059	$1,467,059
Total for FY 06-07	**$5,005,654**	**$2,502,827**	**$2,502,827**
FY 07-08 Inpatient Hospital Payments	$2,154,322	$1,077,161	$1,077,161
FY 07-08 Outpatient Hospital Payments	$3,051,374	$1,525,687	$1,525,687
Total for FY 07-08	**$5,205,696**	**$2,602,848**	**$2,602,848**

Calculation of Provider Assessment, Cash Funds Exempt						
Fiscal Year	**Government**	**Provider Name**	**Hospital Service**	**Assessment Base**	**Assessment Rate**	**Provider Assessment**
FY 06-07	City of Brighton	Platte Valley Medical Center	Inpatient	$18,832,147	5.50%	$1,035,768
FY 06-07	City of Brighton	Platte Valley Medical Center	Outpatient	$26,673,799	5.50%	$1,467,059
FY 07-08	City of Brighton	Platte Valley Medical Center	Inpatient	$19,584,733	5.50%	$1,077,160
FY 07-08	City of Brighton	Platte Valley Medical Center	Outpatient	$27,739,759	5.50%	$1,525,687
Total Provider Assessment (may not total correctly due to rounding)						**$5,105,675**

Calculation of Reimbursement Payment, Total Funds						
Fiscal Year	**Government**	**Provider Name**	**Hospital Service**	**Reimbursement Base**	**Provider Reimbursement**	**Provider Reimbursement**

					Base as Percent of Local Government Total	**Available for Redistribution (assessment plus federal funds)**
FY 06-07	City of Brighton	Platte Valley Medical Center	Inpatient	$1,344,534	100.0%	$2,071,536
FY 06-07	City of Brighton	Platte Valley Medical Center	Outpatient	$422,961	100.0%	$2,934,118
FY 07-08	City of Brighton	Platte Valley Medical Center	Inpatient	$1,292,867	100.0%	$2,154,322
FY 07-08	City of Brighton	Platte Valley Medical Center	Outpatient	$406,708	100.0%	$3,051,374
Total Provider Reimbursement Payment						**$10,211,350**

After responding to the January 30, 2007 Request for Additional Information from the Centers for Medicare and Medicaid Services, the Department assumes the Centers for Medicare and Medicaid Services will approve the Department's State Plan Amendments (TN 06-013 and TN 06-014) during the fourth quarter of FY 07-08. Upon approval, the Department will forward the full amount of the Local Government Inpatient and Outpatient Hospital Reimbursement Payment to the City of Brighton by June 30, 2008. Based on State statute (29-28-103 (2) C.R.S. (2007)), the Department must make the Local Government Inpatient and Outpatient Hospital Payments to the participating local governments rather than directly to the individual hospital providers. Additionally, under the same statute, neither the Department nor the local government is allowed to keep any portion of the provider fee or federal financial participation moneys. It is the responsibility of the participating local government to distribute all federal financial participation received for eligible unreimbursed Medicaid costs and all moneys collected from the imposition of provider fees collected to the qualified providers within the local government's jurisdiction. The distribution of federal financial participation and provider fees will be based on the methodology and calculation set forth in Colorado's Medicaid State Plan, Attachment 4.19-A and Attachment 4.19-B.

The Department assumes that the upper payment limit for either inpatient or outpatient services is sufficient to allow all local governments to receive full federal financial participation on the fees collected. If, however, the upper payment limit for either

inpatient or outpatient services is near its limit, then the fees collected by each local government would be reimbursed with federal financial participation at less than a 1:1 ratio.

Since the Department will not receive the provider's most recent audited Medicare/Medicaid cost report(s) until September 1, 2008 for FY 08-09, the Department assumes the total funds request amount for FY 08-09 will be similar to the calculated figures from FY 07-08 of Inpatient and Outpatient Hospital Payments. Furthermore, the Department assumes that the City of Brighton will maintain its provider assessment rate at its current level for FY 08-09 on both Inpatient and Outpatient Hospital Revenues.

The Department will use the following schedule of dates during each State fiscal year to run the program.

Description of task	Date during each fiscal year
Local governments must notify the Department of its intent to impose the Local Government Provider Fee on private hospital providers of inpatient and/or outpatient hospital services.	August 1st
All required hospital providers within the jurisdiction of a participating local government must provide a copy of their most recent audited Medicare/Medicaid cost report (CMS 2552-96) to the Department.	September 1st
The Department will compute and inform participating local governments and private hospitals of allowable fees that may be imposed for inpatient and/or outpatient hospital services within their jurisdictions.	December 1st
The Department will compute the Local Government Inpatient and/or Outpatient Hospital Payment for each qualified provider.	December 15th
The participating local governments must provide documentation that the fee has been assessed and collected.	June 20th
The Department will make final payments to participating local governments.	June 30th
Hospitals must notify the Department of their receipt of payment from the local government.	July 30th

Cost Benefit Analysis:

Description of Benefits	Cost
This is a zero General Fund request and will use the Local Government Provider Fee as Cash Funds Exempt to draw down federal financial participation for unreimbursed Medicaid costs.	$0
The additional federal funds will help Colorado hospitals with their unreimbursed Medicaid costs and avoid cost shifting within the Colorado health care delivery system.	

Implementation Schedule:

Task	Month/Year
Public notice was made concerning the availability of federal financial participation for unreimbursed Medicaid costs	July 2006
[1]Meetings with CMS to Discuss State Plan Amendment and Responses to Request for Additional Information (to obtain feedback from both the CMS Regional Office in Denver and the Home Office in Baltimore)	August 28, 2006 to August 16, 2007
Department submitted State Plan Amendments (TN 06-013 and TN 06-014)	September 29, 2006
Department received Request for Additional Information from CMS	December 6, 2006
CMS Request for Extension to Respond to Request for Additional Information Letter (90-day extension)	March 5, 2007
Meeting with City of Brighton and Platte Valley	March 19, 2007
Meeting with Brighton City Council and Platte Valley	May 1, 2007
CMS Request for Extension to Respond to Request for Additional Information Letter (90-day extension)	May 16, 2007
CMS Request for Extension to Respond to Request for Additional Information Letter (90-day extension)	August 16, 2007
Teleconference with Platte Valley Medical Center (to discuss updated timelines)	August 18, 2007
Department Submits State Plan Amendments and Responses to Request for Additional Information (TN 06-013 and TN 06-014) to CMS for informal review	December 1, 2007
CMS Provides Department with Informal Response	March, 1 2007
Task, continued	**Month/Year**
Department Submits State Plan Amendments and Responses to Request for Additional Information (TN 06-013 and TN 06-014) to CMS for formal review	March 15, 2007

Anticipated approval of State Plan Amendments by Centers for Medicare and Medicaid Services	June 15, 2007
City of Brighton provides documentation that provider fee was assessed and collected	June 20, 2008
Department will make payments to City of Brighton	June 30, 2008
Platt Valley Medical Center will provide the Department with documentation showing receipt of payment from City of Brighton	July 30, 2008

[1]The Department met with CMS to discuss the State Plan Amendments and Requests for Additional Information on several occasions: August 28, 2006; February 22, 2007; April 6, 2007; April 17, 2007; June 14, 2007; and August 16, 2007. The Department met with CMS on these occasions due to the complexity of the State Plan Amendment and also to discuss feedback provided by the CMS Regional Office and their home office in Baltimore, MD.

Statutory and Federal Authority:

29-28-103 (1)(a) C.R.S (2007), Powers of the governing body – fee authorization – unreimbursed Medicaid costs. *The governing body of a local government may impose a fee on a qualified provider located within its territorial boundaries for the purpose of obtaining federal financial participation under the state's medical assistance program, articles 4, 5, and 6 of title 25.5, C.R.S., to reimburse qualified providers for unreimbursed medicaid costs.*

25.5-4-417 (4) C.R.S (2007), Unreimbursed costs – Medicaid providers – state plan amendment – rules. *Upon notice of the imposition of a fee by a local government as authorized by article 28 of title 29, C.R.S., the state department shall calculate the unreimbursed medicaid costs for qualified providers within the local government, excluding any specific costs the local government exempts from the calculation pursuant to section 29-28-103 (1) (b), C.R.S.*

42 C.F.R. §433.68. Permissible health care-related taxes after the transition period. *(a) General rule. Beginning on the day after a State's transition period, as defined in Sec 433.58(b), ends, a State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.*

Performance Measures:

The Budget Division will maintain or reduce the difference between the Department's spending authority and actual expenditures for Medicaid services.

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:	DHS - Workers' Compensation Common Policy Adjustment			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S1, NP-BA10 (See also DHS Supplemental DPA-7)	**OSPB Approval:**		**Date:** 12/31/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items											
	Total	3,081,121	12,509,047	(352,827)	12,156,220	13,782,333	0	13,782,333	(60,632)	13,721,701	(60,632)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,540,561	6,253,141	(176,414)	6,076,727	6,880,397	0	6,880,397	(30,316)	6,850,081	(30,316)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	1,540,560	6,255,906	(176,413)	6,079,493	6,901,936	0	6,901,936	(30,316)	6,871,620	(30,316)
(6) DHS Medicaid Funded Programs - (A) Executive Director's Office - Medicaid Funding	**Total**	3,081,121	12,509,047	(352,827)	12,156,220	13,782,333	0	13,782,333	(60,632)	13,721,701	(60,632)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,540,561	6,253,141	(176,414)	6,076,727	6,880,397	0	6,880,397	(30,316)	6,850,081	(30,316)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	1,540,560	6,255,906	(176,413)	6,079,493	6,901,936	0	6,901,936	(30,316)	6,871,620	(30,316)

Letternote revised text:	
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX
IT Request: ☐ Yes ☑ No	
Request Affects Other Departments: ☑ Yes ☐ No	**If Yes, List Other Departments Here:** Department of Human Services

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:	DHS - Division for Developmental Disabilities Medicaid Waiver Reform Transition Costs			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP - S2, NP-BA1 (See also DHS Supplemental 4)	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	401,369	0	59,742	59,742	0	0	0	79,028	79,028	79,028
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	200,685	0	29,871	29,871	0	0	0	39,514	39,514	39,514
	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	200,684	0	29,871	29,871	0	0	0	39,514	39,514	39,514
(6) DHS Medicaid Funded Programs - (F) Services for People with Developemental Disabilities - Medicaid Funding, Medicaid Waiver Transition Costs	**Total**	401,369	0	59,742	59,742	0	0	0	79,028	79,028	79,028
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	200,685	0	29,871	29,871	0	0	0	39,514	39,514	39,514
	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	200,684	0	29,871	29,871	0	0	0	39,514	39,514	39,514

Letternote revised text:			
Cash Fund name/number, Federal Fund Grant name:		FF: Title XIX	
IT Request:	Yes ☑ No		
Request Affects Other Departments:	☑ Yes ☐ No	**If Yes, List Other Departments Here:**	Department of Human Services

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:	DHS - Risk Management and Property Funds Common Policy Adjustment			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S3, NP-BA11 (See also DHS Supplemental DPA-8)	**OSPB Approval:**		**Date:** 12/31/07

		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
Total of All Line Items	**Total**	3,081,121	12,509,047	(33,303)	12,475,744	13,782,333	0	13,782,333	4,908	13,787,241	4,908
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,540,561	6,253,141	(16,652)	6,236,489	6,880,397	0	6,880,397	2,454	6,882,851	2,454
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	1,540,560	6,255,906	(16,651)	6,239,255	6,901,936	0	6,901,936	2,454	6,904,390	2,454
(6) DHS Medicaid Funded Programs - (A) Executive Director's Office - Medicaid Funding	**Total**	3,081,121	12,509,047	(33,303)	12,475,744	13,782,333	0	13,782,333	4,908	13,787,241	4,908
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,540,561	6,253,141	(16,652)	6,236,489	6,880,397	0	6,880,397	2,454	6,882,851	2,454
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	1,540,560	6,255,906	(16,651)	6,239,255	6,901,936	0	6,901,936	2,454	6,904,390	2,454

Letternote revised text:			
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX		
IT Request: ☐ Yes ☑ No			
Request Affects Other Departments: ☑ Yes ☐ No	**If Yes, List Other Departments Here:**	Department of Human Services	

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:	DHS - Colorado Benefits Management System (CBMS) Refinancing FY 2004-05			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP - S4 (See also DHS Supplemental 7)	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	7,532,758	8,716,030	359,018	9,075,048	7,975,468	0	7,975,468	0	7,975,468	0
	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	0	4,021,332	3,677,330	0	3,677,330	0	3,677,330	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	516,953	580,621	0	580,621	532,547	0	532,547	0	532,547	0
	FF	3,557,691	4,114,077	359,018	4,473,095	3,765,591	0	3,765,591	0	3,765,591	0
(6) DHS Medicaid Funded Programs - (B) Office of Information Technology Services, Colorado Benefits Management System	**Total**	7,532,758	8,716,030	359,018	9,075,048	7,975,468	0	7,975,468	0	7,975,468	0
	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	0	4,021,332	3,677,330	0	3,677,330	0	3,677,330	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	516,953	580,621	0	580,621	532,547	0	532,547	0	532,547	0
	FF	3,557,691	4,114,077	359,018	4,473,095	3,765,591	0	3,765,591	0	3,765,591	0

Letternote revised text:	Funding provided by the Department of Treasury reserved through HB 07-1359 will represent the State share.
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX
IT Request: ☐ **Yes** ☑ **No**	
Request Affects Other Departments: ☑ **Yes** ☐ **No**	**If Yes, List Other Departments Here:** Department of Human Services, Department of Treasury

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:	DHS - Regional Center Operating Shortfall			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S5 (See also DHS Supplemental 9)	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	44,828,853	42,058,031	112,253	42,170,284	44,627,275	0	44,627,275	0	44,627,275	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	21,650,991	20,207,348	56,127	20,263,475	21,491,970	0	21,491,970	0	21,491,970	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	742,997	821,668	0	821,668	821,668	0	821,668	0	821,668	0
	FF	22,434,865	21,029,015	56,126	21,085,141	22,313,637	0	22,313,637	0	22,313,637	0
(6) DHS Medicaid Funded Programs - (F) Services for People with Developmental Disabilities - Medicaid Funding, Regional Centers - Medicaid Funding	**Total**	44,828,853	42,058,031	112,253	42,170,284	44,627,275	0	44,627,275	0	44,627,275	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	21,650,991	20,207,348	56,127	20,263,475	21,491,970	0	21,491,970	0	21,491,970	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	742,997	821,668	0	821,668	821,668	0	821,668	0	821,668	0
	FF	22,434,865	21,029,015	56,126	21,085,141	22,313,637	0	22,313,637	0	22,313,637	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

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:	DHS - Regional Center Clinical Security System Program			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP - S6 (See also DHS Supplemental 10)	**OSPB Approval:**		**Date:** 12/27/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	44,828,853	42,058,031	174,978	42,233,009	44,627,275	0	44,627,275	0	44,627,275	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	21,650,991	20,207,348	87,489	20,294,837	21,491,970	0	21,491,970	0	21,491,970	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	742,997	821,668	0	821,668	821,668	0	821,668	0	821,668	0
	FF	22,434,865	21,029,015	87,489	21,116,504	22,313,637	0	22,313,637	0	22,313,637	0
(6) DHS Medicaid Funded Programs - (F) Services for People with Developmental Disabilities - Medicaid Funding, Regional Centers - Medicaid Funding	Total	44,828,853	42,058,031	174,978	42,233,009	44,627,275	0	44,627,275	0	44,627,275	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	21,650,991	20,207,348	87,489	20,294,837	21,491,970	0	21,491,970	0	21,491,970	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	742,997	821,668	0	821,668	821,668	0	821,668	0	821,668	0
	FF	22,434,865	21,029,015	87,489	21,116,504	22,313,637	0	22,313,637	0	22,313,637	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

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:	DHS - Funding Adjustments Related to Residential Child Health Care Program			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S7, NP-BA4 (See also DHS Supplemental 7)	**OSPB Approval:**		**Date:** 12/31/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	16,074,966	34,875,613	(11,480,794)	23,394,819	34,836,293	0	34,836,293	(11,480,794)	23,355,499	(11,480,794)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	8,037,483	17,437,807	(5,740,397)	11,697,410	17,418,147	0	17,418,147	(5,740,397)	11,677,750	(5,740,397)
	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	8,037,483	17,437,806	(5,740,397)	11,697,409	17,418,146	0	17,418,146	(5,740,397)	11,677,749	(5,740,397)
(6) DHS Medicaid-Funded Programs (D) Division of Child Welfare - Medicaid, Child Welfare Services	**Total**	16,074,966	34,875,613	(11,480,794)	23,394,819	34,836,293	0	34,836,293	(11,480,794)	23,355,499	(11,480,794)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	8,037,483	17,437,807	(5,740,397)	11,697,410	17,418,147	0	17,418,147	(5,740,397)	11,677,750	(5,740,397)
	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	8,037,483	17,437,806	(5,740,397)	11,697,409	17,418,146	0	17,418,146	(5,740,397)	11,677,749	(5,740,397)

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

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:	DHS - Department Wide Technical Supplemental (Systemic Alien Verification for Eligibility - SAVE)			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S8, NP-BA5 (See also DHS Supplemental 14)	**OSPB Approval:**		**Date:** 12/31/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items											
	Total	2,061,396,808	2,147,858,908	3,019	2,147,861,927	2,147,626,990	0	2,147,626,990	3,194	2,147,630,184	3,194
	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	0	651,512,742	0
	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	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	3,019	1,075,500,803	1,075,381,825	0	1,075,381,825	3,194	1,075,385,019	3,194
(2) Medical Services Premiums											
	Total	2,061,396,808	2,147,858,908	3,019	2,147,861,927	2,147,626,990	0	2,147,626,990	3,194	2,147,630,184	3,194
	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	0	651,512,742	0
	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	0	76,001,368	76,794,167	0	76,794,167	0	76,794,167	0
	FF	1,036,058,888	1,075,497,784	3,019	1,075,500,803	1,075,381,825	0	1,075,381,825	3,194	1,075,385,019	3,194

Letternote revised text:

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

IT Request: ☐ **Yes** ☑ **No**

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

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:	DPA - Administrative Law Judge Common Policy Adjustment			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S9	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	380,930	407,509	32,649	440,158	453,207	0	453,207	0	453,207	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	190,465	203,755	16,325	220,080	226,604	0	226,604	0	226,604	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	190,465	203,754	16,324	220,078	226,603	0	226,603	0	226,603	0
(1) Executive Director's Office, Adminstrative Law Judge Services	**Total**	380,930	407,509	32,649	440,158	453,207	0	453,207	0	453,207	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	190,465	203,755	16,325	220,080	226,604	0	226,604	0	226,604	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	190,465	203,754	16,324	220,078	226,603	0	226,603	0	226,603	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☑ Yes ☐ No — Department of Personnel and Adminstration

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:	DPA - Capitol Complex Leased Space Common Policy Adjustments			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S10, NP-BA6	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	344,022	391,079	6,159	397,238	394,372	0	394,372	238	394,610	238
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	172,011	195,540	3,080	198,620	197,186	0	197,186	119	197,305	119
	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	172,011	195,539	3,079	198,618	197,186	0	197,186	119	197,305	119
(1) Executive Director's Office, Capitol Complex Leased Space	**Total**	344,022	391,079	6,159	397,238	394,372	0	394,372	238	394,610	238
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	172,011	195,540	3,080	198,620	197,186	0	197,186	119	197,305	119
	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	172,011	195,539	3,079	198,618	197,186	0	197,186	119	197,305	119

Letternote revised text:	
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX
IT Request: ☐ Yes ☑ No	
Request Affects Other Departments: ☑ Yes ☐ No	**Department of Personnel and Adminstration**

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:	DPA - Payments to Risk Management and Property Funds Common Policy Adjustments			
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:**	January 2, 2008
Priority Number:	NP-S11, NP- BA7	**OSPB Approval:**	**Date:**	12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	101,810	91,727	(27,990)	63,737	72,367	0	72,367	2,289	74,656	2,289
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	50,905	45,864	(13,995)	31,869	36,184	0	36,184	1,144	37,328	1,144
	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	50,905	45,863	(13,995)	31,868	36,183	0	36,183	1,145	37,328	1,145
(1) Executive Director's Office											
Payments to Risk Management and Property Funds	**Total**	101,810	91,727	(27,990)	63,737	72,367	0	72,367	2,289	74,656	2,289
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	50,905	45,864	(13,995)	31,869	36,184	0	36,184	1,144	37,328	1,144
	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	50,905	45,863	(13,995)	31,868	36,183	0	36,183	1,145	37,328	1,145

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☑ Yes ☐ No Department of Personnel and Administration

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:	DPA - Purchase of Services from Computer Center Common Policy Adjustments			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S12, NP- BA8	**OSPB Approval:**		**Date:** 12/20/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	0	18,516	96,945	115,461	17,250	0	17,250	103,484	120,734	103,484
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	7,590	48,473	56,063	6,957	0	6,957	47,020	53,977	47,020
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	3,337	0	3,337	3,337	0	3,337	0	3,337	0
	FF	0	7,589	48,472	56,061	6,956	0	6,956	56,464	63,420	56,464
(1) Executive Director's Office											
Purchase of Services	**Total**	0	18,516	96,945	115,461	17,250	0	17,250	103,484	120,734	103,484
from Computer Center	**FTE**	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	7,590	48,473	56,063	6,957	0	6,957	47,020	53,977	47,020
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	3,337	0	3,337	3,337	0	3,337	0	3,337	0
	FF	0	7,589	48,472	56,061	6,956	0	6,956	56,464	63,420	56,464

Letternote revised text:

Cash Fund name/number, Federal Fund Grant name: OAP Health and Medical Care Fund, FF: Title XIX

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☑ Yes ☐ No Department of Personnel and Administration

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:	DPA - Workers' Compensation Common Policy Adjustments			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S13, NP- BA8	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	25,760	24,247	1,306	25,553	32,863	0	32,863	(779)	32,084	(779)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	12,880	12,124	653	12,777	16,432	0	16,432	(390)	16,042	(390)
	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	12,880	12,123	653	12,776	16,431	0	16,431	(389)	16,042	(389)
(1) Executive Director's Office											
Workers' Compensation	**Total**	25,760	24,247	1,306	25,553	32,863	0	32,863	(779)	32,084	(779)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	12,880	12,124	653	12,777	16,432	0	16,432	(390)	16,042	(390)
	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	12,880	12,123	653	12,776	16,431	0	16,431	(389)	16,042	(389)

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☑ Yes ☐ No **Department of Personnel and Administration**

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:	DHS - Adjustment to Statewide Multiuse Network Payments			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S14, NP-BA2 (See DHS Statewide-S-DPA-2)	**OSPB Approval:**		**Date:** 12/26/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	402,984	402,909	8,290	411,199	412,026	12,377	424,403	(1,650)	422,753	10,727
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	201,492	201,454	4,145	205,599	206,157	6,189	212,346	(825)	211,521	5,364
	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	201,492	201,455	4,145	205,600	205,869	6,188	212,057	(825)	211,232	5,363
(6) Department of Human Services Medicaid-Funded Programs, (B) Office of Information Technology Services - Medicaid Funding, Other Office of Information Technology Services line items	**Total**	402,984	402,909	8,290	411,199	412,026	12,377	424,403	(1,650)	422,753	10,727
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	201,492	201,454	4,145	205,599	206,157	6,189	212,346	(825)	211,521	5,364
	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	201,492	201,455	4,145	205,600	205,869	6,188	212,057	(825)	211,232	5,363

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

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:	DHS - GGCC Supplemental True-up			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP-S15, NP-BA3 (See DHS Statewide-S-DPA-5)	**OSPB Approval:**		**Date:** 12/28/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	402,984	402,909	(435)	402,474	412,026	0	412,026	170	412,196	170
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	201,492	201,454	(218)	201,236	206,157	0	206,157	85	206,242	85
	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	201,492	201,455	(217)	201,238	205,869	0	205,869	85	205,954	85
(6) Department of Human Services Medicaid-Funded Programs, (B) Office of Information Technology Services - Medicaid Funding, Other Office of Information Technology Services line items	**Total**	402,984	402,909	(435)	402,474	412,026	0	412,026	170	412,196	170
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	201,492	201,454	(218)	201,236	206,157	0	206,157	85	206,242	85
	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	201,492	201,455	(217)	201,238	205,869	0	205,869	85	205,954	85

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☑ Yes ☐ No **If Yes, List Other Departments Here:** Department of Human Services, Department of Personnel and Administration

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:	DHS - Adjustment to Statewide Vehicle Lease Payments			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	NP - S16 (See also DHS Statewide-S-DPA-6)	**OSPB Approval:**		**Date:** 12/22/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	**Total**	5,279,829	6,002,337	(18,009)	5,984,328	6,151,223	0	6,151,223	0	6,151,223	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,639,915	3,001,169	(9,005)	2,992,164	3,078,114	0	3,078,114	0	3,078,114	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	2,639,914	3,001,168	(9,004)	2,992,164	3,073,109	0	3,073,109	0	3,073,109	0
(6) Department of Human Services Medicaid-Funded Programs, (C) Office of Operations-Medicaid Funding	**Total**	5,279,829	6,002,337	(18,009)	5,984,328	6,151,223	0	6,151,223	0	6,151,223	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,639,915	3,001,169	(9,005)	2,992,164	3,078,114	0	3,078,114	0	3,078,114	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	2,639,914	3,001,168	(9,004)	2,992,164	3,073,109	0	3,073,109	0	3,073,109	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

Request Affects Other Departments: ☑ Yes ☐ No **If Yes, List Other Departments Here:** Department of Human Services, Department of Personnel and Administration