Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☑	**Base Reduction Item FY 2009-10** ☐	**Supplemental FY 2008-09** ☐	**Budget Amendment FY 2009-10** ☐

Request Title:	Medicaid Value-Based Care Coordination Initiative				
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	October 31, 2008
Priority Number:	DI-6	**OSPB Approval:**		**Date:**	10-23-08

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
Total of All Line Items	**Total**	2,258,647,383	2,378,179,617	0	2,378,179,617	2,398,637,386	2,397,709	2,401,035,095	0	2,401,035,095	(4,362,254)
	FTE	257.3	272.7	0.0	272.7	276.0	1.8	277.8	0.0	277.8	3.0
	GF	723,799,430	721,922,120	0	721,922,120	722,268,201	899,050	723,167,251	0	723,167,251	(2,267,022)
	GFE	327,500,000	369,000,000	0	369,000,000	369,000,000	0	369,000,000	0	369,000,000	0
	CF	0	88,068,998	0	88,068,998	97,945,566	8,954	97,954,520	0	97,954,520	(65,300)
	CFE/RF	74,496,317	4,439,104	0	4,439,104	4,446,611	0	4,446,611	0	4,446,611	0
	FF	1,132,851,636	1,194,749,395	0	1,194,749,395	1,204,977,008	1,489,705	1,206,466,713	0	1,206,466,713	(2,029,932)
(1) Executive Director's Office; (A) General Administration, Personal Services	**Total**	20,382,113	19,251,491	0	19,251,491	19,989,456	201,440	20,190,896	0	20,190,896	327,409
	FTE	257.3	272.7	0.0	272.7	276.0	1.8	277.8	0.0	277.8	3.0
	GF	8,523,018	7,994,379	0	7,994,379	8,121,243	100,720	8,221,963	0	8,221,963	163,704
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	731,501	0	731,501	786,800	0	786,800	0	786,800	0
	CFE/RF	2,219,695	1,557,401	0	1,557,401	1,564,984	0	1,564,984	0	1,564,984	0
	FF	9,639,400	8,968,210	0	8,968,210	9,516,429	100,720	9,617,149	0	9,617,149	163,705
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	980,465	1,833,478	0	1,833,478	1,681,669	17,584	1,699,253	0	1,699,253	2,850
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	469,925	882,945	0	882,945	811,165	8,792	819,957	0	819,957	1,425
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	23,307	0	23,307	19,221	0	19,221	0	19,221	0
	CFE/RF	24,209	13,377	0	13,377	13,301	0	13,301	0	13,301	0
	FF	486,331	913,849	0	913,849	837,982	8,792	846,774	0	846,774	1,425
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	0	2,443,584	0	2,443,584	1,625,334	125,000	1,750,334	0	1,750,334	125,000
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	1,099,292	0	1,099,292	752,667	62,500	815,167	0	815,167	62,500
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	62,500	0	62,500	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	1,281,792	0	1,281,792	872,667	62,500	935,167	0	935,167	62,500

Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☑	**Base Reduction Item FY 2009-10** ☐	**Supplemental FY 2008-09** ☐	**Budget Amendment FY 2009-10** ☐

Request Title:	Medicaid Value-Based Care Coordination Initiative			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** October 31, 2008
Priority Number:	DI-6	**OSPB Approval:**		**Date:**

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	0	24,094,147	0	24,094,147	23,489,449	1,058,400	24,547,849	0	24,547,849	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	5,499,078	0	5,499,078	5,382,396	264,600	5,646,996	0	5,646,996	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	1,881,903	0	1,881,903	1,833,613	0	1,833,613	0	1,833,613	0
	CFE/RF	0	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	0	16,612,838	0	16,612,838	16,173,112	793,800	16,966,912	0	16,966,912	0
(1) Executive Director's Office; (D) Eligibility Determination and Client Services, Customer Outreach	**Total**	0	3,790,283	0	3,790,283	3,573,001	354,092	3,927,093	0	3,927,093	567,170
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	1,861,628	0	1,861,628	1,752,987	177,046	1,930,033	0	1,930,033	283,585
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	33,514	0	33,514	33,514	0	33,514	0	33,514	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	1,895,141	0	1,895,141	1,786,500	177,046	1,963,546	0	1,963,546	283,585
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**Total**	0	4,669,035	0	4,669,035	4,496,355	105,000	4,601,355	0	4,601,355	604,780
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	1,362,318	0	1,362,318	1,319,148	26,250	1,345,398	0	1,345,398	151,195
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	54,949	0	54,949	54,949	0	54,949	0	54,949	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	3,251,768	0	3,251,768	3,122,258	78,750	3,201,008	0	3,201,008	453,585
(2) Medical Services Premiums	**Total**	2,237,284,805	2,322,097,599	0	2,322,097,599	2,343,782,122	536,193	2,344,318,315	0	2,344,318,315	(5,989,463)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	714,806,487	703,222,480	0	703,222,480	704,128,595	259,142	704,387,737	0	704,387,737	(2,929,431)
	GFE	327,500,000	369,000,000	0	369,000,000	369,000,000	0	369,000,000	0	369,000,000	0
	CF	0	85,281,324	0	85,281,324	95,217,469	8,954	95,226,423	0	95,226,423	(65,300)
	CFE/RF	72,252,413	2,767,998	0	2,767,998	2,767,998	0	2,767,998	0	2,767,998	0
	FF	1,122,725,905	1,161,825,797	0	1,161,825,797	1,172,668,060	268,097	1,172,936,157	0	1,172,936,157	(2,994,732)

Schedule 13 Change Request for FY 2009-10 Budget Request Cycle										
Decision Item FY 2009-10 ☑		**Base Reduction Item FY 2009-10** ☐		**Supplemental FY 2008-09** ☐			**Budget Amendment FY 2009-10** ☐			
Request Title:	Medicaid Value-Based Care Coordination Initiative									
Department:	Health Care Policy and Financing			**Dept. Approval by:**	John Bartholomew		**Date:**	October 31, 2008		
Priority Number:	DI-6			**OSPB Approval:**			**Date:**			
[1]Prior to the reorganization of the Department's budget in the FY 2008-09 Long Bill HB 08-1375, funding for the Medicaid Management Information System contract was appropriated in Long Bill Group (1) Executive Director's Office; Medicaid Management Information System Contract.										
[2]Prior to the reorganization of the Department's budget in the FY 2008-09 Long Bill HB 08-1375, funding for the Enrollment Broker contract was appropriated in Long Bill Group (1) Executive Director's Office; S.B. 97-05 Enrollment Broker.										
[3]Prior to the reorganization of the Department's budget in the FY 2008-09 Long Bill HB 08-1375, funding for external quality review contract was appropriated in Long Bill Group (1) Executive Director's Office; External Quality Review.										
Non-Line Item Request:	None									
Letternote Revised Text:	Medical Services Premiums: [a]Of this amount, $69,957,447 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.; $13,842,626 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program; $233,043 shall be from the Autism Treatment Fund created in Section 25.5-6-805, C.R.S.; $935,044 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a), C.R.S.; and, $10,258,263 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S.									
Cash or Federal Fund Name and COFRS Fund Number:	CF: Health Care Expansion Fund, 18K; FF: Title XIX									
Reappropriated Funds Source, by Department and Line Item Name:	None									
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑							
Schedule 13s from Affected Departments:	None									

CHANGE REQUEST for FY 2009-10 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-6
Change Request Title:	Medicaid Value-Based Care Coordination Initiative

SELECT ONE (click on box):

☒ Decision Item FY 2009-10
☐ Base Reduction Item FY 2009-10
☐ Supplemental Request FY 2008-09
☐ Budget Request Amendment FY 2009-10

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 $2,397,709 total funds, $899,050 General Fund, and 1.8 FTE in FY 2009-10; and, a reduction of $4,362,254 total funds, a reduction of $2,267,022 General Fund, and 3.0 FTE in FY 2010-11 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning April 1, 2010. To ensure that the Department's goals are being achieved, the Department will limit enrollment to 60,000 clients until the efficacy of the program can be demonstrated. Because cost savings will require practice changes by providers, the Department's Request also includes funding to provide a director for the Center for Improving Value in Health Care (CIHVC) to help ensure that those changes can be made.

Background and Appropriation History:

The Department is committed to ensuring that clients are healthier when they leave the Medicaid and Children's Basic Health Plan programs than when they entered. To that end, the Department is proposing a set of enhancements to administrative and program functions and interventions designed to maximize the health, functioning and self-sufficiency of Medicaid clients and providers. The primary goals of all four proposals in the Department's Budget Request for FY 2009-10 are to (1) provide a model that delivers seamless, integrated care to clients between different delivery systems, (2) maximize

client health and satisfaction, and (3) achieve greater cost-effective care. The common thread underlying all of the proposals is making the health care delivery system, and access to programs, more outcomes-focused and client-centered. These enhancements and programmatic changes will lead to a more coordinated system based on shared responsibility; where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents.

The Department's set of proposals are divided into four Change Requests:

- DI-5 Improved Eligibility and Enrollment Processing;
- DI-6 Medicaid Value-Based Care Coordination Initiative;
- BRI-1 Pharmacy Technical and Pricing Efficiencies; and,
- BRI-2 Medicaid Program Efficiencies.

The request in DI-5 would improve eligibility and enrollment processing by creating a single state-level entity to enhance and complement the current multiple county-level processes. This entity would streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, create expedited eligibility and improve outreach and enrollment in both programs. In addition, the entity would modernize the current eligibility determination process by implementing an automated customer contact center and create an electronic document and workflow management system. This would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. These changes would ensure easier, more reliable and timely eligibility and enrollment processes, making the program more efficient and effective and delivering important benefits to clients, providers and enrollment staff.

The request in DI-6 for a Medicaid Value-Based Care Coordination Initiative would enable the Department to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. To achieve this, the Department will undertake a statewide competitive procurement process for physical health services that emphasizes the importance of increasing the availability and services of medical homes for all clients. The Department intends to regionally procure services from Accountable Care Organizations that would operate as Administrative Services Organizations (ASOs) providing enhanced Primary Care Case Management services. The ASOs would be

primarily responsible for establishing a coordinated care delivery system for all clients. The Department anticipates that payments to primary care physicians would be supplemented with care coordination fees as well as outcomes-based performance incentives.

In addition to strengthening primary care services, the ASO would administer a comprehensive network of care coordination services. Care coordinators would be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospitals and community care, and importantly serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. The ASO would also deploy evidence-based medical management tools designed to promote patient safety and reduce unwarranted variation in care practices. The ASO contract would also be performance based with guarantees established around health outcomes, functional improvements, and self-sufficiency attainment. The Department anticipates that ASOs will incorporate an electronic health exchange that will greatly facilitate effective communication between clients, providers, and government agencies. Through such efforts, errors and duplication can be reduced. Clinical decision support tools as well as electronic registries will help improve outcomes at the point of care. This initiative aims to create a comprehensive, coordinated, outcomes focused care delivery system that optimizes the well being of Medicaid clients.

The Department's BRI-1, Pharmacy Technical and Pricing Efficiencies, requests a reduction in funds as a result of implementing an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure. Automating prior authorizations would increase efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process would make it easier for providers to submit requests, it would be easier and faster for clients to obtain drugs with prior authorization restrictions, and provide savings within Medical Services Premiums.

The request in BRI-2, Medicaid Program efficiencies, would improve quality of service for clients through six initiatives:

- Medicaid Benefit Package Reform;
- Health Outcomes Measurement Initiative;
- Fluoride Varnish;
- Hospital Back Up Program Enhancements;
- Oxygen Durable Medical Equipment Administrator; and,
- Serious Reportable Events.

Through the Health Outcomes Measurement Initiative, the Department would directly survey Medicaid clients on a monthly basis regarding their health and functional status to measure effectiveness of the Medicaid program and find areas for improvement. In addition, the Department could analyze geographic indicators to identify and address health disparities between urban and rural areas; and analyze and compare the health and functional status of clients in different groups. Through the Hospital Back Up program, the Department would achieve cost savings and improvements to care by moving clients out of hospitals into more appropriate care settings. Potential cost savings would also be generated through the initiative for 1.0 FTE Oxygen Durable Medical Equipment Administrator. This FTE would help the Department contain oxygen related expenditures, which are the highest expenditure category within durable medical equipment, implement process improvements and introduce more technologically efficient oxygen delivery systems.

This package builds upon many recommendations from the Blue Ribbon Commission for Health Care Reform (commonly referred to as the 208 Commission). It draws upon successful Medicaid reform efforts in North Carolina, Indiana, Oklahoma, Arkansas, and New Hampshire. By awarding health care service contracts regionally, the Department anticipates community organizations coming together to serve their own community and be accountable for their performance. The regional model allows for a rough overlap with behavioral health organization regions allowing for more effective coordination of services between physical and behavioral health. Also, alignment with Children's Basic Health Plan regions will help create seamless care for children traversing between programs. A key goal of these initiatives is seamless care to the client between different delivery systems. The initiatives call for a holistic and systems approach to care delivery.

The Department recognizes the varying needs of different populations served within Medicaid and expects to set outcome measures that differ between TANF, SSI, waiver, and dual eligible populations. A key component of the model is comprehensively defining the Medicaid benefit so coverage, duration, amount, and scope are clearly articulated.

General Description of Request:

The Department requests $2,397,709 total funds, $899,050 General Fund, and 1.8 FTE in FY 2009-10; and, a reduction of $4,362,254 total funds, a reduction of $2,267,022 General Fund, and 3.0 FTE in FY 2010-11 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning April 1, 2010. To ensure that the Department's goals are being achieved, the Department will limit enrollment to 60,000 clients until the efficacy of the program can be demonstrated. Because cost savings will require practice changes by providers, the Department's Request also includes funding to provide a director for the Center for Improving Value in Health Care (CIHVC) to help ensure that those changes can be made.

Statewide Coordinated Delivery System

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

Building on the work of the 208 Commission, the Governor's Building Blocks for Health Care Reform request ("the Building Blocks Request") focused on enhancing provider reimbursement, streamlining administrative processes for eligibility, expanding benefits to clients enrolled in the Children's Basic Health Plan, and ensuring that every child enrolled in Medicaid and the Children's Basic Health Plan have a medical home. This

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

initiative builds upon the efforts begun with respect to the medical home for children and proposes a delivery system that will promote medical homes for both children and adults. Because the implementation of such a delivery system will require buy-in and changes from physicians, providers, and community groups, the Department is also requesting funding to participate in the Center for Improving Value in Health Care (CIVHC). Funding for CIVHC is discussed later in this section of the Request.

In the Building Blocks Request, the Department outlined the core responsibilities of a medical home: "Providers enrolled as medical homes would be responsible for ensuring health maintenance and preventive care; anticipatory guidance and health education; acute and chronic illness care; coordination of medications, specialists, and therapies; provider participation in hospital care; and, twenty-four hour telephone care for all clients enrolled."

The Department has made significant progress in its implementation of the medical home for children. Medical home standards have been developed in collaboration with providers and other community stakeholders. Provider recruiters funded under the Building Blocks Request will identify gaps in the Medicaid and Children's Basic Health Plan provider network and target specialties and geographical areas where capacity must be built to handle enrollment increases. Provider trainers will assess the extent provider practices are meeting medical home standards and offer technical assistance and training to providers to meet the standards. System changes are under development to distinguish clients having a medical home and to appropriately reimburse providers meeting the medical home standards. The evaluation methodology to measure the effectiveness of the medical home model for children is under development. The Department is working with its managed care organizations for the Children's Basic Health Plan to incorporate the principles of the medical home model into the basic contract. On the Medicaid side, the Department has focused its efforts primarily on the fee-for-service providers.

The Department proposes to simultaneously continue its implementation of the medical home model while implementing an administrative services organization (ASO) contract model, also known as primary care case management (PCCM), into which 60,000 fee-for-service clients will be enrolled. The Department's intent is to transform the current

Medicaid delivery model into an outcome-based system, eventually covering all fee-for-service clients. The providers trained and offering medical homes for children will be ideally suited to participate in this new ASO model. This model builds upon Medicaid reform efforts in North Carolina, South Carolina, Indiana, Oklahoma, Arkansas, Oregon, Minnesota, Washington, Texas, Nebraska, Alabama, and New Hampshire; although not every state has a similar program to the Department's proposal. The Department anticipates awarding ASO contracts on a regional basis will leverage the existing resources in a community and will promote greater accountability for performance outcomes. Moreover, by ensuring that the pilot-phase of the program is statewide, if the Department is able to demonstrate the efficacy of the program, the infrastructure will be in place for a rapid expansion to the remaining fee-for-service population.

The scope of services supplied by the ASO is the foundation of Modern Medical Management. "Modern Medical Management" means a highly coordinated system of care that identifies a personal primary care physician (PCP) or provider team for each client as well as enabling that PCP to provide high quality, comprehensive and community-based care. Services provided by the ASOs are geared towards improving access, quality and cost efficiency by supporting the PCP as the "quarterback" in the care delivery system. The client's PCP will be the "one-stop shop" for understanding and improving his/her health status. The ASO serves as the support the PCP's need to quarterback the care. In most cases, the PCP will serve as the client's medical home. Because of the Department's current efforts to train and recruit providers to serve as medical homes, the PCPs transitioning into the new model will be familiar with the concept and approach.

This system of care expressly incorporates and includes essential medical home concepts. Care coordinators will be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospital and community care, and importantly serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. Designated ASO staff would assist providers and clients to access and coordinate recommended medical services. The ASO would assist with multiple-way care coordination among the client, their PCP, and the client's multidisciplinary care

team. Further, designated ASO staff would assist in promoting comprehensive care transitions related to institutional admission or discharge including the following institutional settings: inpatient hospital; emergency room use; and, home health care and/or nursing home care based on already proven evidence-based protocols.

The ASO would also be responsible for a large number of administrative support functions for PCPs. Most notably, the ASO would support practices in transitioning to a "Modern Medical Management" style of care. Support would be based on proven methodologies of practice re-design and would assist the PCP in efficient use of the multi-disciplinary team, continuous quality improvement principles, implementation of chronic care strategies, risk assessment and population based care management. The ASO would be responsible for expanding and developing a network of primary care and specialty providers to assist a client in gaining access to services, and would assist clients and providers in obtaining prior authorization requests (PARs) for needed services by contacting the PARs staff within the Department.

As part of the competitive bid process, the Department would consider the ASO's ability to provide services and support in a modern medical management framework. For example, the Department would seek providers with an already established network of primary care and specialty providers by more favorably scoring bid proposals demonstrating such network development criteria. The Department would require ASOs to incorporate sophisticated provider profiling software and profiling techniques, and have a strong information technology support system. The ASO would be expected to support participating providers by providing a secure shared electronic health information network. The network would have the capability to facilitate care coordination, medication reconciliation, clinical decision support and support practice level quality improvement activities.

The Department would also consider proposals which contain components of intensive care coordination for those clients newly diagnosed with a chronic illness or those who have other intensive needs. Intensive care coordination would be highly coordinated with the client's primary care provider and the multi-disciplinary team caring for the client, and coordination would include evidence based protocols for particular chronic diseases,

including diabetes management, congestive heart failure (CHF), depression, asthma and chronic obstructive pulmonary disease (COPD). Special weighting would be given to ASO bidders having evidence based protocols related to common co-morbid diseases and/or extensive experience in serving high needs Medicaid populations.

In order to facilitate outcomes-based practices and intensive care coordination, the Department would initiate a large-scale data sharing initiative with the ASOs. Each contractor will have access to current claims and eligibility data on clients in its care to ensure that the most appropriate care is being rendered and outcomes are measureable. Data is essential for effective care coordination between plans. In an ASO contract, the State pays claims, so it is essential to feed the data back to the ASOs so that they can monitor their providers and clients effectively.

This proposal is a reversal of long-standing managed care policy to advance capitation contracting. The Department has suspended efforts to expand risk-based managed care and would continue this suspension with the approval of this Request. While many of the principles contained in the Department's proposal have been adopted by traditional managed care plans, the Department does not believe that expanding fully capitated, risk-based care will achieve the goals outlined above. In a capitated risk-based model, there is always an incentive for the managed care organization to focus on reducing costs: the difference between the cost of service and the capitations paid is retained by the health plan, providing that plan with an incentive to maximize that difference. Further, with a large population enrolled in risk-based managed care, the Department loses much of its ability to implement new programs or coordinate with community providers, as it only has limited input into the networks of managed care organizations or payment schedules. Under an ASO model, the Department will be able to more directly focus its contractors on the goals it has established, and focus providers directly on health-outcomes, not only on cost-reductions.

Enhanced care coordination and establishing a focal point of care for current fee-for-service clients will reduce costs related to: duplicative outpatient services; pharmacy utilization; emergency room utilization for conditions that can be treated in an outpatient setting; and, will reduce avoidable, preventable and inappropriate inpatient

hospitalizations. Unlike the service delivery in fee-for-service, in a focal point of care system, laboratory tests, imaging studies, medication information and other diagnostic information is immediately available to the primary provider. The provider's immediate access to this information is shown to reduce costs.

However, the Department will continue to contract with the existing capitation and prepaid-inpatient health plans (PIHP), including contractors associated with the Colorado Regional Integrated Care Collaborative (CRICC) and proposals in accordance with SB 06-128.[2] The Department is also proposing changes to the CRICC initiative as part of this Request; see the section on "*Changes to Existing Managed Care Programs*" in this document.

Coordination with EPSDT Outreach Coordinators

As part of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, children age 20 years old or younger have access to outreach and screening programs aimed at the promotion of health, the prevention of disease, and improved access to health care services. In this regard, the outreach coordinators provide an essential service to Medicaid children, particularly because these coordinators are located in local communities. These coordinators have years of expertise and experience navigating Medicaid and helping clients receive services, and neither the Department nor its clients cannot afford to lose this vital connection to the community provider networks.

The Department envisions that EPSDT coordinators will become an integral part of local outreach activities by ASOs. Because many care coordination activities will be assumed by the ASO, the Department anticipates that the primary function of the EPSDT coordinators will be as "Medical Home Navigators." The Navigators would continue to provide essential front-line services, particularly with regard assisting clients 20 years old and younger navigate within and between the physical health, behavioral health, waiver,

[2] During FY 2007-08, the Department requested and received additional funding to account for cash-flow issues related to enrolling clients in risk-based managed care programs. If this Request is approved, that funding will no longer be required. Because that funding was appropriated in FY 2008-09, this request does not specifically request any offset for that funding. The adjustment to the funding that was appropriated will be contained in the Department's base requests for Medical Services Premiums, DI-1 and S-1.

and long term care service options by eliminating the administrative barriers that prevent children from accessing needed health care services. Moreover, the Navigators will continue to perform current outreach and coordination activities during the start of the program, where not every client will be enrolled in the ASO.

The Department will encourage ASO bidders to acquire formal working arrangements with the Navigators and will reward that early activity in the RFP scoring process. After the full implementation of the ASO model, the Department will reevaluate the funding needs for the Early Periodic Screening, Diagnosis, and Treatment Program line item to ensure that funding is not being spent for duplicative services.

Service Costs and Savings

The Department proposes to pay a monthly management fee on a per-member per-month basis of $20.00 for care coordination. Of this amount, $16.00 would go directly to the ASO for administrative duties; and $4.00 would be placed into an escrow account to fund pay-for-performance incentives. The incentive payment would be divided between the ASO and the provider with the majority of the incentive payment going to the provider. In the event that the ASO or the providers do not meet performance expectations, the unused incentive funding would revert to the Department. Further, the Department anticipates that a monthly management fee that is lower than the fee currently paid to prepaid inpatient health plans is appropriate. Under the ASO model, the Department will retain the responsibility of doing claims processing, validation, and payment. Such an arrangement allows the Department to maintain data on services rendered, which will then be provided to the ASOs to assist in care coordination.

The Department expects that savings to service costs begin immediately, and exceed the cost of the monthly management fee. In Table 1, rows J and K, the Department estimates the cost of both the monthly management fee and the estimated savings generated from the program. The Department is also considering a "shared outcomes" model whereby a percentage of net savings would be paid to providers to monetarily incent desired outcomes. The Department estimates that between 20% and 50% of the savings would be targeted for shared savings; these savings would only above budget neutrality

inclusive of ASO management fees. Because no savings payment could be made until FY 2010-11, if the Department determines that a shared-outcomes incentive model is appropriate, it will request funding in a separate Budget Request.

The Department's calculations are based on the assumption the there will be five ASOs providing comprehensive coverage of the state. To facilitate enrollment, the Department would expand its practice of passive enrollment for all regional plans to assure a majority of Medicaid clients are enrolled into a managed care system by 2011. If enrollment goals are not reached using passive voluntary enrollment, then the Department may file a State Plan amendment or a file for a waiver in 2010 for mandatory enrollment. Each plan is assumed to enroll 3,000 clients per month, for a total of 15,000 clients being enrolled each month into the program. Because of the complexity required in providing clients access to such a wide array of benefits, the Department does not believe that faster enrollment will serve its clients better; if too many clients are enrolled at once, plans will be overwhelmed and clients may lose access to services rather than gain access.

The portion of the monthly management fee paid directly to the ASO, $16.00, will cover the administrative activities described in the previous section. Of the monthly management fee, $4.00 (or 15%) will be immediately placed into an escrow account to provide an incentive pool for the ASOs and the providers to provide higher quality service. The effectiveness of the ASO and the providers in supporting practices in the comprehensive care of their clients would be reflected by performance on several quality metrics. These metrics would include measures such as: hospital admission for ambulatory-sensitive conditions; 30-day hospital re-admission for same diagnosis; emergency department utilization rates; immunization and well care rates for children; rates of chronic disease care; use of evidence based guidelines and clinical decision support; and, patient and provider satisfaction.

By placing clients in the coordinated care program, the Department estimates that it would ultimately save at least 12% of current per capita costs, although savings would start lower and increase over time, estimated at 8% in the first year, 10% in the second year, and 12% in the third year. When combined with the additional cost of the administrative fee, the Department estimates that it will save approximately 3.2% of total

expenditure for these clients in FY 2010-11. Cost savings generally occur when clients are able to use less costly primary care services instead of immediately going to an emergency department, and when unnecessary tests and therapies are eliminated. In order to achieve this, the proposed program will help clients become actively engaged in behavior that mitigates disease or improve purchasing. Further, both the ASO and the PCP will have financial incentives to encourage clients to engage in advantageous behavior, as performance incentives will be tied to outcomes which should reduce the incidence of unnecessary and more costly services. Of note, however, is that ASO and PCP incentives are not tied to financial performance, which would provide an incentive for providers to look for care options based on cost, not necessarily cost-effectiveness.

The Department believes that the proposed savings rates are reasonable and achievable based on a variety of factors. The experience of other states has shown similarly significant reductions in cost. In the most prominent example, North Carolina, independent audits performed by Mercer have shown cost savings of 17% in a mature program.[3] Further, the Department has received information from several other states as well; in particular, South Carolina indicated approximately 14.3% per-member per-month cost savings for clients enrolled in its PCCM model over fee-for-service.[4] Information from Nebraska, Texas, and Alabama also indicates overall cost savings from implementing PCCM programs, although the program implementations do not appear to be directly comparable to the Department's proposal. Because the Department's program is new, a more conservative estimate of cost savings is appropriate. Over time, the Department expects that this initiative would significantly slow per capita growth and provide a measure of cost stability to the Medical Services Premiums line item.

Historically, managed care has not saved the Department money because in a risk-based model, gains realized from decreasing utilization are kept by the managed care organizations as profit. The benefit to the ASO model is that the Department will be able to use cost savings achieved from care coordination to reinvest in the program (in the form of incentives to providers and ASOs) to ensure that quality care continues to be

[3] North Carolina publishes detailed reports on the status of its coordinated care programs on its website: http://www.dhhs.state.nc.us/mhddsas/index.htm
[4] http://www.scstatehouse.net/reports/dhhs/MHNMCOComparison.doc, Table 1.

provided, instead of just a utilization reduction. Further, the Department anticipates that smaller, community based networks will further empower clients, leading to better care coordination and transitions of care due to smaller networks. Better coordination of care reduces unnecessary duplication of services, leading directly to cost savings. Furthermore, under the ASO model, the Department will retain complete access to all claims data, including pharmacy claims, thereby better enabling the Department to better monitor the quality and cost of care and make or direct immediate interventions as needed.

Estimated program enrollment is calculated in table 3.1. Estimated monthly management fees are calculated in table 4.1. Estimated per capita savings are calculated in tables 5.1 and 5.2. Net savings are calculated in table 6.2, and summarized on an annual basis in tables 2.1, 2.2, and 2.3.

Program Evaluation

The Department will conduct a preliminary evaluation of cost savings on the pilot population based on the initial six months of claims data and then evaluate quality of care and cost savings when the first 12 months of claims data are available. The Department will use a similar fee-for-service population as a comparison for cost and quality of services. The Department currently contracts with a Quality Improvement Organization that is capable of designing and executing such an evaluation; if the evaluation is performed by a Quality Improvement Organization, expenditures will receive 75% federal financial participation. Moreover, the Department intends to track repeat inpatient visits and ER visits from immediately from paid claims data, and plans relay these metrics back to the ASOs immediately. This feedback will provide both the ASOs and the Department with early indicators of performance, to ensure that any potential concerns are addressed immediately, rather than after a savings analysis is performed.

Changes to Existing Managed Care Programs

Prepaid Inpatient Health Plans

As part of this initiative, the Department proposes to raise the monthly management fee paid to prepaid inpatient health plans (PIHPs) to $28.00. This increase would cover the increased costs to conforming to the Department's initiatives. The current administration fee of $25 per member per month was set in FY 2005-06 and has not been changed since that time. The increase will enable the Department to retain critical providers, particularly on the western slope, and help to provide a comprehensive provider network throughout the state. This monthly cost remains higher than the proposed ASO cost due to the burden placed on PIHP providers of claims processing. Estimated costs for increasing the administration fee are contained in table 10.1.

Colorado Regional Integrated Care Collaborative

Colorado is one of seven states participating in an initiative entitled, "Rethinking Care Program for America's Highest Need, Highest Cost Populations." This program was started in January 2008 by the Center for Health Care Strategies and is known in Colorado as the Colorado Regional Integrated Care Collaborative (CRICC). The goal of the program is to better manage the care and costs of subsets of the highest-need, highest cost beneficiaries. The Department is partnering with the Center for Health Care Strategies, local health plans and providers, consumer organizations and other stakeholders to maximize the potential for the CRICC to generate sustainable and replicable models that could ultimately reach thousands of Medicaid's most vulnerable patients.

As part of this initiative, the Department is proposing to pay a provider the same $20 PMPM proposed for the ASO initiative for approximately 1,500 clients, also for a period of two years. Clients will be enrolled in the program as part of the study. However, to provide a comprehensive evaluation of these clients, the Department aims to have these clients enrolled in the program through the end of FY 2010-11, a period of two years.

The provider cannot provide services for that length of time without some payment for administration. Calculations for the cost of the study are contained in table 10.2.

Program effectiveness will be assessed by comparing measures of health care quality, utilization and expenditures between the enrolled group and a control group of comparable clients not enrolled in the program. It is expected that the intervention will be implemented for at least a two-year period. Evaluation of the programs will be conducted by the MDRC, a nonprofit, nonpartisan policy research organization with extensive experience in conducting randomized controlled studies of social policy initiatives targeted at low-income populations. At this time, the Department is not including any estimate of cost-savings associated with the CRICC in this Request. While the Department does anticipate that the overall result of the program will result in cost-savings, the Department does not want to condition administration payments on the expectation of savings for such a small group of high-risk clients. Any actual savings will be incorporated in the Department's Base and Supplemental Requests for Medical Services Premiums. If the study does show that savings have been achieved, the Department anticipates that there will be a gain-sharing incentive agreement with the provider so that the provider is financially rewarded if their efforts have been successful. Under no circumstances would the Department make any incentive payment to the provider if the program cannot be shown to be cost-negative.

Current Risk-Based Managed Care Organizations

Furthermore, as part of this initiative, the Department proposes a pay-for-performance program for risk-based managed care. Such a program is allowed by state statute 25.5-5-408 (5), C.R.S. (2008), which states that "[the] state department may develop quality incentive payments to recognize superior quality of care or service provided by a managed care plan." An incentive program is allowable under federal regulations. 42 C.F.R. § 438.6 (5) requires that incentive payments be limited to 5% of capitations paid to the provider, and must be computed on an actuarially sound basis. Additionally, the incentive arrangement must be for a fixed period of time and may not be renewed automatically. The incentive payment would provide similar incentives to risk-based managed care as are provider to the ASOs, and would reward care provided consistent

with modern medical management. Plans would be required to achieve consistently high HEDIS (or other benchmark) scores to receive an incentive. Because the Department must add the performance period to the contracts prior to the payment, the Department's first payment under this initiative will occur in FY 2010-11. As such, if this request is approved, the Department will add language to managed care contracts in FY 2009-10 allowing for an incentive payment in FY 2010-11 subject to available appropriations. The Department will not make a payment to health plans without seeking explicit spending authority in FY 2010-11.

Administrative Costs

As part of this initiative, the Department is requesting funding to ensure that the necessary administrative resources are in place to ensure that the program functions efficiently, effectively, and in compliance with all state and federal laws. The Department must ensure that clients have complete information about the program so that they may make an informed choice. Moreover, the Department must ensure that contractors are given sufficient funding for administrative costs such as printing and postage. There must be adequate internal and external oversight of the programs, and the Department must also ensure that its systems are able to correctly interface with providers' systems. Therefore, the Department requests funding for the following areas: personal services, the ombudsman, actuarial services, the Medicaid management information system, the external quality review organization, and the enrollment broker. Total administrative costs are listed in tables 2.1 through 2.3.

Personal Services: Contract Management and Program Support

As part of this initiative, the Department requests funding for 0.8 FTE in FY 2009-10 and 2.0 FTE in FY 2010-11. To provide contract management services for 5 ASO contracts, the Department would require 2.0 FTE General Professional IV managers. Each contract manager can successfully manage no more than 3 contracts. The Department anticipates that in the first phase of this initiative, contracts will require extensive oversight in order to assure that the Department's goals are being met. The contract managers would start 3

months before clients are enrolled in the program to ensure that contracts are properly executed prior to enrollment. Costs for additional Department staff are shown in table 9.

In addition to the FTE requested above, the Department is also requesting 0.9 FTE in FY 2009-10 and 1.0 FTE in FY 2010-11 to direct the Center for Improving Value in Health Care (CIVHC). This FTE is discussed separately at the end of this section.

Enrollment Broker and Other External Administration

In order to inform clients of their choices under the care coordination initiative, the Department would be required to substantially increase funding for the enrollment broker. The enrollment broker has responsibility for providing Medicaid clients with timely and accurate information regarding choices in managed care organizations. The costs identified are fixed costs and include the increased price of mailings (due to larger packages) and postage for the increased volume of mailings. The Department is also proposing, as part of this request, to transfer certain functions which are currently being performed by the Department's managed care organizations back to the enrollment broker. The Department believes that having managed care organizations provide funding for enrollment broker activities may be a conflict of interest and is not in the best interest of Medicaid clients. If the Centers for Medicare and Medicaid Services determine that the Department's enrollment broker has a conflict of interest, the Department may face loss of federal funding for both its administrative expenditure for the enrollment broker program, and also federal funding for managed care services. Costs for the enrollment broker are contained in tables 7.1 and 7.2

The Department also would have other administrative costs related to increasing access to ombudsman activities. Currently, the Department funds a single ombudsman for all managed care clients; by vastly increasing the number of clients in the care coordination initiative, the Department would require additional ombudsman services to ensure that clients have fair access and representation. Additionally, the Department would need to increase external quality review activities to: conduct HEDIS audits and calculations; perform site reviews; and perform encounter data audits. Calculations for ombudsman services are contained in table 8.3. Calculations for external quality review are contained

in table 8.4. Finally, the Department would also require the services of a professional actuary to certify pay-for-performance calculations and also to provide support for determining appropriate payment methodologies on a go-forward basis.

Medicaid Management Information System

As part of this initiative, the Department must ensure that its claims and enrollment system, the Medicaid Management Information System (MMIS) is able to support the continuous enrollment of 15,000 clients per month into managed care organizations. To date, passive enrollment activities can be performed by the MMIS only in Denver County. Other passive enrollment activities must be performed manually by Department staff and the enrollment broker. Such an arrangement is not feasible for a project with constant enrollment demands. Additionally, the MMIS must be internally able to support the simultaneous payment of the monthly administration costs to several locations (namely, the ASO and the escrow account). The system must also support data sharing and claims access by multiple contractors, who would be required to use actual claims data to determine and enhance outcome-based practices. Based on internal cost estimates, the Department anticipates that programming of these features would take approximately 8,400 programming and testing hours. The costs components are listed in Table 8.2

Early Periodic Screening, Diagnosis, and Treatment Program

The Department is not requesting any change to the funding for this line item at this time. Because not all Medicaid children will be enrolled in the ASO at once, there will be a significant need for the current EPSDT outreach and coordination services to continue. Moreover, as stated above, the Department will be transitioning the EPSDT outreach coordinators to Medical Home Navigators to ensure that local community providers remain essential parts of a client's care network. The Department will re-evaluate the funding need for this program after the ASO provider network is fully operational.

The Center for Improving Value in Health Care

In February 2008, Governor Ritter issued Executive Order D 005 08 *Establishing the Center for Improving Value in Health Care* (CIVHC) "to develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care." The order was based on recommendations of the Blue Ribbon Commission for Health Care Reform and modeled after an approach pursued in other states to create an interagency, multi-disciplinary group to facilitate and implement strategies to improve quality and contain costs.

The Department's goal of a statewide coordinated delivery system is not a program which can be implemented in isolation. The Department can implement the administrative framework to allow the program to succeed, but in order to improve health outcomes and reduce long-term costs, there must be broader changes to the health-care delivery system in Colorado as a whole, not just in the Medicaid program. This requires involvement from physicians, providers, and community groups. If the Department unilaterally implements its coordinated care network without providing a strong mechanism for support for its partners and stakeholders, the initiative may not succeed.

It is unrealistic to expect that a number of independent administrative service organizations will immediately apply a consistent statewide standard for all Medicaid clients, particularly because such a standard does not yet exist. Moreover, as clients transition back and forth between public and private health care, care coordination in the current system can be difficult, if not impossible. Such differences can lead to vast discrepancies in the quality of care that Medicaid clients would receive. Such discrepancies reduce the overall effectiveness of care, and require additional administrative resources in order to deal with differences between regions.

Because CIVHC does not focus exclusively on the public sector, it will be in a unique position to influence statewide health outcomes, affecting not just the Department, but those providers, partners, and stakeholders who directly influence the lives of clients. Regardless of the administrative framework the Department implements, the success of the program is tied directly to the care that clients receive, and so it is critical that the

administrative changes that would be implemented by the Department are done in tandem with changes to the overall health care system.

The remainder of this Request details the overall role of CIVHC, and the Department's involvement in the program.

Role of the Center for Improving Value in Health Care

In general, Coloradans are not, for the most part, getting the best value for their health care dollar. Every year Colorado businesses, consumers, health care providers and government spend in aggregate more than $30 billion on health care. Yet an examination of various quality measures shows Colorado falling short when it comes to cost-effective outcomes of care. (See table on the next page for some examples.) The Commonwealth Fund ranks Colorado 30th among the states for quality of care; the Agency for Healthcare Research and Quality (AHRQ) ranks the state just slightly above average. Colorado spends too little on prevention, public health and chronic disease management and too much on expensive, avoidable hospitalizations and end-of-life care.

A number of factors contribute to the quality care chasm. AHRQ points to five major ones:[5] 1) variations in health care practice from community to community, which AHRQ says is a clear indicator that health care practice has not kept pace with the evolving science of health care to ensure evidence-based practice by all providers; 2) underuse of services by a significant number of people who do not receive necessary care and suffer needless complications that add to costs and reduce productivity; 3) overuse of services by many others who receive health care services that are unnecessary, increase costs and may even endanger their health; 4) misuse of services by patients who are injured during the course of their treatment, with some dying prematurely as a result; and 5) disparities in quality, especially for ethnic and racial minorities.

Over the past decade, an increasing number of groups have come to recognize, or been formed to address, the need to improve health care quality in Colorado. Examples include the Colorado Regional Health Information Organization, Colorado Clinical

[5] Agency for Healthcare Research and Quality, "Improving Health Care Quality Fact Sheet," http://www.ahrq.gov/news/qualfact.htm.

Guidelines Collaborative, Colorado Springs Bridges to Excellence, Colorado Business Group on Health, Patient Safety Coalition, Colorado Hospital Association Report Card, Colorado Foundation for Medical Care and Colorado Improving Performance in Practice project. However, according to the Final Report of the Blue Ribbon Commission on Health Care Reform, what is missing is "an organization that can work across the health care system to create a vision and consensus for improving Colorado's health care system." The Commission concluded that broad quality improvements can be achieved only by "fundamentally realigning incentives." Providers, patients and others will respond appropriately to well-structured, evidence-based incentives for improved health and health care outcomes. But this cannot occur as the health system currently functions, with mixed signals from health plans, payers and others, such that some incent one behavior and others another (e.g., different payment schemes, different chronic care management protocols, etc.).

The purpose of the Center for Improving Value in Health Care is to be the entity described by the Blue Ribbon Commission--one that can create and implement a consensus vision for improving Colorado's health care system. As the Governor noted in his executive order authorizing creation of the Center, "In Colorado, there is an evident need to develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care."

The Center will bring consumers, businesses, health care providers, local public health officials, insurance companies and state agencies together to develop long-term strategies to identify, implement and evaluate quality improvement strategies to ensure a better value for the care received by Colorado residents. Over the next couple of years, the Center will be housed within the Colorado Department of Health Care Policy Financing, although it may become an independent, nonprofit later.

Phase 1 in establishing the Center (February through September 2008) was recently completed. This phase involved creating a planning steering committee of public and private stakeholders to identify existing programs in Colorado dedicated to the improvement of quality and cost containment; researching quality forums and councils in other states and best practices regarding governance structure, funding, roles and

responsibilities and engagement of the private sector; and examining general trends in the private sector that relate to quality improvement and cost management. Other activities included researching strategies for tying quality measurement to rate setting methodologies and payment structures; identifying priorities and strategies for improving quality and containing costs; and developing recommendations for a formalized governance structure, funding and sustainability plans for the Center and for any legislation needed to support the work of the Center. Four work groups were also created.

Phase 2 (October 2008 through June 2009) involves hiring a director and establishing the permanent governance structure for the Center; appointing a high-level, formal steering committee of business and community leaders; carrying out specific "foundation projects" designed to improve care quality, coordination and efficiency; and securing long-term funding.

The framework the Center will use to organize its work is taken from the report, "It Takes a Region: Creating a Framework to Improve Chronic Disease Care."[6] The report discusses how to build an effective collaboration to improve health care and reduce costs. It also presents a "Framework for Creating a Regional Health Care System." The model identifies four essential strategies: sharing data to measure performance, engaging customers, supporting delivery system improvement, and aligning benefits and finances. The work groups that were created in Phase 1 were built around these four elements. They include the Data Sharing for Performance Measurement Work Group, Consumer Engagement Work Group, Improving Health Care Delivery Work Group and Aligning Benefits and Finances Work Group. During Phase 2, the work groups will develop and ensure the implementation of specific strategies for quality performance measurement, consumer engagement, delivery system improvement and alignment of benefits and finances to improve health care quality.

[6] Ed Wagner, Brian Austin, and Catherine Coleman, "It Takes a Region: Creating a Framework to Improve Chronic Disease Care" (Oakland, Ca: California Health Care Foundation, November 2006), http://www.chcf.org/documents/chronicdisease/CreatingAFrameworkToImproveChronicDiseaseCare.pdf

Department Involvement in CIVHC

The Executive Order directs the Department to collaborate with the Governor's Office of Policy Initiatives to provide the blueprint for CIVHC, and outlines its initial tasks. These tasks include:

- convening a health care quality steering committee of relevant state departments, health care stakeholder organizations and individuals;
- establishing priorities, developing strategies, coordinating existing efforts and implementing strategies to improve health care quality and manage the growth of health care costs;
- researching quality forums or councils in other states, including best practices on governance structure, funding, roles and responsibilities and engagement of the private sector; and
- identifying strategies for tying quality measurement to rate setting methodologies and payment structures for providers in public insurance programs. This includes researching general trends in the private sector that relate to quality improvement and cost management.

A senior executive service position is needed to direct CIVHC and lead efforts to fulfill its goals and objectives consistent with recommendations of the steering committee. Research by JSI Research & Training Institute (JSI) in a draft white paper dated July 7, 2008 on the state of Colorado's health quality and cost councils reports:

> *[T]he system transformation needed to significantly impact quality and cost at a community and statewide level requires a vision and strategy that unites payers and providers across the health care system. … By adopting a new structure and leadership to provide direction and coordination, Colorado will be able to integrate and expand existing health care quality and cost initiatives…that could not be accomplished with the existing state structure.*

Preliminary research from JSI also suggests avoiding the creation of a large new structure, but rather to act as an entity that coordinates and leverages existing resources.

The Blue Ribbon Commission for Health Care Reform recommended the following roles for CIVHC:

Become a rule-making authority by:

- reducing administrative costs through administrative streamlining and review of regulatory requirements;
- ensuring that the information on insurers, provider price and provider quality is available to all Coloradans; and
- designing the minimum benefit package and consumer advocacy program.

Become an advisory authority by:

- increasing the use of prevention and chronic care management;
- paying providers based on quality;
- supporting the provision of evidence-based medicine;
- improving end-of-life care;
- providing a medical home for all Coloradans;
- supporting the adoption of health information technology;
- overseeing development of a statewide system for aggregating data from all payer plans, public and private; and
- assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety-net providers.

In order for CIVHC to drive health care systems changes, its board of directors needs to include chief executive officers of health corporations and its director needs to be an influential leader with executive authority. Other states with quality institutes or centers typically hire doctors of medicine to serve as director. The requested senior executive service position would be responsible for coordinating quality improvement efforts at the Department with those of other organizations in Colorado, including the Business Group on Health, Colorado Medical Society, Centers for Medicare and Medicaid Services, and the Clinical Guidelines Collaborative. The requested position is needed to help provide

statewide leadership on health care quality reform, leverage and consolidate existing efforts and resources, and strengthen public and private partnerships for improving value in health care.

The Department has received a grant from the Caring for Colorado Foundation to hire a director for CIVHC through the end of FY 2008-09. The Department anticipates that the director will continue with the project for the foreseeable future, and therefore would join the Department on a full-time basis effective July 1, 2009.

Consequences if Not Funded:

If this request is not funded, the Department will not be able to ensure that every Medicaid client has access to a coordinated delivery system. The Department would continue to utilize existing methods to attempt to coordinate care, but it is unlikely that significant improvement in quality or any cost savings will be achieved under current practices. The significant savings that have been proven to be the result of coordinated care delivery systems will not be achieved.

The continuing absence of a care coordination system limits the Department's ability to succeed in its mission. The Department is committed to ensuring that clients remain empowered to make good health care choices incorporating prevention and early intervention, and that the services purchased by the Department achieve value for the clients and the public. The Department recognizes the varying needs of different populations served within Medicaid, and cannot address these needs with the current system that is in place.

The Department has the responsibility to focus on cost, quality, and access to health care, and to take a realistic, building-block approach to making progress toward covering more of the uninsured. As the Department finds efficiencies in the system, cuts waste and brings more transparency to the system, it can reinvest those savings toward coverage and access. The Department views each of the steps outlined in this Change Request as critical in order to prepare for broader health care reform in the state of Colorado. Under the current structure for eligibility and the provision of services, the Department will not be able to keep pace with large shifts in enrollment and the expansion of benefits. Failure to fund analysis and infrastructure is likely to result in a destabilized system environment

that will significantly reduce the Department's ability to meet its state and federal obligations for health care programs. The administrative and systems barriers to enrollment must be addressed before the Department can expand coverage for children and families; to increase eligibility but then continue to make it difficult for families to receive comprehensive coordinated care is counter-productive.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	FTE	General Fund	Cash Funds	Federal Funds
Total Request	**$2,397,709**	**1.8**	**$899,050**	**$8,954**	**$1,489,705**
(1) Executive Director's Office; (A) General Administration, Personal Services	$201,440	1.8	$100,720	$0	$100,720
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$17,584	0.0	$8,792	$0	$8,792
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$125,000	0.0	$62,500	$0	$62,500
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$1,058,400	0.0	$264,600	$0	$793,800
(1) Executive Director's Office; (D) Eligibility Determination and Client Services, Customer Outreach	$354,092	0.0	$177,046	$0	$177,046
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$105,000	0.0	$26,250	$0	$78,750
(2) Medical Services Premiums	$536,193	0.0	$259,142	$8,954	$268,097

Summary of Request FY 2010-11	Total Funds	FTE	General Fund	Cash Funds	Federal Funds
Total Request	**($4,362,254)**	**3.0**	**($2,267,022)**	**($65,300)**	**($2,029,932)**
(1) Executive Director's Office; (A) General Administration, Personal Services	$327,409	3.0	$163,704	$0	$163,705
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$2,850	0.0	$1,425	$0	$1,425
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$125,000	0.0	$62,500	$0	$62,500
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$0	0.0	$0	$0	$0
(1) Executive Director's Office; (D) Eligibility Determination and Client Services, Customer Outreach	$567,170	0.0	$283,585	$0	$283,585
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$604,780	0.0	$151,195	$0	$453,585
(2) Medical Services Premiums	($5,989,463)	0.0	($2,929,431)	($65,300)	($2,994,732)

Cash Funds Projections:

Cash Fund Name	Cash Fund Number	FY 2007-08 Expenditures	FY 2007-08 End of Year Cash Balance	FY 2008-09 End of Year Cash Balance Estimate *	FY 2009-10 End of Year Cash Balance Estimate *	FY 2010-11 End of Year Cash Balance Estimate *
Health Care Expansion Fund	18K	$76,441,702	$135,721,617	$111,499,132	$72,449,213	$32,395,800

* Cash Balance Estimates do not incorporate the impact of any Change Requests.

Assumptions for Calculations:

Where applicable, assumptions are noted in the relevant locations in each table in the relevant appendix, and in the narrative above. The Department has estimated projected expenditure and utilization based on historical information and assumptions about future increases in caseload. Additionally, as the Department receives actual bids from contractors through the request for proposals process, the Department may require more or less funding to implement the specified programs. As actual experience with new programs is obtained, the Department would use the standard budget process to request adjustments to funding as appropriate. Tables 1, 2.1, 2,2, and 2.3 summarize the request by area, and by line item.

- Tables 3.1 through 6.1 calculate the cost of the monthly administration fee and the associated savings of the coordinated care model.
- Tables 7.1 and 7.2 calculate the impact to the Enrollment Broker.
- Tables 8.1 through 8.4 calculate impacts to the MMIS, ombudsman, and external quality review organization.
- Table 9 calculates costs associated with the FTE portion of this request.
- Tables 10.1 and 10.2 calculate the impact to prepaid inpatient health plans and the Colorado Regional Integrated Care Collaborative (CRICC).

Impact on Other Government Agencies:

None.

Cost Benefit Analysis:

Although administrative costs outweigh savings in FY 2009-10, this initiative is expected to generate $5,989,463 total funds program cost savings in FY 2010-11 against $1,627,209 in administrative costs. Because of the significant cost savings expected as a

result of implementing this program, the Department believes that the benefits in terms of improved quality of care and cost savings due to more efficient utilization patterns outweigh the required investment in administrative costs.

Implementation Schedule:

Task	**Month/Year**
Internal Research/Planning Period	January 2008 - March 2009
RFP Written	April 2009
RFP Issued	July 2009
System Modifications Made	July 2009 - March 2010
Contract Managers Hired	January 2010
RFP Awarded	January 2010
Contract or MOU Written	February 2010
Passive Enrollment Begins	March 2010
First Clients Enrolled	April 2010

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2008). Program of medical assistance - single state agency.
(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

25.5-5-101, C.R.S. (2008). Mandatory provisions - eligible groups - repeal.
(1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for

medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203.

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 maintaining an adequate provider network through fair and competitive rates will increase overall access to health care, thereby increasing customer satisfaction and quality of health outcomes.

Table 1
Summary of Expenditure by Function

Row	Line Item	FY 2009-10	FY 2010-11	Source
	(1) Executive Director's Office			
A	Personal Services	$196,040	$283,009	Table 9
B	Operating Expenses	$17,584	$2,850	Table 9
C	Ombudsman	$5,400	$44,400	Table 8.1
D	Actuarial Services	$125,000	$125,000	See Narrative
E	Medicaid Management Information System	$1,058,400	$0	Table 8.1
F	Enrollment Broker	$354,092	$567,170	Table 7.1
G	External Quality Review Organization	$105,000	$604,780	Table 8.1
H	*Subtotal Executive Director's Office*	*$1,861,516*	*$1,627,209*	
	(2) Medical Services Premiums			
I	PCCM Monthly Management Fees	$1,729,080	$14,296,260	Table 4.1
J	Increase to PIHP Administration	$433,137	$433,137	Table 10.1
K	CRICC Monthly Management Fees	$360,000	$360,000	Table 10.2
L	Savings	($1,986,024)	($21,078,860)	Table 5.1
M	*Subtotal Medical Services Premiums*	*$536,193*	*($5,989,463)*	
N	**Grand Total**	**$2,397,709**	**($4,362,254)**	

Table 2.1
FY 2009-10 Fund Splits

Line Item	Area	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP Rate
(1) Executive Director's Office							
(A) General Administration Personal Services	Personal Services, Ombudsman	$201,440	1.8	$100,720	$0	$100,720	50%
(A) General Administration Operating Expenses	Operating Expenses	$17,584	0.0	$8,792	$0	$8,792	50%
(A) General Administration General Professional Services and Special Projects	Actuarial Services	$125,000	0.0	$62,500	$0	$62,500	50%
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$1,058,400	0.0	$264,600	$0	$793,800	75%
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$354,092	0.0	$177,046	$0	$177,046	50%
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Organization	$105,000	0.0	$26,250	$0	$78,750	75%
(2) Medical Services Premiums	Services	$536,193	0.0	$259,142	$8,954	$268,097	50%
Grand Total		**$2,397,709**	**1.8**	**$899,050**	**$8,954**	**$1,489,705**	
Cash Funds: Health Care Expansion Fund							

Table 2.2
FY 2010-11 Fund Splits

Line Item	Area	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP Rate
(1) Executive Director's Office							
(A) General Administration Personal Services	Personal Services, Ombudsman	$327,409	3.0	$163,704	$0	$163,705	50%
(A) General Administration Operating Expenses	Operating Expenses	$2,850	0.0	$1,425	$0	$1,425	50%
(A) General Administration General Professional Services and Special Projects	Actuarial Services	$125,000	0.0	$62,500	$0	$62,500	50%
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$0	0.0	$0	$0	$0	75%
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$567,170	0.0	$283,585	$0	$283,585	50%
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Organization	$604,780	0.0	$151,195	$0	$453,585	75%
(2) Medical Services Premiums	Services	($5,989,463)	0.0	($2,929,431)	($65,300)	($2,994,732)	50%
Grand Total		**($4,362,254)**	**3.0**	**($2,267,022)**	**($65,300)**	**($2,029,932)**	
Cash Funds: Health Care Expansion Fund							

Table 3.1
Monthly Program Enrollment

	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	TOTAL
Estimated FY 2009-10 Caseload	37,478	6,330	51,057	46,444	13,260	303	233,082	18,682	7,566	414,202
Fraction of Total	9.05%	1.53%	12.33%	11.21%	3.20%	0.07%	56.27%	4.51%	1.83%	100.00%
Estimated Monthly Attrition	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Monthly Program Enrollment										
April 2010	1,354	230	1,850	1,682	480	11	8,441	677	275	15,000
May 2010	2,634	445	3,588	3,262	931	20	16,375	1,312	533	29,100
June 2010	3,833	648	5,222	4,748	1,355	30	23,833	1,910	775	42,354
July 2010	4,961	839	6,758	6,145	1,754	38	30,843	2,472	1,003	54,813
August 2010	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
September 2010	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
October 2010	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
November 2010	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
December 2010	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
January 2011	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
February 2011	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
March 2011	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
April 2011	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
May 2011	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000
June 2011	5,430	918	7,398	6,726	1,920	42	33,762	2,706	1,098	60,000

Table 4.1
Monthly Administration Cost

	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Total
Estimated Per Member Per Month Administration	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	$20.00	
Estimated Monthly Administration Cost										
April 2010	$27,080	$4,600	$37,000	$33,640	$9,600	$220	$168,820	$13,540	$5,500	$300,000
May 2010	$52,680	$8,900	$71,760	$65,240	$18,620	$400	$327,500	$26,240	$10,660	$582,000
June 2010	$76,660	$12,960	$104,440	$94,960	$27,100	$600	$476,660	$38,200	$15,500	$847,080
July 2010	$99,220	$16,780	$135,160	$122,900	$35,080	$760	$616,860	$49,440	$20,060	$1,096,260
August 2010	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
September 2010	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
October 2010	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
November 2010	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
December 2010	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
January 2011	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
February 2011	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
March 2011	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
April 2011	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
May 2011	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000
June 2011	$108,600	$18,360	$147,960	$134,520	$38,400	$840	$675,240	$54,120	$21,960	$1,200,000

Table 5.1
Per Capita Savings

Estimated Per Capita Savings	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	TOTAL
Estimated FY 2009-10 Per Capita Cost	$2,610.31	$8,474.36	$9,260.48	$4,406.56	$2,470.14	$27,199.71	$1,836.30	$3,828.10	$7,643.78	-
Estimated Savings Percent	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	-
Estimated FY 2009-10 Monthly Reduction to Expenditure	($17.40)	($56.50)	($61.74)	($29.38)	($16.47)	($181.33)	($12.24)	($25.52)	($50.96)	-
Estimated FY 2010-11 Per Capita Cost	$2,667.94	$8,619.11	$9,500.42	$4,543.28	$2,648.95	$28,216.41	$1,860.56	$4,151.11	$7,975.60	-
Estimated Savings Percent	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	-
Estimated FY 2010-11 Monthly Reduction to Expenditure	($22.23)	($71.83)	($79.17)	($37.86)	($22.07)	($235.14)	($15.50)	($34.59)	($66.46)	-

Table 5.2
Estimated Monthly Program Savings

Estimated Monthly Program Savings	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	TOTAL
April 2010	($23,562)	($12,994)	($114,213)	($49,412)	($7,904)	($1,995)	($103,335)	($17,277)	($14,014)	($344,706)
May 2010	($45,837)	($25,141)	($221,511)	($95,828)	($15,331)	($3,627)	($200,463)	($33,483)	($27,161)	($668,382)
June 2010	($66,702)	($36,609)	($322,388)	($139,482)	($22,314)	($5,440)	($291,764)	($48,744)	($39,493)	($972,936)
July 2010	($110,297)	($60,262)	($535,032)	($232,654)	($38,719)	($8,935)	($478,210)	($85,513)	($66,663)	($1,616,285)
August 2010	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
September 2010	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
October 2010	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
November 2010	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
December 2010	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
January 2011	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
February 2011	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
March 2011	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
April 2011	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
May 2011	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)
June 2011	($120,724)	($65,936)	($585,701)	($254,651)	($42,383)	($9,876)	($523,469)	($93,608)	($72,977)	($1,769,325)

Table 6.1
Net Costs (Savings)

Net Costs (Savings)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	TOTAL
April 2010	$3,518	($8,394)	($77,213)	($15,772)	$1,696	($1,775)	$65,485	($3,737)	($8,514)	($44,706)
May 2010	$6,843	($16,241)	($149,751)	($30,588)	$3,289	($3,227)	$127,037	($7,243)	($16,501)	($86,382)
June 2010	$9,958	($23,649)	($217,948)	($44,522)	$4,786	($4,840)	$184,896	($10,544)	($23,993)	($125,856)
July 2010	($11,077)	($43,482)	($399,872)	($109,754)	($3,639)	($8,175)	$138,650	($36,073)	($46,603)	($520,025)
August 2010	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
September 2010	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
October 2010	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
November 2010	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
December 2010	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
January 2011	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
February 2011	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
March 2011	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
April 2011	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
May 2011	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)
June 2011	($12,124)	($47,576)	($437,741)	($120,131)	($3,983)	($9,036)	$151,771	($39,488)	($51,017)	($569,325)

Table 7.1
Summary of Enrollment Broker Costs

Row	Summary	FY 2009-10	FY 2010-11	Source
A	Passive Enrollment Packet	$180,000	$237,904	Table 2, Row D
B	Quality Report Card Mailing	$10,801	$61,200	Table 2, Row G
C	Maximus Customer Service Staff	$16,625	$137,000	Table 2, Row O
D	Adding Current Passive Enrollment Activities to Enrollment Broker	$146,666	$146,666	Table 2, Row W
E	Cessation of PCPP Handbook	$0	($15,600)	Based on current cost
F	**Total Increase to Enrollment Broker**	**$354,092**	**$567,170**	

Table 7.2
Itemized Enrollment Broker Costs

Row	Passive Enrollment Packet	FY 2009-10	FY 2010-11	Source
A	Enrolled Clients Per Month	15,000	4,956	Assumed, based on capped enrollment.
B	Cost Per Enrollment Packet	$4.00	$4.00	Based on current cost
C	Months in Operation	3	12	Assumed
D	**Total Cost**	**$180,000**	**$237,904**	Row A * Row B * Row C
Row	**Quality Report Card Mailing**	**FY 2009-10**	**FY 2010-11**	**Source**
E	Total Enrolled Clients (Eligible for Mailing)	10,589	60,000	Table 3.1 (Total enrollment)(1)
F	Cost Per Quality Report Card Mailing	$1.02	$1.02	Based on current cost
G	**Total Cost**	**$10,801**	**$61,200**	Row E * Row F
Row	**Enrollment Broker Customer Service Staff**	**FY 2009-10**	**FY 2010-11**	**Source**
H	Average Monthly Enrollment	28,818	59,568	Table 3.1 (Annual average)
I	Number of Calls Per Enrolled Client	0.58	0.58	Based on current contract data
J	Estimated Number of Customer Service Calls	16,714	34,549	Row H * Row I
K	Number of Calls Per FTE	12,600	12,600	Based on current contract data
L	Estimated Number of Required FTE	1.33	2.74	Row J / Row K
M	Cost Per Customer Service Representative FTE	$50,000	$50,000	Based on estimates from current contractor.
N	Percentage of Year in Operation	25%	100%	Assumed
O	**Total Cost**	**$16,625**	**$137,000**	Row L * Row M * Row N
Row	**Adding Current Passive Enrollment Activities to Enrollment Broker**	**FY 2009-10**	**FY 2010-11**	**Source**
P	Number of Passive Enrollment Packets Funded by Current Managed Care Plans	26,000	26,000	Based on current enrollment.
Q	Base Cost Per Packet	$5.13	$5.13	Based on current contract data
R	Base Cost of Mailing	$133,380	$133,380	Row P * Row Q
S	Percent of Population Receiving EPSDT Material	70%	70%	Based on current contract data
T	Population Receiving EPSDT Material	18,200	18,200	Row P * Row S
U	Incremental Cost of EPSDT Mailing	$0.73	$0.73	Based on current contract data
V	Additional Cost for EPSDT Mailings	$13,286	$13,286	Row T * Row U
W	**Total Cost**	**$146,666**	**$146,666**	Row R + Row V
(1)	Because quality report cards are send on the client's birthday, in FY 2009-10, only 25% of enrolled clients will receive a report card.			

Table 8.1
Other Administration Costs

Row	Summary	FY 2009-10	FY 2010-11	Source
A	Medicaid Management Information System	$1,058,400	$0	Table 8.2, Row D
B	Ombudsman	$5,400	$44,400	Table 8.3, Row F
C	External Quality Review Organization	$105,000	$604,780	Table 8.4, Row H
D	**Total Other Administration**	**$1,168,800**	**$649,180**	

Table 8.2
Medicaid Management Information System

Row	Item	FY 2009-10	FY 2010-11	Source
A	Information Sharing Capabilities	$302,400	$0	Development hours: 2,400
B	Passive Enrollment System Enhancements	$504,000	$0	Development hours: 4,000
C	Managed Care System Enhancements	$252,000	$0	Development hours: 2,000
D	**Total Cost**	**$1,058,400**	**$0**	

Note: Development costs assume $126 per hour.

Table 8.3
Ombudsman

Row	Item	FY 2009-10	FY 2010-11	Source
A	Client-load per Ombudsman	80,000	80,000	Based on current contract data
B	Average Monthly Caseload	28,818	59,568	Table 3.1 (Annual average)
C	Required Ombudsman FTE	0.36	0.74	Row B / Row A
D	Cost per Ombudsman	$60,000	$60,000	Based on current contract data
E	Percentage of Year in Operation	25%	100%	Assumed
F	**Total Cost**	**$5,400**	**$44,400**	Row C * Row D * Row E

Table 8.4
External Quality Review Organization

Row	Item	FY 2009-10	FY 2010-11	Source
A	Encounter Data Validation Audits (for MCOs)	$0	$54,820	Per site, Based on current contract data
B	Number of MCOs	4	4	Assumed
C	*Subtotal EQRO Costs Related to MCOs*	*$0*	*$219,280*	*Row A * Row B*
D	HEDIS Audit and Calculation	$0	$12,400	Per site, Based on current contract data
E	Site Review	$21,000	$21,000	Per site, Based on current contract data
F	Number of PCCMs	5	5	Assumed
G	*Subtotal EQRO Costs Related to PCCMs*	*$105,000*	*$167,000*	*(Row D + Row E) * Row F*
H	Program Evaluation	$0	$250,000	Assumed, see narrative.
I	End of PCP Functions	$0	($31,500)	Based on current contract data.
J	**Total Cost**	**$105,000**	**$604,780**	Row C + Row G + Row H + Row I

Table 9
FTE Request for Coordinated Care Initiative
OSPB Common Policy for FTE Requests

FTE and Operating Costs						***GRAND TOTAL***	
Fiscal Year(s) of Request		**FY 2009-10**	**FY 2010-11**	**FY 2009-10**	**FY 2010-11**	**FY 2009-10**	**FY 2010-11**
PERSONAL SERVICES	**Title:**	**General Professional IV**		**Management/Senior Executive Service (CIVHC Director)**			
Number of PERSONS / class title		2	2	1	1		
Number of months working in FY 08-09, FY 09-10 and FY 10-11		6	12	12	12		
Number months paid in FY 08-09, FY 09-10 and FY 10-11[1]		5	12	11	12		
Calculated FTE per classification		**0.8**	**2.0**	**0.9**	**1.0**	1.8	3.0
Annual base salary		$56,796	$56,796	$140,000	$140,000		
Salary		$47,330	$113,592	$128,333	$140,000	$175,663	$253,592
PERA	**10.15%**	$4,804	$11,530	$13,026	$14,210	$17,830	$25,740
Medicare	**1.45%**	$686	$1,647	$1,861	$2,030	$2,547	$3,677
Subtotal Personal Services at Division Level		**$52,820**	**$126,769**	**$143,220**	**$156,240**	**$196,040**	**$283,009**
OPERATING EXPENSES							
Supplies @ $500/$500[2]	**$500**	$500	$1,000	$500	$500	$1,000	$1,500
Computer @ $900/$0	**$900**	$1,800	$0	$900	$0	$2,700	$0
Office Suite Software @ $330/$0	**$330**	$660	$0	$330	$0	$990	$0
Office Equipment @ $3,998/$0 (includes cubicle and chair)	**$3,998**	$7,996	$0	$3,998	$0	$11,994	$0
Telephone Base @ $450/$450[2]	**$450**	$450	$900	$450	$450	$900	$1,350
Subtotal Operating Expenses		**$11,406**	**$1,900**	**$6,178**	**$950**	**$17,584**	**$2,850**
GRAND TOTAL ALL COSTS		**$64,226**	**$128,669**	**$149,398**	**$157,190**	**$213,624**	**$285,859**

1 - Initial year full salary is 11 months to account for Pay Date Shift if General Fund employee.

2 - The $450 for Telephone Base and $500 for Supplies will carry over each year as an acceptable expense. Items are prorated for partial FTE.

Table 10.1
Estimated Increase to PIHP Administration

Row	Item	FY 2009-10	FY 2010-11	Source
A	Estimated Annual PIHP Administration Expenditure	$3,609,472	$3,609,472	Based on FY 2007-08 Expenditure; No change in caseload is assumed.
B	Increase in Administration Fee	12.00%	12.00%	Increase from $25 to $28
C	**Estimated Increase in Expenditure**	**$433,137**	**$433,137**	Row A * (1 + Row B)

Table 10.2
CRICC Study Administration Costs

Row	Item	FY 2009-10	FY 2010-11	Source
A	Estimated Enrolled Clients	1,500	1,500	Based on current enrollment with anticipated growth.
B	Monthly Administration Fee	$20.00	$20.00	Assumed; pilot ends after two years.
C	Number of Months Enrolled	12	12	Assumed; see narrative.
D	**Estimated Incentive Payment**	**$360,000**	**$360,000**	