Schedule 10
Summary of FY 2010-11 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 4, 2010
Number of Decision Items: 6
Number of Base Reduction Items: 7
Number of Non Prioritized Items: 11

Total Impact					**$16,511,744**	**(24.10)**	**($192,388,415)**	**($5,229)**	**($29,677,547)**	**$9,215,859**	**$229,367,076**
Schedule 10 Priority	**Nov. 6, 2009 Priority**	**Jan. 4, 2010 Priority**	**Title**	**IT Request**	**Total Request (FY 2010-11)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Decision Items											
1	DI-1	N/A	Request for Medical Services Premiums	No	$207,323,569	0.00	$134,715,479	$0	($29,498,967)	$390,381	$101,716,676
2	DI-2	N/A	Medicaid Mental Health Community Programs	No	$21,381,804	0.00	$10,807,345	$0	($75,390)	$4,338	$10,645,511
3	DI-3	N/A	Children's Basic Health Plan Medical Premium and Dental Benefit Costs	No	$27,066,326	0.00	$9,435,683	$0	($3,287,635)	$9,435,683	$11,482,595
4	DI-4	N/A	Medicare Modernization Act State Contribution Payment	No	$1,727,607	0.00	$1,727,607	$0	$0	$0	$0
5	DI-5	N/A	Medicaid Management Information System Cost Adjustment	Yes	$269,528	0.00	$65,361	$0	$2,830	$0	$201,337
6	DI-6	N/A	Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures	No	$100,000	0.00	$50,000	$0	$0	$0	$50,000
7	N/A	BA-5	Accountable Care Collaborative	No	($584,580)	0.00	($328,177)	$0	$15,448	$0	($271,851)
8	N/A	BA-6	Federally Mandated CHP+ Program Changes	No	$236,150	0.00	$74,679	$0	$46,661	$135	$114,675
9	N/A	BA-7	Public School Health Services Administrative Claiming	No	$4,087,324	0.00	$0	$0	$2,043,662	$0	$2,043,662
10	N/A	BA-8	Acute Care Utilization Review Adjustments	No	$149,560	0.00	$19,419	$0	$0	$0	$130,141
11	N/A	BA-9	Refinance Colorado Benefit Management System Improvements	No	($1,749,976)	0.00	($814,545)	$0	$0	$5,515	($940,946)
FY 2010-11 Decision Items					**$260,007,312**	**0.00**	**$155,752,851**	**$0**	**($30,753,391)**	**$9,836,052**	**$125,171,800**
FY 2010-11 Base Reduction Items											
1	BRI-1	N/A	Prevention and Benefits for Enhanced Value (P-BEV)	No	$118,359	0.00	($11,201)	$0	($1,672)	$0	$131,232
2	BRI-2	N/A	Coordinated Payment and Payment Reform	No	($2,532,684)	0.90	($454,577)	$0	($219,260)	$0	($1,858,847)
3	BRI-3	N/A	Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology	No	($960,682)	0.00	($443,253)	$0	$0	$0	($517,429)
4	BRI-4	N/A	Medicaid Program Efficiencies	No	($10,097,162)	0.00	($4,463,448)	$0	$0	$0	($5,633,714)
5	BRI-5	N/A	Medicaid Payment Timing	No	($188,101,520)	0.00	($93,822,636)	$0	($5,227,680)	($77,508)	($88,973,696)
6	BRI-6	N/A	Medicaid Program Reductions	No	($35,234,040)	0.00	($27,963,869)	$0	$11,350,706	($214)	($18,620,663)
7	BRI-7	N/A	This priority has been intentionally left blank.	No	$0	0.00	$0	$0	$0	$0	$0

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Summary of FY 2010-11 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 4, 2010
Number of Decision Items: 6
Number of Base Reduction Items: 7
Number of Non Prioritized Items: 11

Total Impact					**$16,511,744**	**(24.10)**	**($192,388,415)**	**($5,229)**	**($29,677,547)**	**$9,215,859**	**$229,367,076**
Schedule 10 Priority	**Nov. 6, 2009 Priority**	**Jan. 4, 2010 Priority**	**Title**	**IT Request**	**Total Request (FY 2010-11)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
8	BRI-8	N/A	Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage	No	$0	0.00	($192,394,435)	($5,229)	($30,506,863)	($440,258)	$223,346,785
FY 2010-11 Base Reduction Items					**($236,807,729)**	**0.90**	**($319,553,419)**	**($5,229)**	**($24,604,769)**	**($517,980)**	**$107,873,668**
FY 2010-11 Non-Prioritized Decision Items											
1	NP-1	N/A	DHS - CBMS Client Correspondence Costs	No	$463,422	0.00	$229,803	$0	$948	$1,108	$231,563
2	NP-2	N/A	Statewide Information Technology Staff Consolidation	No	($196,172)	(25.00)	($46,405)	$0	$0	($103,363)	($46,404)
3	NP-3	N/A	DHS - Enforcing Sponsorship Commitment for Applicants and Recipients of Adult Financial Programs	No	($248,510)	0.00	($124,325)	$0	$35	$41	($124,261)
4	NP-4	N/A	DPHE - Amendment 35 Funding Reduction	No	$0	0.00	($25,691,418)	$0	$25,691,418	$0	$0
5	NP-5	N/A	DHS - Annual Fleet Vehicle Replacement	No	$16,275	0.00	$8,138	$0	$0	$0	$8,137
6	NP-6	N/A	DHS - Two Percent (2%) Community Provider Rate Base Decrease	No	($6,545,135)	0.00	($2,881,495)	$0	($11,789)	$0	($3,651,851)
7	NP-7	N/A	DHS - Statewide Information Technology Staff Consolidation	No	($163,341)	0.00	($77,387)	$0	$1	$1	($85,956)
8	NP-8	N/A	DPHE - Statewide Information Technology Staff Consolidation	No	($14,378)	0.00	($4,758)	$0	$0	$0	($9,620)
9	N/A	NP-BA1	This priority has been intentionally left blank.	No	$0	0.00	$0	$0	$0	$0	$0
10	N/A	NP-BA6	Mail Equipment Upgrade Supplemental and Budget Amendment	No	$308	0.00	$154	$0	$0	$0	$154
11	N/A	NP-BA7	DHS - Annual Fleet Vehicle Replacements Technical True-up	No	$1,855	0.00	$928	$0	$0	$0	$927
12	N/A	NP-BA8	DHS - Mail Equipment Upgrade Supplemental and Budget Amendment	No	$29,668	0.00	$14,714	$0	$60	$70	$14,824
FY 2010-11 Non-Prioritized Decision Items					**($6,687,839)**	**(25.00)**	**($28,587,847)**	**$0**	**$25,680,613**	**($102,213)**	**($3,678,392)**

Schedule 11

Summary of Supplemental Requests for FY 2009-10

Department Name: Health Care Policy and Financing
Submission Date: January 4, 2010
Number of Prioritized Supplemental Requests: 18

Priority #	Page #	Title	IT Request	Total Request (FY 2009-10)	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2009-10 Prioritized Supplemental Requests										
ES-1	ES-1.1	Enhanced Federal Funding Adjustments	No	$0	0.00	($52,469,404)	$0	($1,735,344)	($48,186)	$54,252,934
ES-2	ES-2.1	Medicaid Program Reductions	No	($38,590,574)	0.00	($17,020,348)	$0	$532,225	($7,002)	($22,095,449)
ES-3	ES-3.1	Department Administrative Reductions	No	($1,166,768)	0.00	($2,151,651)	$0	$1,736,356	$0	($751,473)
ES-4	ES-4.1	Reduce Funding for Indigent Care Programs	No	($62,205,816)	0.20	($21,539,689)	$13,827	($152,540)	($11,956,827)	($28,570,587)
ES-5	ES-5.1	Reduce Appropriation for Enhanced Federal Funds	No	$0	0.00	($341,995,112)	$0	($59,307,369)	($833,989)	$402,136,470
ES-6	ES-6.1	Medicaid Provider Rate Reduction	No	($8,332,713)	0.00	($3,070,402)	$0	($147,883)	$0	($5,114,428)
ES-7	ES-7.1	Medicaid Payment Timing	No	($44,704,341)	0.00	($16,284,757)	$0	($897,552)	($20,388)	($27,501,644)
S-1	S.1-1	Request for Medical Services Premiums (Placeholder from November 6, 2009 Request)	No	$86,404,006	0.00	$28,042,522	$0	$10,414,246	$219,526	$47,727,712
S-2	S.2-1	Medicaid Mental Health Community Programs (Placeholder from November 6, 2009 Request)	No	$4,051,231	0.00	$2,297,944	$0	($733,568)	$1,377	$2,485,478
S-3	S.3-1	Children's Basic Health Plan Medical Premium and Dental Benefit Costs (Placeholder for February 15, 2010 Request)	No	$33,008,119	0.00	$0	$0	$11,618,040	$0	$21,390,079
S-4	S.4-1	Medicare Modernization Act State Contribution Payment (Placeholder from November 6, 2009 Request)	No	($1,987,584)	0.00	($1,987,584)	$0	$0	$0	$0
S-5	S.5-1	FY 2008-09 Personal Services Over-expenditure	No	$557,788	0.00	$147,605	$0	$0	$0	$410,183
S-6	S.6-1	Accountable Care Collaborative	No	($677,636)	0.00	($200,659)	$0	$0	$0	($476,977)
S-7	S.7-1	Federally Mandated CHP+ Program Changes	No	$113,527	0.00	$0	$0	$39,734	$0	$73,793
S-8	S.8-1	This priority has been intentionally left blank.	No	$0	0.00	$0	$0	$0	$0	$0
S-9	S.9-1	Public School Health Services Administrative Claiming	No	$529,968	0.00	$0	$0	$264,984	$0	$264,984
S-10	S.10-1	Acute Care Utilization Review Adjustments	No	$85,400	0.00	$3,379	$0	$0	$0	$82,021
S-11	S.11-1	Refinance Colorado Benefit Management System Improvements	No	($1,749,976)	0.00	($814,545)	$0	$0	$5,515	($940,946)
S-12	S.12-1	This priority has been intentionally left blank.	No	$0	0.00	$0	$0	$0	$0	$0

Schedule 11
Summary of Supplemental Requests for FY 2009-10

Department Name: Health Care Policy and Financing
Submission Date: January 4, 2010
Number of Prioritized Supplemental Requests: 18

Priority #	Page #	Title	IT Request	Total Request (FY 2009-10)	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
S-13	S.13-1	CBMS Client Correspondence Caseload Increase	No	$184,275	0.00	$91,568	$0	$0	$816	$91,891
FY 2009-10 Supplemental Request Subtotal				**($34,481,094)**	**0.20**	**($426,951,133)**	**$13,827**	**($38,368,671)**	**($12,639,158)**	**$443,464,041**
FY 2009-10 Non-Prioritized Supplemental Requests										
NP-ES1	NP-ES.1-1	DHS - Information Technology Services - Personal Services FTE Reduction	No	($18,000)	0.00	($9,000)	$0	$0	$0	($9,000)
NP-ES2	NP-ES.2-1	OIT - Personal Services Reduction Initiative	No	($5,940)	0.00	($2,970)	$0	$0	$0	($2,970)
NP-ES3	NP-ES.3-1	DHS - Increase State Capacity to 120% at State Commitment Facilities	No	($166,246)	0.00	($63,855)	$0	$0	$0	($102,391)
NP-ES4	NP-ES.4-1	DHS - Office of Operations Personal Services and Operating Reduction	No	($39,922)	0.00	($19,960)	$0	$0	$0	($19,962)
NP-ES5	NP-ES.5-1	DHS - Close 59 beds at the Colorado Mental Health Institute at Fort Logan	No	$524,863	0.00	$201,601	$0	$0	$0	$323,262
NP-ES6	NP-ES.6-1	DHS - Reclassification of Licensing Category of Ridgeview Youth Services Center for Medicaid Billing	No	$412,083	0.00	$158,282	$0	$0	$0	$253,801
NP-ES7	NP-ES.7-1	DHS - DDD Medicaid Waivers Provider Rate Retraction	No	($5,888,663)	0.00	($2,253,482)	$0	($8,353)	$0	($3,626,828)
NP-ES8	NP-ES.8-1	DHS -Closure of 32 bed Nursing Facility at Grand Junction Regional Center	No	($1,922,142)	0.00	($703,448)	$0	$24,435	($116,380)	($1,126,749)
NP-ES9	NP-ES.9-1	DHS - Reduction to the Child Welfare Services Block	No	($4,238,722)	0.00	($1,628,093)	$0	$0	$0	($2,610,629)
NP-ES10	NP-ES.10-1	Risk Management Contract Review and Reduction	No	($515)	0.00	($258)	$0	$0	$0	($257)
NP-ES11	NP-ES.11-1	Risk Management Reduction of Liability, Property and Workers' Compensation Volatility	No	($6,207)	0.00	($3,103)	$0	$0	$0	($3,104)
NP-ES12	NP-ES.12-1	Building Maintenance Reductions	No	($5,408)	0.00	($2,704)	$0	$0	$0	($2,704)
NP-ES13	NP-ES.13-1	FY 2009-10 OIT Management and Administration One-time Adjustment	No	($68,435)	0.00	($34,217)	$0	$0	$0	($34,218)
NP-ES14	NP-ES.14-1	Commission on Family Medicine General Fund Reduction	No	($193,206)	0.00	($96,603)	$0	$0	$0	($96,603)
NP-ES16	NP-ES.16-1	DPHE - Cash Fund Financing- Tobacco Education Program Fund 18M	No	$0	0.00	($7,000,000)	$0	$7,000,000	$0	$0
NP-ES17	NP-ES.17-1	DPHE - Cash Fund Financing- Health Disparities Grant Program Fund 19F	No	$0	0.00	($1,000,000)	$0	$0	$1,000,000	$0

Schedule 11

Summary of Supplemental Requests for FY 2009-10

Department Name: Health Care Policy and Financing
Submission Date: January 4, 2010
Number of Prioritized Supplemental Requests: 18

Priority #	Page #	Title	IT Request	Total Request (FY 2009-10)	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
NP-ES18	NP-ES.18-1	DPHE - Cash Fund Financing- Prevention, Detection and Treatment Fund 18N	No	$0	0.00	($7,000,000)	$0	$7,000,000	$0	$0
NP-ES19	NP-ES.19-1	DHS - Risk Management Reduction of Liability, Property and Workers' Compensation Volatility	No	($135,008)	0.00	($67,504)	$0	$0	$0	($67,504)
NP-ES20	NP-ES.20-1	DHS - Risk Management Contract Review and Reduction	No	($42,710)	0.00	($21,355)	$0	$0	$0	($21,355)
NP-ES21	NP-ES.21-1	DHS - FY 2009-10 OIT Management and Administration One-Time Adjustment	No	($5,686)	0.00	($2,843)	$0	$0	$0	($2,843)
NP-ES22	NP-ES.22-1	DHS - State Fleet Rebates - One-Time Refinance	No	($8,422)	0.00	($4,211)	$0	$0	$0	($4,211)
NP-S1	NP-S1.1	This priority has been intentionally left blank.	No	$0	0.00	$0	$0	$0	$0	$0
NP-S2	NP-S2.1	Statewide Furlough Impact	No	($239,760)	0.00	($109,884)	$0	($13,626)	$5,602	($121,852)
NP-S3	NP-S3.1	DHS - Statewide Furlough Impact	No	$478,691	0.00	$239,275	$0	($15)	($2)	$239,433
NP-S4	NP-S4.1	DPHE - Statewide Furlough Impact	No	$9,970	0.00	$3,390	$0	$0	$0	$6,580
NP-S5	NP-S5.1	Mail Equipment Upgrade Supplemental and Budget Amendment	No	($15,442)	0.00	($7,721)	$0	$0	$0	($7,721)
NP-S6	NP-S6.1	DHS - Annual Fleet Vehicle Replacements Technical True-up	No	($12,707)	0.00	($6,353)	$0	$0	$0	($6,354)
NP-S7	NP-S7.1	DHS - Mail Equipment Upgrade Supplemental and Budget Amendment	No	($85,215)	0.00	($42,261)	$0	($172)	($201)	($42,581)
Non-Prioritized FY 2009-10 Supplemental Requests Subtotal				**($11,672,749)**	**0.00**	**($19,477,277)**	**$0**	**$14,002,269**	**$889,019**	**($7,086,760)**
GRAND TOTAL FY 2009-10 Supplemental Requests				**($46,153,843)**	**0.20**	**($446,428,410)**	**$13,827**	**($24,366,402)**	**($11,750,139)**	**$436,377,281**

Schedule 12
Summary of FY 2010-11 Budget Amendments

Department Name: Health Care Policy and Financing
Submission Date: January 4, 2010
Number of Prioritized Budget Amendments: 9

Priority#	Page #	Title	IT Request	Total Request (FY 2010-11)	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Health Care Policy and Financing FY 2010-11 Late Budget Amendments									
BA-1	S.1-1	Request for Medical Services Premiums (Placeholder for February 15, 2010 Request)	No	$0	0.00	$0	$0	$0	$0
BA-2	S.2-1	Medicaid Mental Health Community Programs (Placeholder for February 15, 2010 Request)	No	$0	0.00	$0	$0	$0	$0
BA-3	S.3-1	Children's Basic Health Plan Medical Premium and Dental Benefit Costs (Placeholder for February 15, 2010 Request)	No	$0	0.00	$0	$0	$0	$0
BA-4	S.4-1	Medicare Modernization Act State Contribution Payment (Placeholder for February 15, 2010 Request)	No	$0	0.00	$0	$0	$0	$0
BA-5	S.6-1	Accountable Care Collaborative	No	($584,580)	0.00	($328,177)	$15,448	$0	($271,851)
BA-6	S.7-1	Federally Mandated CHP+ Program Changes	No	$236,150	0.00	$74,679	$46,661	$135	$114,675
BA-7	S.9-1	Public School Health Services Administrative Claiming	No	$4,087,324	0.00	$0	$2,043,662	$0	$2,043,662
BA-8	S.10-1	Acute Care Utilization Review Adjustments	No	$149,560	0.00	$19,419	$0	$0	$130,141
BA-9	S.11-1	Refinance Colorado Benefit Management System Improvements	No	($1,749,976)	0.00	($814,545)	$0	$5,515	($940,946)
FY 2010-11 Prioritized Subtotals				**$2,138,478**	**0.00**	**($1,048,624)**	**$2,105,771**	**$5,650**	**$1,075,681**
Health Care Policy and Financing FY 2010-11 Non-Prioritized Late Budget Amendments									
NP-BA1	NP-S1.1	This priority has been intentionally left blank.	No	$0	0.00	$0	$0	$0	$0
NP-BA6	NP-S5.1	Mail Equipment Upgrade Supplemental and Budget Amendment	No	$308	0.00	$154	$0	$0	$154
NP-BA7	NP-S6.1	DHS - Annual Fleet Vehicle Replacements Technical True-up	No	$1,855	0.00	$928	$0	$0	$927
NP-BA8	NP-S7.1	DHS - Mail Equipment Upgrade Supplemental and Budget Amendment	No	$29,668	0.00	$14,714	$60	$70	$14,824
FY 2010-11 Non-Prioritized Subtotals				**$31,831**	**0.00**	**$15,796**	**$60**	**$70**	**$15,905**
GRAND TOTAL FY 2010-11 Late Budget Amendments				**$2,170,309**	**0.00**	**($1,032,828)**	**$2,105,831**	**$5,720**	**$1,091,586**

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ✓	Base Reduction Item FY 2010-11	Supplemental FY 2009-10	Budget Amendment FY 2010-11

Request Title: Request for Medical Services Premiums
Department: Health Care Policy and Financing
Priority Number: DI-1
Dept. Approval by: John Bartholomew **Date:** November 6, 2009 10/21/09
OSPB Approval: **Date:** 10-20-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,526,991,443	2,542,923,842	86,404,006	2,629,327,848	3,000,913,062	207,323,569	3,208,236,631	0	3,208,236,631	207,323,569
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	772,372,990	28,042,522	800,415,512	1,140,610,858	134,715,479	1,275,326,337	0	1,275,326,337	134,715,479
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	168,808,223	10,414,246	179,222,469	352,549,563	(29,498,967)	323,050,596	0	323,050,596	(29,498,967)
	CFE/RF	2,631,068	2,739,519	219,526	2,959,045	2,736,160	390,381	3,126,541	0	3,126,541	390,381
	FF	1,455,765,086	1,599,003,110	47,727,712	1,646,730,822	1,505,016,481	101,716,676	1,606,733,157	0	1,606,733,157	101,716,676
(2) Medical Services Premiums [3]	Total	2,526,991,443	2,542,923,842	86,404,006	2,629,327,848	3,000,913,062	207,323,569	3,208,236,631	0	3,208,236,631	207,323,569
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	1,037,363,033	48,486,520	1,085,849,553	1,140,610,858	134,715,479	1,275,326,337	0	1,275,326,337	134,715,479
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	226,708,414	(7,272,461)	219,435,953	352,549,563	(29,498,967)	323,050,596	0	323,050,596	(29,498,967)
	CFE/RF	2,631,068	2,739,519	219,526	2,959,045	2,736,160	390,381	3,126,541	0	3,126,541	390,381
	FF	1,455,765,086	1,276,112,876	44,970,421	1,321,083,297	1,505,016,481	101,716,676	1,606,733,157	0	1,606,733,157	101,716,676
(2) Medical Services Premiums; Long Bill Group Total	Total	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(264,990,043)	(20,443,998)	(285,434,041)	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(57,900,191)	17,686,707	(40,213,484)	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	322,890,234	2,757,291	325,647,525	0	0	0	0	0	0

Non-Line Item Request: None
Letternote Revised Text: See Exhibit D, Page ED-1, for the incremental request by cash fund.
Cash or Federal Fund Name and COFRS Fund Number: CF: Colorado Autism Treatment Fund 18A; Breast and Cervical Cancer Prevention and Treatment Fund 15D; Certified Public Expenditures; Health Care Expansion Fund 18K; Medicaid Nursing Facility Cash Fund 22X; Coordinated Care for People with Disabilities Fund 19Z; Hospital Provider Fee Cash Fund; Supplemental Old Age Pension Health and Medical Care Fund 15K; Tobacco Education Programs Fund; Health Disparities Grant Program Fund; Primary Care Fund 18L. FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name: Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund
Approval by OIT? Yes: No: ✓ N/A: ✓
Schedule 13s from Affected Departments: N/A

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☑	**Base Reduction Item FY 2010-11**	☐
Supplemental FY 2009-10	☐	**Budget Amendment FY 2010-11**	☐
Request Title:	Medicaid Mental Health Community Programs		
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew JB **Date:** November 2, 2009 10/15/09
Priority Number:	DI-2	**OSPB Approval:**	**Date:** 10-26-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	217,637,190	207,166,540	4,051,231	211,217,771	235,143,348	21,381,804	256,525,152	0	256,525,152	21,381,804
	FTE	0.0	0	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	87,500,300	72,657,334	2,297,944	74,955,278	104,592,221	10,807,345	115,399,566	0	115,399,566	10,807,345
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	5,219,083	6,483,686	(733,568)	5,750,119	13,018,666	(75,390)	12,943,276	0	12,943,276	(75,390)
	CFE/RF	7,330	9,016	1,377	10,393	8,950	4,338	13,288	0	13,288	4,338
	FF	124,910,477	128,016,504	2,485,478	130,501,982	117,523,511	10,645,511	128,169,022	0	128,169,022	10,645,511
(3) Medicaid Mental Health Community Programs; (A) Mental Health Capitation Payments	Total	215,860,937	205,435,011	3,783,856	209,218,867	233,411,819	20,807,570	254,219,389	0	254,219,389	20,807,570
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	86,769,471	94,262,892	2,843,388	97,106,280	103,726,456	10,520,228	114,246,684	0	114,246,684	10,520,228
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	5,219,083	8,434,054	(956,303)	7,477,752	13,018,666	(75,390)	12,943,276	0	12,943,276	(75,390)
	CFE/RF	7,330	9,016	1,377	10,393	8,950	4,338	13,288	0	13,288	4,338
	FF	123,865,053	102,729,049	1,895,394	104,624,443	116,657,747	10,358,394	127,016,141	0	127,016,141	10,358,394
(3) Medicaid Mental Health Community Programs; (B) Other Medicaid Mental Health Payments, Medicaid Mental Health Fee for Services Payments	Total	1,776,253	1,731,529	267,375	1,998,904	1,731,529	574,234	2,305,763	0	2,305,763	574,234
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	730,829	865,765	133,687	999,452	865,765	287,117	1,152,882	0	1,152,882	287,117
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,045,424	865,764	133,688	999,452	865,764	287,117	1,152,881	0	1,152,881	287,117

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☑	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10** ☐	**Budget Amendment FY 2010-11** ☐
Request Title:	Medicaid Mental Health Community Programs			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 2, 2009
Priority Number:	DI-2	**OSPB Approval:**		**Date:**	

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
(3) Medicaid Mental Health Community Programs; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	(22,471,323)	(679,131)	(23,150,454)	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	(1,950,368)	222,735	(1,727,633)	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	24,421,691	456,396	24,878,087	0	0	0	0	0	0

Non-Line Item Request:	None.
Letternote Revised Text:	[a] Of this amount, $8,998,386 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I) C.R.S.; and $31,469 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund as directed by Section 25.5-5-308 (9) (d) C.R.S; and $3,913,421 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4) C.R.S.
	[b] The Reappropriated Funds shall be transferred from the Department of Public Health and Environment pursuant to Section 24-22-117 (2) (d) (II) (D), C.R.S.
Cash or Federal Fund Name and COFRS Fund Number:	CF: Health Care Expansion Fund (Fund 18K); Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D); Hospital Provider Fee Cash Fund. FF: Title XIX.
Reappropriated Funds Source, by Department and Line Item Name:	Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund.
Approval by OIT?	**Yes:** ☐ **No:** ☐ **N/A:** ☑
Schedule 13s from Affected Departments:	None.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ✓	Base Reduction Item FY 2010-11	Supplemental FY 2009-10	Budget Amendment FY 2010-11

Request Title: Medicare Modernization Act State Contribution Payment
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew **Date:** November 2, 2009 10/21/09
Priority Number: DI-4 **OSPB Approval:** **Date:** 10-26-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(5) Other Medical Services; Medicare Modernization Act of 2003 State Contribution Payment	Total	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
	GF	73,720,837	88,808,586	(1,987,584)	86,821,002	88,808,586	1,727,607	90,536,193	0	90,536,193	1,727,607
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0

Non-Line Item Request: None.
Letternote Revised Text: None.
Cash or Federal Fund Name and COFRS Fund Number: None.
Reappropriated Funds Source, by Department and Line Item Name: None.
Approval by OIT? Yes: No: N/A: ✓
Schedule 13s from Affected Departments: None.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐	**Base Reduction Item FY 2010-11** ☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☐
Request Title:	FY 2008-09 Personal Services Over-expenditure		
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew TB **Date:** January 4, 2010 12/28/09
Priority Number:	S-5	**OSPB Approval:**	**Date:** 12/28/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	**Total**	19,502,741	20,901,734	557,788	21,459,522	22,608,612	0	22,608,612	0	22,608,612	0
	FTE	266.1	287.8	0.0	287.8	317.0	0.0	317.0	0.0	317.0	0.0
	GF	8,010,994	8,645,285	147,605	8,792,890	7,505,041	0	7,505,041	0	7,505,041	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	604,469	618,917	0	618,917	1,884,880	0	1,884,880	0	1,884,880	0
	CFE/RF	1,501,807	1,579,589	0	1,579,589	1,830,045	0	1,830,045	0	1,830,045	0
	FF	9,385,471	10,057,943	410,183	10,468,126	11,388,646	0	11,388,646	0	11,388,646	0
(1) Executive Director's Office; (A) General Administration, Personal Services	**Total**	19,502,741	20,901,734	557,788	21,459,522	22,608,612	0	22,608,612	0	22,608,612	0
	FTE	266.1	287.8	0.0	287.8	317.0	0.0	317.0	0.0	317.0	0.0
	GF	8,010,994	8,645,285	147,605	8,792,890	7,505,041	0	7,505,041	0	7,505,041	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	604,469	618,917	0	618,917	1,884,880	0	1,884,880	0	1,884,880	0
	CFE/RF	1,501,807	1,579,589	0	1,579,589	1,830,045	0	1,830,045	0	1,830,045	0
	FF	9,385,471	10,057,943	410,183	10,468,126	11,388,646	0	11,388,646	0	11,388,646	0

Non-Line Item Request:	None.
Letternote Revised Text:	None.
Cash or Federal Fund Name and COFRS Fund Number:	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 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-5
Change Request Title:	FY 2008-09 Personal Services Over-expenditure

SELECT ONE (click on box):

☐ Decision Item FY 2009-10
☐ Base Reduction Item FY 2009-10
☒ Supplemental Request FY 2009-10
☐ 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: This request is to remove the restriction of $557,788 total funds and $147,605 General Fund, placed on the Department's Personal Services appropriation funding for FY 2009-10 by the State Controller's Office due to an over-expenditure in FY 2008-09.

Background and Appropriation History: Prior to FY 2008-09 the Department was able to operate within its Personal Services appropriation, by maintaining judicious hiring practices and through vacancy savings associated with a high average employee turnover.

Employee turnover at the Department has been historically high due to the complexity of the Department's programs, a lean number of staff, and historically lower compensation than found in the private sector. The Department also operates at a lower administrative percentage of 3.8% than the industry standard of 8-12%. The Department believes these conditions have lead to high turnover rates in the past and has made efforts to address and reduce employee turnover. The following table highlights the Department's historical turnover rates from FY 2005-06 to the present.

Fiscal Year	Separations	Average FTE Count	Turnover
FY 2005-06	53	199.5	26.57%
FY 2006-07	50	208.6	23.98%
FY 2007-08	44	237.3	18.55%
FY 2008-09	24	263.2	9.12%

During FY 2005-06 and FY 2006-07 employee turnover at the Department averaged about 25% annually. The Department countered these vacancy savings by creating additional positions in an effort to fully utilize its annual FTE count and appropriated dollars. Every employee separation takes time to both find and train a replacement. In order to maintain Departmental productivity, the Department used these additional positions to maintain efficiency while it sought to fill its vacancies. These positions were created so the Department could manage to its appropriated FTE count and dollar appropriation, compensate for its high turnover rate, and maintain its level of service to the citizens of Colorado and continue to responsibly manage the funding provided by the General Assembly and the federal government.

During FY 2007-08, as a result of the change in administration, the Department implemented initiatives aimed at reducing this extremely high employee turnover and, in fact, the annual employee turnover decreased to 18.55%, a nearly 23% decrease from the previous fiscal year. The Department expected to reduce this rate further in FY 2008-09; however, it did not expect it to plummet to 9.12%.

This steep decline in the Department's employee turnover is the result of both the initiatives above and current economic realities; since State employees no longer have the same opportunities to move to other open positions within or outside of State government. This has been good overall for the Department, as it has been able to keep its employee knowledge base and existing staff are more knowledgeable and experienced in the management of the Department's multiple complex programs. However, this drastically reduced turnover rate has resulted in an over-expenditure in its Personal Services appropriation of $557,788 total funds and $147,605 General Fund. This lack of

staff movement, coupled with new legislative initiatives placed on the Department has resulted in the Department over expending its total appropriation for FY 2008-09. Finally during FY 2008-09 the Department incurred unanticipated personnel payouts that further exacerbated it expenditure issue.

In the winter of FY 2008-09, the Department became aware of the unexpectedly low turnover rate and anticipated a likely over-expenditure in Personal Services as a result. To address this situation the Department began adjusting expenditures in its Operating Expenses appropriation in an effort to un-encumber funds in order to fund the shortfall in Personal Services using current resources and the emergency supplemental process to transfer those funds. Administratively, the Department was able to reduce its planned expenditures in its Operating Expenses appropriation without impacting the Department's overall effectiveness and free up $458,018 to cover the anticipated over-expenditure. The Department planned to transfer funds from its Operating Expenses appropriation to cover the Personal Services shortfall through the normal State Controller's Office and Governor's Office of State Planning and Budgeting processes. However, such a transfer turned out to be inconsistent with statute (24-75-108 C.R.S. (2009)) and therefore was not performed. The over-expenditure was ultimately approved by the State Controller's Office and the Governor through the Governor's over-expenditure authority. However any action through the over-expenditure authority creates an automatic restriction in the following fiscal year and requires General Assembly approval to remove this restriction.

General Description of Request: This request is to remove the restriction of $557,788 total funds and $147,605 General Fund placed on the Department's Personal Services appropriation for FY 2009-10 by the State Controller's Office due to an over-expenditure in FY 2008-09.

Consequences if Not Funded: If the restriction is not lifted, it would result in the Department possibly over-expending its Personal Services appropriation in FY 2009-10. This would result in further hardship as the Department's FY 2010-11 Personal Services funding would likely be reduced by the amount of the anticipated FY 2009-10 over-expenditure.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	General Fund	Federal Funds	FTE
Total Request	$557,788	$147,605	$410,183	0.0
(1) Executive Director's Office; (A) General Administration, Personal Services	$557,788	$147,605	$410,183	0.0

Assumptions for Calculations: The amounts above represent the actual FY 2008-09 over-expenditure from its Personal Services appropriation that resulted in the restriction being placed on its FY 2009-10 Personal Services appropriation. For FY 2008-09, the Department also received an appropriation for both cash funds and re-appropriated funds in its Personal Services line. However, during FY 2008-09, the Department did not overexpend the cash funds or re-appropriated funding sources and therefore there is no restriction to release.

Impact on Other Government Agencies: None

Cost Benefit Analysis: For the cost of $557,788 total funds and $147,605 General Fund, the Department will be able to maintain staffing at levels that will allow it to continue to implement legislative and other initiatives without disruption of service to both internal and external clients. Without this funding, the Department would need to reduce its staffing level by approximately 69 positions for one month (or 6 positions for one full year) to make up the shortfall. The Department would be forced to eliminate certain services at a time of greatest need within the State.

Implementation Schedule: Not Applicable

Statutory and Federal Authority: 25.5-1-108, C.R.S. (2009) Executive director - rules. *(1) The executive director shall have authority to promulgate rules in connection with the policies and procedures governing the administration of the department including, but not limited to, rules concerning the following: (a) Matters of internal administration of the department,*

including organization, staffing, records, reports, systems, and procedures; (b) Fiscal and personnel administration for the department; (c) Accounting and fiscal reporting policies and procedures for disbursement of federal funds, contingency funds, and distribution of available appropriations; (d) Such other rules relating to those functions the executive director is required to carry out pursuant to the provisions of this title. (2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority in relation to a specific program to the executive director.

Performance Measures: Not Applicable

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐	Base Reduction Item FY 2010-11 ☐	Supplemental FY 2009-10 ☑	Budget Amendment FY 2010-11 ☑	
Request Title:	Accountable Care Collaborative			
Department:	Health Care Policy and Financing	Dept. Approval by:	John Bartholomew	Date: January 4, 2010
Priority Number:	S-6, BA-5	OSPB Approval:		Date: 1-4-10

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	2,577,891,994	2,632,639,622	(677,636)	2,631,961,986	3,073,712,185	0	3,073,712,185	(584,580)	3,073,127,605	(12,067,158)
	FTE	266.1	287.8	0.0	287.8	317.0	0.0	317.0	0.0	317.0	0.0
	GF	936,560,200	1,132,583,032	(200,659)	1,132,382,373	1,159,134,940	0	1,159,134,940	(328,177)	1,158,806,763	(6,122,329)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	110,863,796	168,669,273	0	168,669,273	357,646,206	0	357,646,206	15,448	357,661,654	0
	CFE/RF	4,233,203	4,426,246	0	4,426,246	4,666,533	0	4,666,533	0	4,666,533	0
	FF	1,486,983,003	1,326,971,071	(476,977)	1,326,494,094	1,552,264,506	0	1,552,264,506	(271,851)	1,551,992,655	(5,944,829)
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	19,502,741	20,901,734	0	20,901,734	22,608,612	0	22,608,612	8,400	22,617,012	45,000
	FTE	266.1	287.8	0.0	287.8	317.0	0.0	317.0	0.0	317.0	0.0
	GF	8,010,994	8,645,285	0	8,645,285	7,505,041	0	7,505,041	4,200	7,509,241	22,500
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	604,469	618,917	0	618,917	1,884,880	0	1,884,880	0	1,884,880	0
	CFE/RF	1,501,807	1,579,589	0	1,579,589	1,830,045	0	1,830,045	0	1,830,045	0
	FF	9,385,471	10,057,943	0	10,057,943	11,388,646	0	11,388,646	4,200	11,392,846	22,500
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	1,298,595	3,711,605	(125,000)	3,586,605	3,910,800	0	3,910,800	(125,000)	3,785,800	(125,000)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	771,478	1,455,543	(62,500)	1,393,043	1,320,400	0	1,320,400	(62,500)	1,257,900	(62,500)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	326,250	0	326,250	562,500	0	562,500	0	562,500	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	527,117	1,939,812	(62,500)	1,877,312	2,027,900	0	2,027,900	(62,500)	1,965,400	(62,500)

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☑
Request Title:	Accountable Care Collaborative			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	January 4, 2010
Priority Number:	S-6, BA-5	**OSPB Approval:**		**Date:**	

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	1,298,595	3,711,605	(125,000)	3,586,605	3,910,800	0	3,910,800	(125,000)	3,785,800	(125,000)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	771,478	1,455,543	(62,500)	1,393,043	1,320,400	0	1,320,400	(62,500)	1,257,900	(62,500)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	326,250	0	326,250	562,500	0	562,500	0	562,500	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	527,117	1,939,812	(62,500)	1,877,312	2,027,900	0	2,027,900	(62,500)	1,965,400	(62,500)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	22,200,548	27,834,289	(552,636)	27,281,653	36,883,007	0	36,883,007	158,004	37,041,011	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,299,911	6,708,927	(138,159)	6,570,768	6,205,903	0	6,205,903	39,501	6,245,404	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	540,118	538,643	0	538,643	2,488,901	0	2,488,901	0	2,488,901	0
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,486,391	(414,477)	20,071,914	28,087,875	0	28,087,875	118,503	28,206,378	0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	**Total**	3,312,379	3,573,001	0	3,573,001	4,192,321	0	4,192,321	27,327	4,219,648	76,385
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,625,469	1,752,987	0	1,752,987	2,022,395	0	2,022,395	13,663	2,036,058	38,192
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	30,721	33,514	0	33,514	73,766	0	73,766	0	73,766	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,656,189	1,786,500	0	1,786,500	2,096,160	0	2,096,160	13,664	2,109,824	38,193

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10**	☑
Budget Amendment FY 2010-11	☑				

Request Title:	Accountable Care Collaborative			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 4, 2010
Priority Number:	S-6, BA-5	**OSPB Approval:**		**Date:**

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**Total**	4,586,288	4,576,355	0	4,576,355	5,204,383	0	5,204,383	(249,780)	4,954,603	(249,780)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,142,390	1,359,148	0	1,359,148	1,470,343	0	1,470,343	(213,640)	1,256,703	(213,640)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	54,949	54,949	0	54,949	86,596	0	86,596	0	86,596	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,388,949	3,162,258	0	3,162,258	3,647,444	0	3,647,444	(36,140)	3,611,304	(36,140)
(2) Medical Services Premiums	**Total**	2,526,991,443	2,572,042,638	0	2,572,042,638	3,000,913,062	0	3,000,913,062	(403,531)	3,000,509,531	(11,813,763)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	919,709,958	1,112,661,142	0	1,112,661,142	1,140,610,858	0	1,140,610,858	(216,025)	1,140,394,833	(5,906,881)
	GFE	39,251,792	0	0	0	0	0	0	0	0	0
	CF	109,633,539	167,097,000	0	167,097,000	352,549,563	0	352,549,563	14,260	352,563,823	0
	CFE/RF	2,631,068	2,746,329	0	2,746,329	2,736,160	0	2,736,160	0	2,736,160	0
	FF	1,455,765,086	1,289,538,167	0	1,289,538,167	1,505,016,481	0	1,505,016,481	(201,766)	1,504,814,715	(5,906,882)
(2) Medical Services Premiums; Long Bill Group Total	**Total**	0	0	0	0	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	106,624	106,624	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	1,188	1,188	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	(107,812)	(107,812)	0

Non-Line Item Request:	None.
Letternote Revised Text:	FY 2010-11 (2) Medical Services Premiums (a) Of this amount, $85,401,320 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.; $21,498,147 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program; $784,875 shall be from the Autism Treatment Fund created in Section 25.5-6-805, C.R.S.; $1,725,479 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a), C.R.S.; $27,040,854 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S.; $250,000 shall be from the Coordinated Care for People with Disabilities Fund; and, $212,806,547 shall be from Hospital Provider Fee Cash Fund.
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 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-6, BA-5
Change Request Title:	Accountable Care Collaborative

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☐ Base Reduction Item FY 2010-11
☒ Supplemental Request FY 2009-10
☒ Budget Request Amendment FY 2010-11

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 a reduction of $677,636 total funds and reduction of $200,659 General Fund in FY 2009-10 as well as a reduction of $584,580 total funds and a reduction of $328,177 General Fund in FY 2010-11 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning November 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. This request alters the scope, funding, and implementation timeline for this initiative, first presented in the Department's FY 2009-10 DI-6 "Medicaid Value-Based Care Coordination Initiative." and modified in the FY 2009-10 budget request BA-38 "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative."

Background and Appropriation History:

In the Department's FY 2009-10 Budget Request, the Department had proposed 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 that request were 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 Department's set of proposals were divided into four Change Requests:

- DI-5 Improved Eligibility and Enrollment Processing;
- DI-6 Medicaid Value-Based Care Coordination Initiative;
- DI-7 Medicaid Benefit and Outcomes Enhancements; and,
- BRI-1 Pharmacy Technical and Pricing Efficiencies.

As presented in the DI-6 request, the Department intends to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. To achieve this, the Department proposed to undertake a statewide competitive procurement process for physical health services that emphasizes the importance of increasing the availability and services of coordinated, "whole-person" care for all clients. The Department proposed to regionally procure services from five organizations that would provide enhanced Primary Care Case Management services. They were to be primarily responsible for establishing a coordinated care delivery system for all clients.

In mid July of 2009, the Department released a Request for Information (RFI) regarding the "Medicaid Value-Based Care Coordination Initiative," soliciting feedback from stakeholders including providers, advocates, clients, current vendors, and managed care organizations. In July 2009, the Department released its RFI, formally requesting information and gauging the interest of the community. The Department allowed potential respondents approximately one month to submit feedback via email, letters, and conversation. The Department spent approximately two months evaluating the responses and seeking follow-up clarification. From this process, the Department discovered almost all of the 89 respondents (individuals and organizations) were in favor of the concept and a number of organizations suggested they would bid for appropriate contracts. The RFI process also yielded a number of suggestions which helped the Department further refine its conception of the program and which are presented in this request.

As a result of the stakeholder input process, the Department has altered and updated various components of the original "Medicaid Value-Based Care Coordinate Initiative" into a new framework, now known as the Accountable Care Collaborative (ACC). This request articulates the roles to be played by the organizations which will play central roles in the ACC, namely the Regional Care Collaboration Organizations (RCCOs) and the statewide Health Data and Information Organization (HDIO), and identifies immediately eligible populations.

General Description of Request:

The Department requests a reduction of $677,636 total funds and reduction of $200,659 General Fund in FY 2009-10 as well as a reduction of $584,580 total funds and a reduction of $328,177 General Fund in FY 2010-11 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning November 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. This request alters the scope, funding, and implementation timeline for this initiative, first presented in the Department's FY 2009-10 DI-6 "Medicaid Value-Based Care Coordination Initiative." and modified in the FY 2009-10 budget request BA-38 "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative."

The Department intends to regionally procure services from five Regional Care Collaboration Organizations (RCCOs) providing enhanced Primary Care Case Management services (ePCCM) for non-dual eligible (non-Medicare) clients. The Department also requests funding to procure one statewide Health Data and Information Organization (HDIO). Collectively, the Department, the six contracted organizations, and participating providers would form the "Accountable Care Collaborative" (ACC).

The proposed division of responsibilities is designed to facilitate trust between the local providers and their RCCOs as regional support entities. The administration of Primary Care Medical Provider (PCMP) functions, provider coordination, client support services, and outcomes accountability would be placed under the purview of the RCCOs. The data and information technology issues would be placed under the HDIO. The RCCOs would be facilitators: they would assist both clients' and providers' navigation through the Medicaid system and ensure coordinated care focused on the wellbeing and health

outcomes of the clients. The HDIO would operate as an oversight entity: it would discover and report gaps, malfeasance, poor performance, broken systems and any client dissatisfaction. The Department believes it is important to provide solutions to providers' concerns regarding participation in any form of managed care by providing an oversight entity that can report data that directs providers to the most effective utilization of care for their clients, allowing providers to react to solid data reports rather than being burdened with needing to perform the data analysis and investigations themselves. By offering this solution, the Department anticipates convincing providers to join and maintain participation within the program.

The Department intends to enroll 60,000 fee-for-service clients to test the viability and success of the model before requesting permission to expand the program statewide to cover all Medicaid clients. 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 due to the existence of full regional coverage. As part of this initial phase of the program, the Department would limit passive enrollment (see the "Client Enrollment" section of this narrative) to Medicaid clients who are only receiving Medicaid benefits rather than a combination of Medicaid and Medicare benefits ("non-dual eligibles"). This is because, for dual-eligibles, the Department is not solely responsible for the health care delivery system, and thus cannot fully manage the benefit. Therefore, the Adults 65 and Over are assumed to not be part of the initial phase of this program and dual-eligible members of the Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories are also not included in any calculations for this request.

Regional Care Collaboration Organizations (RCCOs)

The scope of services supplied by the RCCOs is the foundation of the Accountable Care Collaborative (ACC). RCCO services are geared towards improving access, quality and cost efficiency by supporting the client's Primary Care Medical Provider (PCMP). The client's PCMP is the "one-stop shop" for understanding and improving his/her health status. The RCCOs serve as the support to the PCMPs' need for access to specialists and help coordinate care for their clients. In most cases, the PCMP will serve as the client's

medical home. The ACC expressly incorporates and includes essential medical home concepts. Regional entities would be responsible for offering extensive care coordination and other services in support of PCMP services.

The RCCOs would be primarily responsible for establishing a coordinated care delivery system for all enrolled clients. The Department anticipates that payments to primary care physicians would be supplemented with care coordination fees as well as outcomes-based performance incentives (see the "Service Costs and Savings" section, below). In addition to strengthening primary care services, the RCCOs would administer a comprehensive network of care coordination services. The RCCOs would establish, maintain, and cultivate relationships with contracted community based care coordinators. These coordinators would help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospitals and community care, and importantly serve as client advocates in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. The care coordinators would look to the RCCOs for best practices and the deployment of evidence-based medical management tools designed to promote patient safety and reduce unwarranted variation in care practices. The RCCO contracts with the Department would be performance-based with incentive payments structured around health outcomes, functional improvements, and self-sufficiency attainment.

The five RCCOs would be phased in over five month's time beginning November 1, 2010, one new RCCO becoming operational in each of the next sequential months. There will be approximately 2,000 clients enrolled with each RCCO per month on average until the maximum enrollment census of 12,000 per RCCO is achieved. The Department intends to cap enrollment for each RCCO to 12,000 clients to ensure uniformity between regions in the first phase of the pilot 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 may be overwhelmed, and clients may lose access to services rather than gain access. Calculations of client enrollment are presented in table 3.1 in the appendix. Please note that table 3.1 shows enrollment totals in aggregate, as it will not be

determined until the procurement process is complete how enrollment by region may vary.

Primary Care Medical Providers

PMPM payments would also go to the Primary Care Medical Providers (PCMPs) for their participation and enhanced care coordination activities. An exception is for the service costs pertaining to children. Providers serving as Medical Homes for children in the Medicaid system already receive enhanced payments. The Accountable Care Collaborative (ACC) would not pay these providers a second enhancement for participation in a similar program to a medical home. For the subset of children enrolled in a medical home, the PMPM for ACC would be reduced by the PMPM already given to these Medical Home providers. The functions of the Regional Care Collaboration Organizations (RCCOs) and the HDIO would still be applied to Children under this request.

Health Data and Information Organization (HDIO)

The HDIO is responsible for data management and information sharing as needed by the Accountable Care Collaborative (ACC) and within the bounds of applicable state and federal law. The statewide HDIO would be responsible for advanced analytics; predictive modeling; risk stratification; reporting; monitoring regional metrics; coordinating with the Colorado Regional Health Information Organization (CORHIO); facilitating the use and development of clinical registries; and building and maintaining new web-based services for providers, Regional Care Collaboration Organizations (RCCOs), and clients while offering secure email services to all program participants.

The HDIO would have the expertise to do predictive modeling, perform analytics, designate risk stratification, and identify a hierarchy of intervention for enrolled clients. The entity would evaluate all information; perform trend analyses; profile; calculate client risk-scores; and respond to provider, regional entity, and state inquiries for information and analysis. With this information the RCCOs can better inform their contracted providers of client behavior and risks so that the providers can intervene if and

as necessary. Providers will receive information allowing them to be proactive in managing their clients' care, rather than reactive.

The statewide HDIO would also promote a sustainable culture of continuous quality improvement at the PCMP and RCCO level by providing the data which would drive Professional Development and Quality Assurance (PDQA) processes. This would include collecting clinical measures beyond standard claims data to provide constructive insight as to the discrepancies between regional outcomes and performance.

The HDIO would have the expertise to build and maintain large complex web-based applications, information tools, and registries all with the necessary securities and designs to meet state laws and the requirements of the Health Insurance Portability and Accountability Act (HIPAA). The organization would have the technical expertise to interface with other systems (e.g. the Colorado Immunization Information System (CIIS) for tracking all vaccinations) regardless of their technical platforms in order to share information bilaterally and efficiently.

Because the work functions of the HDIO should not be substantially affected by caseload trends after the start-up phase, the Department intends to negotiate a fixed price contract for the HDIO in order to contain costs. The data elements tracked by the HDIO will expand if the program expands beyond 60,000 clients in future years; however the primary reporting and information sharing functions will be limited by the number of providers and RCCOs participating. At completion of the first phase of this initiative, the continuous enrollment of 60,000 clients, the Department anticipates that for a not-to-exceed fixed price, the HDIO should be able to fulfill its contract requirements. This amount was determined by examining care and data management services for similarly sized initiatives. In FY 2010-11, demands on the HDIO will be focused on start-up and infrastructure development rather than standard operations. The HDIO should begin work in August 2010. Given the differing nature of the work and the 11 months of the fiscal year remaining, the Department anticipates a slightly reduced total expenditure as compared to the expenditure when the program is operating at full capacity.

Service Costs

When the Department submitted the DI-6 Request in November 2009, the Department calculated costs based upon an all-inclusive $20.00 per-member-per-month (PMPM) capitation. After considering other models for care coordination, feedback from stakeholders, and the capacity of potential vendors, the Department now proposes to pay to Regional Care Collaboration Organizations (RCCOs) a monthly management fee on a per-member per-month (PMPM) basis for administration of the services provided in the program. The Department also anticipates paying a PMPM fee to the participating Primary Care Medical Providers (PCMPs) as well as incentives to be split between the RCCOs and the PCMPs for achievement of various outcome and performance benchmarks (see pages 14 and 15 of this narrative). Additionally, the Department proposes to pay a fixed price contract to the Health Data and Information Organization (HDIO) for this initial phase of the program. The Department believes that, as discussed previously, that a fixed price contract for the HDIO can best control costs and should be separated from the PMPM funding mechanism paid to the RCCOs and explicitly tied to caseload.

The Department intends to pay a set of tiered PMPMs based on cost of supplying Accountable Care Collaborative (ACC) services to the various eligibility populations. As examples, the cost of supplying enhanced care coordination for disabled clients is likely to exceed the cost of supplying those same services for income qualifying adult populations. The Department would set a tiered set of rates and incorporate those rates into the various contracts to reflect the reality of disparate costs.

Estimated program administration costs for the RCCOs, PCMPs, and HDIO are presented in table 4.1 and table 4.2. For the purpose of this request, the RCCO, PCMP, and HDIO expenses are presented as a single PMPM "administrative" capitation in table 4.2. This is done in order to ensure the Department receives competitive bids for these proposed services while still demonstrating the overall impact of the program. Although represented as a PMPM capitation payment in table 4.2, only a portion of the administration expense would be paid in this fashion. When implemented, the administration payments would fall into four categories: 1) monthly PMPM capitation

payments made to the RCCOs; 2) monthly PMPM capitation payments made to PCMPs, and; 3) a monthly lump sum payment to the HDIO under a fixed-price contract.

The Department anticipates paying the RCCOs and PCMPs a reduced PMPM in FY 2010-11 to account for the more minimal workload of these organizations and physicians. In FY 2011-12, the PMPM payment to the RCCOs and PCMPs will see a permanent increase to reflect the increased demands due to the program operating at capacity. This increase in the PMPM will be offset by a reduction to the implicit PMPM paid to the HDIO (described below). The Department does not anticipate any other adjustments to the PMPM expenditure as the program continues into the future.

Additionally, the Department will also pay a monthly incentive payment to the RCCOs and PCMPs. The Department's estimate for the monthly incentive payments is presented in table 4.3. The PMPM incentive payment would be divided between the RCCOs and the PCMPs. In the event that the RCCOs or the PCMPs do not meet performance expectations, the providers would only receive a portion, if any, of the incentive PMPM. In addition to missing out on incentive payments, RCCOs that persistently do not meet performance expectations could also lose enrollment, part of their base PMPM, or both.

Incentive payments would be made following the completion of a fiscal quarter and after three months lag time to receive and validate performance data and determine the amount of incentive payments earned. For example performance incentives for services provided in January through March 2011 will be received, cleaned, and validated from April through June 2011 and paid in July 2011. The HDIO would be responsible for calculating the achievement of and payment amounts for achieved incentives. The RCCOs would distribute the payments to the PCMPs. The Department anticipates making performance incentive payments beginning in FY 2010-11.

Overall, the Department estimates that the administrative costs for these four expenses (RCCO, PCMP, HDIO, and incentives) would be $0 in FY 2009-10, as clients would not yet be enrolled; in FY 2010-11, the cost would be $3,341,132; and the cost would be $13,871,348 in FY 2011-12. These costs are offset by reduced medical services expenditure for enrolled clients, described below.

The Department is unsure at this time whether the administrative expenditure for the RCCOs, PCMPs, and HDIOs will qualify for the enhanced federal match from the American Recovery and Reinvestment Act (ARRA). The Department has examined the cost of similar care coordination and administrative services in the Department's managed care programs to develop a PMPM that would go directly to the RCCOs for its care coordination services. The Department is seeking guidance from the Centers for Medicare and Medicaid Services (CMS) regarding whether expenditure for RCCOs will receive the enhanced FMAP specified in ARRA. ARRA does not provide enhanced match for services deemed to be administrative, rather than medical. Recent communications with CMS suggest that CMS may view RCCO expenditure as administrative. The Department believes that the coordination services provided by the RCCOs require a fundamental understanding of the various treatments provided to any one client as well as the medical interactions of those treatments. However, because this interpretation is subject to CMS approval, the Department has altered this supplemental as compared to previous submissions in order to conservatively assume that CMS will classify these services as administrative, and therefore not subject to enhanced federal match. Should CMS agree to the Department's interpretation of these functions, the Department would use the regular budget process to request the subsequent reduction in General Fund that enhanced ARRA match would create.

Per Capita Savings

The Department expects that savings to service costs would begin in November 2010, and would reduce the average per capita costs of enrolled clients by 8%. In most cases, the Department uses the per capita estimates developed in the Department's Base Request for Medical Services Premiums (Decision Item 1, November 2009). However, for Disabled Adults 60 to 64, and Disabled Individuals to 59, the per capita costs are adjusted to account for the lack of dual-eligible clients from the program's population. The per capita costs for those populations reflect the cost to the Department for serving a client without Medicare.

In previous requests, the Department has presented an escalating scale of savings, from 8% in the initial year of operation up to 10% and then 12% as the program continues.

The Department has chosen to alter its savings calculation methodology in this request. The Department's initial savings calculations were based upon the experience of other states had shown significant reductions in costs. Particularly, independent audits performed by Mercer in North Carolina had shown cost savings of 17% in a mature program.[1] The methodology behind these audit findings have since been cast into doubt, and the Department feels that those doubts coupled with the current state budget climate warrant a conservative approach to savings calculations.

In addition, an evaluation of the Colorado Children's Healthcare Access Program (FY 2007-08) performed by the Children's Outcomes Research Program, the Children's Hospital, and the University of Colorado – Denver quantified savings for that program, which sought to focus children on a "medical home," or a primary care physician administering coordinated and focused preventive care. This is a major component of the Accountable Care Model. The study quantified savings for avoided medical costs. "Total 12-month median reimbursed medical costs per child were significantly lower in CCHAP children compared to non-CCHAP children in both the Denver Metro area and El Paso counties (Denver Metro: $571 vs. $740; El Paso County: 684 vs. 861).[2] That represents a 22.84% cost difference in the Denver Metro area and a 20.56% cost difference in El Paso county.

While specific to the Colorado experience, the program was entered into voluntarily by clients and did not include rural counties. These differences may result in program performance that is more robust than it would be when applied to the general population.

Given the issues surrounding comparative studies, it is the Department's view that the savings estimates from the studies above, 17% (North Carolina) and 22% (Colorado), should be substantially reduced before using them as a benchmark for the ACC. For example, if the savings figures were reduced by half, this would produce a range of 8.5% to 11%. Further, because of the limitations of the studies, and the Department's choice to

[1] 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

[2] Morrato, Elaine H; Allen, Richard; Kempe, Allison, "Colorado Children's Healthcare Access Program (CCHAP): 12-Month Evaluation of the Program (July 1, 2007 – June 30, 2008)." March 19, 2009.

limit the ACC's initial enrollment in the program of 60,000 clients, the Department believes that a conservative estimate is warranted. Therefore, the Department assumes a per capita savings rate of 8%. In light of the multiple studies demonstrating the efficacy of similar programs, the Department believes that this savings rate presents a conservative but realistic estimate. Should the program out-perform these estimates, any additional savings above the assumed 8% will be accounted for in future budget requests.

The Department also anticipates that the estimated 8% savings will occur regardless of whether or not a client is already enrolled in a medical home, but the actual dollars saved would differ depending on their current utilization.[3] This is because the new regional and statewide entities will affect all enrolled clients, and provide additional support to participating physicians, thus enabling additional savings. While the figures above (from the Colorado Children's Healthcare Access Program) indicate that savings occurs from placing a client in a medical home, the Department believes that the RCCOs and the HDIO will provide savings above and beyond the savings from enrolling clients in a medical home.

The Department believes that even greater savings will be generated over the long term due to improved health outcomes for clients, allowing clients to be less demanding of expensive acute or emergency treatments. In the short term, the 8% savings will be driven by targeted reductions in five areas: 1. ER utilization, 2. avoidable hospital and repeat hospitalization, 3. durable medical equipment costs, 4. home health costs related to avoidable acute conditions and 5. outpatient services (e.g. CT scans and x-rays). As clients take advantage of improved preventive care and better health management, these areas of expenditure will reduce. The savings calculations are presented in tables 5.1 and 5.2 in the appendix.

Appendix table 6.1 presents the net service savings.

[3] For example, if a client enrolled in a medical home has a lower per capita cost than a client who is not enrolled in a medical home, the Department will achieve less total savings on the client enrolled in a medical home. However, the Department anticipates that it will achieve a constant percentage savings, on average, regardless of whether or not a client is enrolled in a medical home.

In the future, the Department may consider a "shared outcomes" or "gain-share" program, similar to the model of shared savings in South Carolina, whereby a percentage of net savings would be paid to Primary Care Medical Providers (PCMPs) and/or RCCOs to monetarily incent desired outcomes. These savings would be generated by achievement of measurable cost savings results. Federal law requires than any such shared savings plans be capped at 5% of the medical costs. The Department would make any such requests through the regular budget process.

Program Evaluation

The Department would conduct evaluations of both cost savings and quality of care. The Department will use as a control group similar fee-for-service populations as a comparison for cost and quality of services.

The Department currently contracts with a Quality Improvement Organization (QIO) that is capable of designing and executing such an evaluation; if the evaluation is performed by a Quality Improvement Organization (QIO), expenditures will receive 75% federal financial participation. Additionally, the Department would seek to follow federal best practices regarding care management programs, by performing a series of quality assurance activities such as site reviews, records audits and the like. The Department assumes a cost of $355,000 total funds in FY 2010-11 and again in FY 2011-12, based upon projects of similar scope. The costs are presented in tables 8.1. Fund splits are presented in tables 2.2 and 2.3.

Moreover, for the initial phase, the Department intends to track five metrics immediately and continuously, linking the targeted savings areas described above to the quarterly incentive payments. As defined above, the five metrics will cover: 1. emergency department utilization, 2. avoidable hospital visits and repeat hospitalization, 3. durable medical equipment costs, 4. home health costs related to avoidable acute conditions, and 5. outpatient services (e.g. CT scans and x-rays). The Department will work with its contracted Regional Care Collaboration Organizations (RCCOs) and providers to articulate the performance standards to be tied to these metrics.

In addition to overall cost savings and the five identified metrics, the program would also implement long-term heath outcome metrics. The Department is dedicated to improving the health, functioning, and self-sufficiency of all clients, as well as assuring that clients receive good heath care when they are sick. Some of the metrics of good health include: physical and mental health assessments, health related days of missed school, functional assessments, suicide rates, rates of physical assault by current or former intimate partners, driving under the influence rates, sexual violence rates, school violence rates, and child abuse rates. Other metrics related to healthy lifestyles and risk factors include obesity rates, smoking rates, drug and alcohol abuse rates, physical activity participation, binge drinking rates, and the like. The Department will explore the viability of incorporating these outcome measures into the overall program evaluation and any future gain-sharing models of program administration.

Client Enrollment

As described above, the initial phase of the Accountable Care Collaborative (ACC) would involve enrolling 60,000 Medicaid-only clients.

To facilitate enrollment, the Department would expand its practice of "passive" enrollment for all regional plans to assure an established program is in place in FY 2010-11 and that the system has built into it the capacity to enroll the majority of Medicaid clients in the future. However, unlike the current passive enrollment program, the Department would provide the enrollment broker with claims data to allow many clients to be enrolled while maintaining their existing Primary Care Medical Provider (PCMP), thus ensuring continuity of care. Clients would be enrolled into the program as follows:

- Clients with existing claims history in the Medicaid Management Information System (MMIS) will be enrolled with the PCMP that appears most likely to be the client's historical attending physician.
- Clients without existing claims history will be assigned to a willing PCMPs based upon client characteristics and PCMP preferences, up to the enrollments limits set by each PCMP.

- Clients without existing claims history, who cannot be assigned to a willing PCMP, will be temporarily enrolled with a regional umbrella entity. Formal assignment to a PCMP will only occur when the client first seeks care from a PCMP or upon outreach efforts by the regional entity to obtain a formal PCMP choice.

If enrollment goals are not reached using passive enrollment, then the Department may file a State Plan amendment or a file for a waiver in 2011 for mandatory enrollment.

Clients currently enrolled in other physical health managed care programs will not be enrolled into the ACC. This will help ensure that any savings measured will be based on a currently unmanaged population, and the comparison is not affected by any management which may have been performed by the current managed care organization.

Client enrollment by month is presented in table 3.1 and described on page 8 of this narrative. The various costs of enrollment broker activities are presented in tables 7.1 and 7.2 and include the design, production, and mailing of enrollment materials, the production and mailing of quality report cards to clients, customer service line functions, and contract costs for the passive enrollment administrative functions.

Administrative Costs

As part of this initiative, the Department is requesting funding for the necessary administrative resources which would 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. Currently, the Department funds a single ombudsman for all managed care clients; by vastly increasing the number of clients in the Accountable Care Collaborative (ACC), the Department would require additional ombudsman services to ensure that clients have fair access and representation. The Department must also ensure that its information technology systems are able to correctly interface with providers' systems. Therefore, the Department requests funding for the following areas: an ombudsman, and changes to the Medicaid Management Information

System (MMIS). Total administrative costs are listed and calculated in tables 8.1 through 8.3. The quality review components of these costs are narrated on pages 13 and 14 of this document. The Department has used current contracts to estimate the costs of ombudsman services.

In the Department's previous request, total costs for MMIS changes were $1,058,400 total funds. The Department must ensure that its claims and enrollment system, the Medicaid MMIS, is able to support the payment of the monthly administration costs to RCCOs and Primary Care Medical Providers (PCMPs); the system must also support data sharing and claims access by multiple contractors. Since the time of that previous request, the Department has further refined the requirements needed for system compatibility, and this has resulted in a decrease in needed funds. The Department's MMIS contractor, Affiliated Computer Services (ACS) has estimated a revised total project cost at $663,768, spread out over two fiscal years. Table 8.1 illustrates a $505,764 total funds cost in FY 2009-10 and a $158,004 cost in FY 2010-11. MMIS system changes receive a 75% federal match rate.

In the prior requests, the Department included funding for actuarial services. The new role of the HDIOs make this funding unnecessary, and therefore this request does not include any actuarial funding.

Incremental Funding Request

The Department has made previous requests relating to this initiative. As described, above, originally submitted over the FY 2009-10 budget cycle as DI-6 and later altered through BA-38, the Department has most recently incorporated annualizations of these requests into its November 6, 2009 Budget Request for FY 2010-11.

Total costs for the program (non-incremental costs) are presented in table 1.1, and the funds splits are presented in tables 2.1 through 2.3. All calculations in subsequent tables are total costs.

Incremental calculations are presented in the schedule 13 and summary tables, along with tables 1.2, 1.3, 2.4, 2.5, and 2.6 in the appendix. These incremental requests are built off of either the current appropriation (as in the case of FY 2009-10) or the current request (in the case of FY 2010-11, including the November 6 Request).

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 fully 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 will not achieve the Department's goals of increasing access to health care and containing health care costs.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	FTE	General Fund	Cash Funds	Federal Funds
Total Request	**($677,636)**	**0.0**	**($200,659)**	**$0**	**($476,977)**
(1) Executive Director's Office; (A) General Administration, Personal Services	$0	0.0	$0	$0	$0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	($125,000)	0.0	($62,500)	$0	($62,500)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	($552,636)	0.0	($138,159)	$0	($414,477)

Summary of Request FY 2010-11	Total Funds	FTE	General Fund	Cash Funds	Federal Funds
Total Request	**($584,580)**	**0.0**	**($328,177)**	**$15,448**	**($271,851)**
(1) Executive Director's Office; (A) General Administration, Personal Services	$8,400	0.0	$4,200	$0	$4,200
(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	$158,004	0.0	$39,501	$0	$118,503
(1) Executive Director's Office; (D) Eligibility Determination and Client Services, Customer Outreach	$27,327	0.0	$13,663	$0	$13,664
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($249,780)	0.0	($213,640)	$0	($36,140)
(2) Medical Services Premiums	($403,531)	0.0	($216,025)	$14,260	($201,766)
American Recovery and Reinvestment Act	$0	-	$106,624	$1,188	($107,812)

Cash Funds: Health Care Expansion Fund

Summary of Request FY 2011-12	Total Funds	FTE	General Fund	Cash Funds	Federal Funds
Total Request	**($12,103,758)**	**0.0**	**($6,140,629)**	**$0**	**($5,963,129)**
(1) Executive Director's Office; (A) General Administration, Personal Services	$8,400	0.0	$4,200	$0	$4,200
(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; (D) Eligibility Determination and Client Services, Customer Outreach	$76,385	0.0	$38,192	$0	$38,193
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	($249,780)	0.0	($213,640)	$0	($36,140)
(2) Medical Services Premiums[(a)]	($11,813,763)	0.0	($5,906,881)	$0	($5,906,882)

(a) Based on the enrollment and per capita projections, this request normally would require $62,154 from the Health Care Expansion Fund (see table 2.6 in the appendix). However, because the Health Care Expansion Fund is projected to be insolvent in FY 2011-12, that amount is requested, on this table and the Schedule 13, as General Fund.

Cash Funds Projections:

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate *	FY 2010-11 End of Year Cash Balance Estimate *	FY 2011-12 End of Year Cash Balance Estimate *
Health Care Expansion Fund	18K	$94,003,143	$119,601,623	$81,320,908	$34,980,659	($22,674,568)

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

As part of this request, the Department would enroll clients whose expenses are paid for from the Health Care Expansion Fund. In table 2.6, the Department estimates that this request will require an additional $62,154 from the Health Care Expansion Fund for the incremental costs associated with this program. However, the Health Care Expansion Fund is projected to exceed be insolvent in FY 2011-12. As a result, the Department has requested the necessary $62,154 as General Fund in FY 2011-12.

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.

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

FY 2009-10 Cost Benefit Analysis	Costs	Benefits
Request	There is no FY 2009-10 cost.	This request is a reduction of $677,636 total funds and a reduction of $200,659 General Fund in deferred administrative costs. In addition to the financial benefits, this request would serve to provide clients with a more integrated system of care, which likely will generate additional cost savings in the future by preventing unnecessary health care costs in the long term.
Consequences if not Funded	If this request is not approved, the Department will revert the funding that is currently appropriated for the identified tasks.	No benefits.

FY 2010-11 Cost Benefit Analysis	Costs	Benefits
Request	This request includes an increase to certain line items in the Executive Director's Office Long Bill Group of $193,731 total funds, $57,364 General Fund. Overall, the request includes $1,089,747 total funds in its Executive Director's Office Long Bill Group for program implementation. The request also includes $3,341,132 total funds in its Medical Services Premiums Long Bill Group expenditure for program operations.	This request is an overall reduction of $778,311 total funds, $385,541 General Fund as compared to the currently appropriated funds for this program. In total, the request is a net reduction of $584,580 total funds, $328,177 General Fund. Overall, the request includes an estimated gross reduction in expenditure of $5,975,697 in FY 2010-11 due to avoided medical service costs. This yields a net savings of $1,544,818 total funds over implementation and operational expenditure in FY 2010-11. In addition to the financial benefits, this request would serve to provide clients with a more integrated system of care, which likely will generate additional cost savings in the future by preventing unnecessary health care costs in the long term.
Consequences if not Funded	If this request is not approved, the Department will not have the required funding for necessary system changes to implement the Accountable Care Collaborative. The Department would not realize the cost savings that are included in its FY 2010-11 base, and would require an additional appropriation to backfill the difference.	No benefits.

FY 2011-12 Cost Benefit Analysis	Costs	Benefits
Request	The request includes $980,801 total funds in its Executive Director's Office Long Bill Group for program implementation. The request also includes $13,871,348 total funds in its Medical Services Premiums Long Bill Group expenditure for program operations.	The request includes an estimated gross reduction in expenditure of $27,916,145 in FY 2011-12 due to avoided medical service costs. This yields a net savings of $12,103,758 total funds over implementation and operational expenditure in FY 2011-12. In addition to the financial benefits, this request would serve to provide clients with a more integrated system of care, which likely will generate additional cost savings in the future by preventing unnecessary health care costs in the long term.
Consequences if not Funded	If this request is not approved, the Department will not have the required funding for necessary system changes to implement the Accountable Care Collaborative. The Department would not realize the cost savings that are included in its FY 2010-11 base, and would require an additional appropriation to backfill the difference.	No benefits.

Implementation Schedule:

Task	**Month/Year**
RFPs Written	December 2009
RFPs Issued	March 2010
System Modifications Made	January 2010 – October 2010
RFPs Awarded	August 2010
Contracts or MOUs Written	September 2010
Passive Enrollment Begins	October 2010
First Clients Enrolled	November 2010

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2009). 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. (2009). 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 1.1
Summary of Total Funds Expenditure by Function [1]

Row	Line Item	FY 2009-10	FY 2010-11	FY 2011-12	Source
	(1) Executive Director's Office				
A	Ombudsman	$0	$8,400	$45,000	Table 8.1
B	Medicaid Management Information System	$505,764	$158,004	$0	Table 8.1
C	Enrollment Broker	$0	$568,343	$617,401	Table 7.1
D	External Quality Review Activities	$0	$355,000	$355,000	Table 8.1
E	*Subtotal Executive Director's Office*	*$505,764*	*$1,089,747*	*$1,017,401*	
	(2) Medical Services Premiums				
F	Monthly Management Fees	$0	$3,341,132	$13,871,348	Table 4.1
G	Savings	$0	($5,975,697)	($27,916,145)	Table 5.1
H	*Subtotal Medical Services Premiums*	*$0*	*($2,634,565)*	*($14,044,797)*	
I	**ARRA Impacts**	$0	$0	$0	
J	**Grand Total**	**$505,764**	**($1,544,818)**	**($13,027,396)**	

[1] This table represents the total cost of the initiative and not the incremental cost as compared to other related and previous Department requests; this table will not match the Schedule 13. The incremental costs are presented in Tables 1.2 and 1.3, below (in aggregate), and in tables 2.4, 2.5, and 2.6 (with fund splits).

Table 1.2
Summary of FY 2009-10 Incremental Total Funds Request by Function

Row	Line Item	Appropriation to Date	Supplemental Total	Incremental Change	Source [1]
	(1) Executive Director's Office				
A	Ombudsman	$0	$0	$0	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
B	Actuarial Services	$125,000	$0	($125,000)	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
C	Medicaid Management Information System	$1,058,400	$505,764	($552,636)	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
D	Enrollment Broker	$0	$0	$0	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
E	External Quality Review Organization	$0	$0	$0	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
F	*Subtotal Executive Director's Office*	*$1,183,400*	*$505,764*	*($677,636)*	
	(2) Medical Services Premiums				
G	Monthly Management Fees	$0	$0	$0	November 6, 2009, FY 2010-11 Budget Request DI-1, exhibit F.
H	Savings	$0	$0	$0	November 6, 2009, FY 2010-11 Budget Request DI-1, exhibit F.
I	*Subtotal Medical Services Premiums*	*$0*	*$0*	*$0*	
J	ARRA Impacts	$0	$0	$0	
K	**Grand Total**	**$1,183,400**	**$505,764**	**($677,636)**	

[1] The Department has included annualizations of Accountable Care Collaborative in both its Executive Director's Office and Medical Services Premiums November 6, 2009 Requests; so as to avoid double counting, this supplemental builds off of the already requested annualizations. Information is pulled from Table 1.1 of this request and the sources listed.

Table 1.3
Summary of FY 2010-11 Incremental Total Funds Request by Function

Row	Line Item	Request to Date	Total Revised Request	Incremental Change	Source [1]
	(1) Executive Director's Office				
A	Ombudsman	$0	$8,400	$8,400	November 6, 2009, FY 2010-11 Budget Request Line Item Description, page H-3.
B	Actuarial Services	$125,000	$0	($125,000)	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
C	Medicaid Management Information System	$0	$158,004	$158,004	November 6, 2009, FY 2010-11 Budget Request Line Item Description, page H-25.
D	Enrollment Broker	$541,016	$568,343	$27,327	DI-6, November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66.
E	External Quality Review Organization	$604,780	$355,000	($249,780)	November 6, 2009, FY 2010-11 Budget Request Line Item Description, page H-46.
F	*Subtotal Executive Director's Office*	*$1,270,796*	*$1,089,747*	*($181,049)*	
	(2) Medical Services Premiums				
G	Monthly Management Fees	$12,425,340	$3,341,132	($9,084,208)	November 6, 2009, FY 2010-11 Budget Request DI-1, exhibit F.
H	Savings	($14,656,374)	($5,975,697)	$8,680,677	November 6, 2009, FY 2010-11 Budget Request DI-1, exhibit F.
I	*Subtotal Medical Services Premiums*	*($2,231,034)*	*($2,634,565)*	*($403,531)*	
J	ARRA Impacts	$0	$0	$0	
K	**Grand Total**	**($960,238)**	**($1,544,818)**	**($584,580)**	

[1] The Department has included annualizations of Accountable Care Collaborative in both its Executive Director's Office and Medical Services Premiums November 6, 2009 Requests; so as to avoid double counting, this supplemental builds off of the already requested annualizations. Information is pulled from Table 1.1 of this request and the sources listed.

Table 1.4
Summary of FY 2011-12 Incremental Total Funds Request by Function

Row	Line Item	FY 2010-11 Base	Annualized FY 2011-12	Incremental Change	Source
	(1) Executive Director's Office				
A	Ombudsman	$0	$45,000	$45,000	Table 1.3
B	Actuarial Services	$125,000	$0	($125,000)	Table 1.3
C	Medicaid Management Information System	$0	$0	$0	Table 1.3
D	Enrollment Broker	$541,016	$617,401	$76,385	Table 1.3
E	External Quality Review Organization	$604,780	$355,000	($249,780)	Table 1.3
F	*Subtotal Executive Director's Office*	*$1,270,796*	*$1,017,401*	*($253,395)*	
	(2) Medical Services Premiums				
G	PCCM Monthly Management Fees	$12,425,340	$13,871,348	$1,446,008	Table 1.3
H	Savings	($14,656,374)	($27,916,145)	($13,259,771)	Table 1.3
I	*Subtotal Medical Services Premiums*	*($2,231,034)*	*($14,044,797)*	*($11,813,763)*	
J	ARRA Impacts	$0	$0	$0	
K	**Grand Total**	**($960,238)**	**($13,027,396)**	**($12,067,158)**	

Table 2.1
FY 2009-10 Total Program 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	Ombudsman	$0	0.0	$0	$0	$0	50%
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$505,764	0.0	$126,441	$0	$379,323	75%
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$0	0.0	$0	$0	$0	50%
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Activites	$0	0.0	$0	$0	$0	75%
(2) Medical Services Premiums	HDIO, RCCO, PCMP, Incentives, Service Savings	$0	0.0	$0	$0	$0	50%
ARRA Impacts	Services	$0	0.0	$0	$0	$0	11.59%
Grand Total		**$505,764**	**0.0**	**$126,441**	**$0**	**$379,323**	

Cash Funds: Health Care Expansion Fund

*The External Quality Review Organization receives a 75% federal match; the Health Data and Information Organizaiton receives a 50% federal match.

Table 2.2
FY 2010-11 Total Program 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	Ombudsman	$8,400	0.0	$4,200	$0	$4,200	50%
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$158,004	0.0	$39,501	$0	$118,503	75%
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$568,343	0.0	$284,171	$0	$284,172	50%
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Activities	$355,000	0.0	$88,750	$0	$266,250	75%
(2) Medical Services Premiums	HDIO, RCCO, PCMP, Incentives, Service Savings	($2,634,565)	0.0	($1,293,178)	($24,104)	($1,317,283)	50%
ARRA Impacts	Services	$0	0.0	$169,978	$3,168	($173,146)	5.80%
Grand Total		**($1,544,818)**	**0.0**	**($706,578)**	**($20,936)**	**($817,304)**	

Cash Funds: Health Care Expansion Fund

Table 2.3
FY 2011-12 Total Program 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	Ombudsman	$45,000	0.0	$22,500	$0	$22,500	50%
(A) General Administration General Professional Services and Special Projects	Actuarial Services	$0	0.0	$0	$0	$0	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	$617,401	0.0	$308,700	$0	$308,701	50%
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Activities, Health Data and Information Organization	$355,000	0.0	$88,750	$0	$266,250	75%
(2) Medical Services Premiums	HDIO, RCCO, PCMP, Incentives, Service Savings	($14,044,797)	0.0	($7,046,188)	$23,790	($7,022,399)	50%
Grand Total		**($13,027,396)**	**0.0**	**($6,626,238)**	**$23,790**	**($6,424,948)**	

Cash Funds: Health Care Expansion Fund

Table 2.4
FY 2009-10 Incremental Request 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	Ombudsman	$0	0.0	$0	$0	$0	50%
Appropriation to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$0**	**0.0**	**$0**	**$0**	**$0**	
(A) General Administration General Professional Services and Special Projects	Actuarial Services	$0	0.0	$0	$0	$0	50%
Appropriation to Date		*$125,000*	*0.0*	*$62,500*	*$0*	*$62,500*	
Incremental Request		**($125,000)**	**0.0**	**($62,500)**	**$0**	**($62,500)**	
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$505,764	0.0	$126,441	$0	$379,323	75%
Appropriation to Date		*$1,058,400*	*0.0*	*$264,600*	*$0*	*$793,800*	
Incremental Request		**($552,636)**	**0.0**	**($138,159)**	**$0**	**($414,477)**	
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$0	0.0	$0	$0	$0	50%
Appropriation to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$0**	**0.0**	**$0**	**$0**	**$0**	
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Activities	$0	0.0	$0	$0	$0	75%
Appropriation to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$0**	**0.0**	**$0**	**$0**	**$0**	
(2) Medical Services Premiums	HDIO, RCCO, PCMP, Incentives, Service Savings	$0	0.0	$0	$0	$0	50%
Appropriation to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$0**	**0.0**	**$0**	**$0**	**$0**	
Incremental Request Total		**($677,636)**	**0.0**	**($200,659)**	**$0**	**($476,977)**	
ARRA Impacts	Medical Services Premiums	$0	-	$0	$0	$0	11.59%
Appropriation to Date		*$0*	-	*$0*	*$0*	*$0*	
Incremental Request		**$0**	**-**	**$0**	**$0**	**$0**	
Grand Total, Incremental Request		**($677,636)**	**0.0**	**($200,659)**	**$0**	**($476,977)**	

Cash Funds: Health Care Expansion Fund

The American Recovery and Reinvestment Act (ARRA) only impacts the Medical Services Permiums line of this request.

Table 2.5
FY 2010-11 Incremental Request 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	Ombudsman	$8,400	0.0	$4,200	$0	$4,200	50%
Request to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$8,400**	**0.0**	**$4,200**	**$0**	**$4,200**	
(A) General Administration General Professional Services and Special Projects	Actuarial Services	$0	0.0	$0	$0	$0	50%
Request to Date		*$125,000*	*0.0*	*$62,500*	*$0*	*$62,500*	
Incremental Request		**($125,000)**	**0.0**	**($62,500)**	**$0**	**($62,500)**	
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$158,004	0.0	$39,501	$0	$118,503	75%
Request to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$158,004**	**0.0**	**$39,501**	**$0**	**$118,503**	
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$568,343	0.0	$284,171	$0	$284,172	50%
Request to Date		*$541,016*	*0.0*	*$270,508*	*$0*	*$270,508*	
Incremental Request		**$27,327**	**0.0**	**$13,663**	**$0**	**$13,664**	
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Activities	$355,000	0.0	$88,750	$0	$266,250	75%
Request to Date		*$604,780*	*0.0*	*$302,390*	*$0*	*$302,390*	
Incremental Request		**($249,780)**	**0.0**	**($213,640)**	**$0**	**($36,140)**	
(2) Medical Services Premiums	HDIO, RCCO, PCMP, Incentives, Service Savings	($2,634,565)	0.0	($1,293,178)	($24,104)	($1,317,283)	50%
Request to Date		*($2,231,034)*	*0.0*	*($1,077,153)*	*($38,364)*	*($1,115,517)*	
Incremental Request		**($403,531)**	**0.0**	**($216,025)**	**$14,260**	**($201,766)**	
Incremental Request Total		**($584,580)**	**0.0**	**($434,801)**	**$14,260**	**($164,039)**	
ARRA Impacts	Medical Services Premiums	$0	-	$169,978	$3,168	($173,146)	5.80%
Request to Date		*$0*	-	*$63,354*	*$1,980*	*($65,334)*	
Incremental Request		**$0**	**-**	**$106,624**	**$1,188**	**($107,812)**	
Grand Total, Incremental Request		**($584,580)**	**0.0**	**($328,177)**	**$15,448**	**($271,851)**	

Cash Funds: Health Care Expansion Fund

The American Recovery and Reinvestment Act (ARRA) increases federal match by 11.59% for half of the fiscal year, or a 5.80% annualized increase.

Table 2.6
FY 2011-12 Incremental Request Fund Splits (Change from FY 2010-11 Base)

Line Item	Area	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP Rate
(1) Executive Director's Office							
(A) General Administration Personal Services	Ombudsman	$45,000	0.0	$22,500	$0	$22,500	50%
Request to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$45,000**	**0.0**	**$22,500**	**$0**	**$22,500**	
(A) General Administration General Professional Services and Special Projects	Actuarial Services	$0	0.0	$0	$0	$0	50%
Request to Date		*$125,000*	*0.0*	*$62,500*	*$0*	*$62,500*	
Incremental Request		**($125,000)**	**0.0**	**($62,500)**	**$0**	**($62,500)**	
(C) Information Technology Contracts and Projects Information Technology Contracts	Medicaid Management Information System	$0	0.0	$0	$0	$0	75%
Request to Date		*$0*	*0.0*	*$0*	*$0*	*$0*	
Incremental Request		**$0**	**0.0**	**$0**	**$0**	**$0**	
(D) Eligibility Determination and Client Services Customer Outreach	Enrollment Broker	$617,401	0.0	$308,700	$0	$308,701	50%
Request to Date		*$541,016*	*0.0*	*$270,508*	*$0*	*$270,508*	
Incremental Request		**$76,385**	**0.0**	**$38,192**	**$0**	**$38,193**	
(E) Utilization and Quality Review Contracts Professional Services Contracts	External Quality Review Activities	$355,000	0.0	$88,750	$0	$266,250	75%
Request to Date		*$604,780*	*0.0*	*$302,390*	*$0*	*$302,390*	
Incremental Request		**($249,780)**	**0.0**	**($213,640)**	**$0**	**($36,140)**	
(2) Medical Services Premiums	HDIO, RCCO, PCMP, Incentives, Service Savings	($14,044,797)	0.0	($7,046,188)	$23,790	($7,022,399)	50%
Request to Date		*($2,231,034)*	*0.0*	*($1,077,153)*	*($38,364)*	*($1,115,517)*	
Incremental Request		**($11,813,763)**	**0.0**	**($5,969,035)**	**$62,154**	**($5,906,882)**	
Incremental Request Total		**($12,067,158)**	**0.0**	**($6,184,483)**	**$62,154**	**($5,944,829)**	

Cash Funds: Health Care Expansion Fund

The American Recovery and Reinvestment Act (ARRA) is currently scheduled to expire Dec 31, 2010.

Table 3.1
Monthly Program Enrollment

	Adults 65 and Older (OAP-A) [1]	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	-	6,837	52,711	59,581	29,636	424	277,805	18,715	7,448	453,157
Fraction of Total	0.00%	1.51%	11.63%	13.15%	6.54%	0.09%	61.30%	4.13%	1.64%	100.00%
Estimated Monthly Attrition	-	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Monthly Program Enrollment										
July 2010	-	-	-	-	-	-	-	-	-	-
August 2010	-	-	-	-	-	-	-	-	-	-
September 2010	-	-	-	-	-	-	-	-	-	-
October 2010	-	-	-	-	-	-	-	-	-	-
November 2010	-	30	232	263	131	2	1,226	83	33	2,000
December 2010	-	89	685	773	385	5	3,604	243	96	5,880
January 2011	-	174	1,342	1,516	754	10	7,066	476	189	11,527
February 2011	-	284	2,192	2,477	1,232	17	11,546	778	309	18,835
March 2011	-	418	3,226	3,643	1,812	25	16,983	1,144	454	27,705
April 2011	-	626	4,826	5,451	2,711	37	20,000	1,712	680	36,043
May 2011	-	932	7,181	8,114	4,036	56	20,000	2,548	1,013	43,880
June 2011	-	1,219	9,396	10,617	5,281	74	20,000	3,334	1,326	51,247
FY 2010-11 Total	**-**	**3,772**	**29,080**	**32,854**	**16,342**	**226**	**100,425**	**10,318**	**4,100**	**197,117**
July 2011	-	1,489	11,478	12,971	6,451	90	20,000	4,073	1,620	58,172
August 2011	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
September 2011	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
October 2011	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
November 2011	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
December 2011	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
January 2012	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
February 2012	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
March 2012	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
April 2012	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
May 2012	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
June 2012	-	1,560	12,029	13,592	6,760	94	20,000	4,268	1,697	60,000
FY 2011-12 Total	**-**	**18,649**	**143,797**	**162,483**	**80,811**	**1,124**	**240,000**	**51,021**	**20,287**	**718,172**

[1] Adults 65 and Older as assumed to be dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations.

Table 4.1
Monthly Per Member Per Month Cost by Fiscal Year

	Adults 65 and Older (OAP-A) [1]	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) [2]	Foster Care	Baby Care Program-Adults	Total
Estimated FY 2010-11 Incentive Expenditure	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2010-11 PMPM Administrative Expenditure [3]	$0	$63,936	$492,906	$556,874	$276,995	$3,831	$1,702,205	$174,890	$69,495	$3,341,132
Total Estimated FY 2010-11 PMPM Expenditure	$0	$63,936	$492,906	$556,874	$276,995	$3,831	$1,702,205	$174,890	$69,495	$3,341,132
Estimated FY 2011-12 Incentive Expenditure	$0	$30,308	$233,674	$264,022	$131,318	$1,822	$592,040	$82,910	$32,958	$1,369,052
Estimated FY 2011-12 PMPM Administrative Expenditure [3]	$0	$335,682	$2,588,346	$2,924,694	$1,454,598	$20,232	$3,895,200	$918,378	$365,166	$12,502,296
Total Estimated FY 2011-12 PMPM Expenditure	$0	$365,990	$2,822,020	$3,188,716	$1,585,916	$22,054	$4,487,240	$1,001,288	$398,124	$13,871,348

[1] Adults 65 and Older as assumed to be dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations.

[2] Children will simultaneously be enrolled in the Medical Home program, which reimburses physicians for providing similar services. Approximately 59.03% of Medicaid Children are currently enrolled in the Medical Home program. This request has reduced the amount of PMPM provided for children by the $3 applied per child in the medical home program to avoid double payments to Medical Home providers.

[3] The Department assumes expenditure related to RCCO and HDIO activities will not be eligible for American Recovery and Reinvestment Act enhanced federal funding.

Table 4.2
Monthly Per Member Per Month Administration Cost [1]

	Adults 65 and Older (OAP-A) [2]	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) [3]	Foster Care	Baby Care Program-Adults	Total
Estimated Per Member Per Month Administration Cost	$0.00	$16.95	$16.95	$16.95	$16.95	$16.95	$16.95	$16.95	$16.95	
Estimated Monthly Administration Cost										
July 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
August 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
September 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
October 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
November 2010	$0	$509	$3,932	$4,458	$2,220	$34	$20,781	$1,407	$559	$33,900
December 2010	$0	$1,509	$11,611	$13,102	$6,526	$85	$61,088	$4,119	$1,627	$99,667
January 2011	$0	$2,949	$22,747	$25,696	$12,780	$170	$119,769	$8,068	$3,204	$195,383
February 2011	$0	$4,814	$37,154	$41,985	$20,882	$288	$195,705	$13,187	$5,238	$319,253
March 2011	$0	$7,085	$54,681	$61,749	$30,713	$424	$287,862	$19,391	$7,695	$469,600
April 2011	$0	$10,611	$81,801	$92,394	$45,951	$627	$339,000	$29,018	$11,526	$610,928
May 2011	$0	$15,797	$121,718	$137,532	$68,410	$949	$339,000	$43,189	$17,170	$743,765
June 2011	$0	$20,662	$159,262	$179,958	$89,513	$1,254	$339,000	$56,511	$22,476	$868,636
FY 2010-11 Total	**$0**	**$63,936**	**$492,906**	**$556,874**	**$276,995**	**$3,831**	**$1,702,205**	**$174,890**	**$69,495**	**$3,341,132**
Estimated Per Member Per Month Administration Cost	$0.00	$18.00	$18.00	$18.00	$18.00	$18.00	$16.23	$18.00	$18.00	
Estimated Monthly Administration Cost										
July 2011	$0	$26,802	$206,604	$233,478	$116,118	$1,620	$324,600	$73,314	$29,160	$1,011,696
August 2011	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
September 2011	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
October 2011	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
November 2011	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
December 2011	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
January 2012	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
February 2012	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
March 2012	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
April 2012	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
May 2012	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
June 2012	$0	$28,080	$216,522	$244,656	$121,680	$1,692	$324,600	$76,824	$30,546	$1,044,600
FY 2011-12 Total	**$0**	**$335,682**	**$2,588,346**	**$2,924,694**	**$1,454,598**	**$20,232**	**$3,895,200**	**$918,378**	**$365,166**	**$12,502,296**

[1] The Department assumes expenditure related to RCCO activities will not be eligible for American Recovery and Reinvestment Act enhanced federal funding.

[2] Adults 65 and Older as assumed to be dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations.

[3] Children will simultaneously be enrolled in the Medical Home program, which reimburses physicians for providing similar services. This request has reduced the ammount of PMPM provided for children in the second year avoid double payments to Medical Home providers.

Table 4.3
Monthly Incentive Cost

	Adults 65 and Older (OAP-A) [1]	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 Cost	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
Estimated Monthly Administration Cost										
July 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
August 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
September 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
October 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
November 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
December 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
January 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
February 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
March 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
April 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
May 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
June 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2010-11 Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated Per Member Per Month Administration Cost	$0.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	
Estimated Monthly Administration Cost										
July 2011	$0	$1,752	$13,520	$15,272	$7,596	$104	$71,190	$4,796	$1,904	$116,134
August 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
September 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
October 2011	$0	$5,554	$42,806	$48,364	$24,056	$334	$120,000	$15,188	$6,038	$262,340
November 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
December 2011	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
January 2012	$0	$13,642	$105,174	$118,834	$59,106	$820	$280,850	$37,318	$14,834	$630,578
February 2012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
March 2012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
April 2012	$0	$9,360	$72,174	$81,552	$40,560	$564	$120,000	$25,608	$10,182	$360,000
May 2012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
June 2012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12 Total	**$0**	**$30,308**	**$233,674**	**$264,022**	**$131,318**	**$1,822**	**$592,040**	**$82,910**	**$32,958**	**$1,369,052**

[1] Adults 65 and Older as assumed to be dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations.

Table 5.1
Per Capita Savings

Estimated Per Capita Savings	Adults 65 and Older (OAP-A) [1]	Disabled Adults 60 to 64 (OAP-B) [2]	Disabled Individuals to 59 (AND/AB) [2]	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	$2,644.42	$12,106.76	$13,952.90	$3,775.72	$2,604.67	$21,575.81	$1,672.73	$3,391.62	$8,644.44	-
Estimated Savings Percent	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-
Estimated FY 2009-10 Monthly Reduction to Expenditure	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-
Estimated FY 2010-11 Per Capita Cost	$2,758.27	$12,957.39	$14,858.15	$3,763.81	$2,739.53	$22,045.80	$1,673.03	$3,552.14	$9,105.14	-
Estimated Savings Percent	0.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	-
Estimated FY 2010-11 Monthly Reduction to Expenditure	$0.00	($86.38)	($99.05)	($25.09)	($18.26)	($146.97)	($11.15)	($23.68)	($60.70)	-
Estimated FY 2011-12 Per Capita Cost	$2,877.00	$13,868.00	$15,822.00	$3,752.00	$2,881.00	$22,526.00	$1,673.00	$3,720.00	$9,590.00	-
Estimated Savings Percent	0.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	-
Estimated FY 2011-12 Monthly Reduction to Expenditure	$0.00	($92.45)	($105.48)	($25.01)	($19.21)	($150.17)	($11.15)	($24.80)	($63.93)	-

Table 5.2
Estimated Monthly Program Savings

Estimated Monthly Program Savings	Adults 65 and Older (OAP-A) [1]	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
July 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
August 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
September 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
October 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
November 2010	$0	($2,591)	($22,981)	($6,599)	($2,393)	($294)	($13,674)	($1,966)	($2,003)	($52,501)
December 2010	$0	($7,688)	($67,852)	($19,396)	($7,031)	($735)	($40,197)	($5,754)	($5,827)	($154,480)
January 2011	$0	($15,031)	($132,931)	($38,040)	($13,771)	($1,470)	($78,811)	($11,272)	($11,472)	($302,798)
February 2011	$0	($24,533)	($217,127)	($62,153)	($22,501)	($2,499)	($128,779)	($18,424)	($18,757)	($494,773)
March 2011	$0	($36,108)	($319,549)	($91,410)	($33,094)	($3,674)	($189,420)	($27,091)	($27,558)	($727,904)
April 2011	$0	($54,076)	($478,036)	($136,777)	($49,512)	($5,438)	($223,071)	($40,542)	($41,277)	($1,028,729)
May 2011	$0	($80,509)	($711,309)	($203,597)	($73,712)	($8,230)	($223,071)	($60,339)	($61,490)	($1,422,257)
June 2011	$0	($105,300)	($930,715)	($266,402)	($96,450)	($10,876)	($223,071)	($78,952)	($80,489)	($1,792,255)
FY 2010-11 Total	**$0**	**($325,836)**	**($2,880,500)**	**($824,374)**	**($298,464)**	**($33,216)**	**($1,120,094)**	**($244,340)**	**($248,873)**	**($5,975,697)**
July 2011	$0	($137,663)	($1,210,699)	($324,448)	($123,902)	($13,516)	($223,067)	($101,010)	($103,572)	($2,237,877)
August 2011	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
September 2011	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
October 2011	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
November 2011	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
December 2011	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
January 2012	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
February 2012	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
March 2012	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
April 2012	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
May 2012	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
June 2012	$0	($144,227)	($1,268,819)	($339,981)	($129,837)	($14,116)	($223,067)	($105,846)	($108,495)	($2,334,388)
FY 2011-12 Total	**$0**	**($1,724,160)**	**($15,167,708)**	**($4,064,239)**	**($1,552,109)**	**($168,792)**	**($2,676,804)**	**($1,265,316)**	**($1,297,017)**	**($27,916,145)**

[1] Adults 65 and Older as assumed to be dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations.

[2] Disabled Adults 60 to 64 and Disabled Individuals to 59 have some proprotion of clients who are dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations. The per capita presented is an estimate removing dual-eligible expenditure and therefore will not match other budget request documents submitted by the Department. All other per capita estimates are drawn from the Department's November 6, 2009 Request, Exhibit F.

Table 6.1
Net Costs (Savings)

Net Costs (Savings)	Adults 65 and Older (OAP-A) [1]	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
July 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
August 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
September 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
October 2010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
November 2010	$0	($2,082)	($19,049)	($2,141)	($173)	($260)	$7,107	($559)	($1,444)	($18,601)
December 2010	$0	($6,179)	($56,241)	($6,294)	($505)	($650)	$20,891	($1,635)	($4,200)	($54,813)
January 2011	$0	($12,082)	($110,184)	($12,344)	($991)	($1,300)	$40,958	($3,204)	($8,268)	($107,415)
February 2011	$0	($19,719)	($179,973)	($20,168)	($1,619)	($2,211)	$66,926	($5,237)	($13,519)	($175,520)
March 2011	$0	($29,023)	($264,868)	($29,661)	($2,381)	($3,250)	$98,442	($7,700)	($19,863)	($258,304)
April 2011	$0	($43,465)	($396,235)	($44,383)	($3,561)	($4,811)	$115,929	($11,524)	($29,751)	($417,801)
May 2011	$0	($64,712)	($589,591)	($66,065)	($5,302)	($7,281)	$115,929	($17,150)	($44,320)	($678,492)
June 2011	$0	($84,638)	($771,453)	($86,444)	($6,937)	($9,622)	$115,929	($22,441)	($58,013)	($923,619)
FY 2010-11 Total	**$0**	**($261,900)**	**($2,387,594)**	**($267,500)**	**($21,469)**	**($29,385)**	**$582,111**	**($69,450)**	**($179,378)**	**($2,634,565)**
July 2011	$0	($109,109)	($990,575)	($75,698)	($188)	($11,792)	$172,723	($22,900)	($72,508)	($1,110,047)
August 2011	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
September 2011	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
October 2011	$0	($110,593)	($1,009,491)	($46,961)	$15,899	($12,090)	$221,533	($13,834)	($71,911)	($1,027,448)
November 2011	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
December 2011	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
January 2012	$0	($102,505)	($947,123)	$23,509	$50,949	($11,604)	$382,383	$8,296	($63,115)	($659,210)
February 2012	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
March 2012	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
April 2012	$0	($106,787)	($980,123)	($13,773)	$32,403	($11,860)	$221,533	($3,414)	($67,767)	($929,788)
May 2012	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
June 2012	$0	($116,147)	($1,052,297)	($95,325)	($8,157)	($12,424)	$101,533	($29,022)	($77,949)	($1,289,788)
FY 2011-12 Total	**$0**	**($1,358,170)**	**($12,345,688)**	**($875,523)**	**$33,807**	**($146,738)**	**$1,810,436**	**($264,028)**	**($898,893)**	**($14,044,797)**

[1] Adults 65 and Older as assumed to be dual-eligibiles, receiving Medicare along with Medicaid services. The Department's proposal initially targets non-dual eligible populations.

Table 7.1
Summary of Enrollment Broker Costs

Row	Summary	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Design, Production and Mailing of Passive Enrollment	$0	$500,000	$410,540	Table 2, Row E
B	Quality Report Card Mailing	$0	$34,849	$61,200	Table 2, Row G
C	Maximus Customer Service Staff	$0	$25,333	$137,500	Table 2, Row O
D	Adding Current Passive Enrollment Activities to Enrollment Broker	$0	$8,161	$8,161	Table 2, Row W
E	**Total Increase to Enrollment Broker**	**$0**	**$568,343**	**$617,401**	

Table 7.2
Itemized Enrollment Broker Costs

Row	Enrollment Packets and Member Handbooks	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Design and Development of Member Handbooks	$0	$20,000	$0	Assumed.
B	Enrolled Clients Per Month	0	7,500	4,276	Assumed, based on capped enrollment.
C	Cost Per Enrollment Packet	$8.00	$8.00	$8.00	Based on current cost
D	Months in Operation	-	8	12	Assumed
E	**Total Cost**	**$0**	**$500,000**	**$410,540**	Row A + (Row B * Row C * Row D)

Row	Quality Report Card Mailing	FY 2009-10	FY 2010-11	FY 2011-12	Source
E	Total Enrolled Clients (Eligible for Mailing)	-	34,166	60,000	Table 3.1 (Total enrollment)[(1)]
F	Cost Per Quality Report Card Mailing	$1.02	$1.02	$1.02	Based on current cost
G	**Total Cost**	**$0**	**$34,849**	**$61,200**	Row E * Row F

Row	Enrollment Broker Customer Service Staff	FY 2009-10	FY 2010-11	FY 2011-12	Source
H	Average Monthly Enrollment	-	16,426	59,848	Table 3.1 (Annual average)
I	Number of Calls Per Enrolled Client	0.58	0.58	0.58	Based on current contract data
J	Estimated Number of Customer Service Calls	-	9,527	34,712	Row H * Row I
K	Number of Calls Per Contractor Customer Service Agent	12,600	12,600	12,600	Based on current contract data
L	Estimated Number of Required Contractor Staff	0	0.76	2.75	Row J / Row K
M	Cost Per Customer Service Contractor Staff	$50,000	$50,000	$50,000	Based on estimates from current contractor.
N	Percentage of Year in Operation	0%	67%	100%	Assumed
O	**Total Cost**	**$0**	**$25,333**	**$137,500**	Row L * Row M * Row N

Row	Adding Current Passive Enrollment Activities to Enrollment Broker	FY 2009-10	FY 2010-11	FY 2011-12	Source
P	Number of Passive Enrollment Packets Funded by Current Managed Care Plans	26,000	26,000	26,000	Based on current enrollment.
Q	Base Cost Per Packet	$0.00	$0.00	$0.00	Based on current contract data
R	Base Cost of Mailing	$0	$0	$0	Row P * Row Q
S	Percent of Population Receiving EPSDT Material	0%	43%	43%	Based on current contract data
T	Population Receiving EPSDT Material	-	11,180	11,180	Row P * Row S
U	Incremental Cost of EPSDT Mailing	$0.73	$0.73	$0.73	Based on current contract data
V	Additional Cost for EPSDT Mailings	$0	$8,161	$8,161	Row T * Row U
W	**Total Cost**	**$0**	**$8,161**	**$8,161**	Row R + Row V

[1] Because quality report cards are sent on the client's birthday, in FY 2010-11, only 66.67% of enrolled clients will receive a report card.

Table 8.1
Other Administration Costs

Row	Summary	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Medicaid Management Information System	$505,764	$158,004	$0	Table 8.2, Row D
B	Ombudsman	$0	$8,400	$45,000	Table 8.3, Row F
C	Quality Review	$0	$355,000	$355,000	Assumed, see narrative.
D	**Total Other Administration**	**$505,764**	**$521,404**	**$400,000**	

Table 8.2
Medicaid Management Information System

Row	Item	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Information Sharing Capabilities	$189,630	$0	$0	Development hours: 1,505
B	Passive Enrollment System Enhancements	$316,134	$0	$0	Development hours: 2,509
C	Managed Care System Enhancements	$0	$158,004	$0	Development hours: 1,254
D	**Total Cost**	**$505,764**	**$158,004**	**$0**	

Note: Development costs assume $126 per hour.

Table 8.3
Ombudsman

Row	Item	FY 2009-10	FY 2010-11	FY 2011-12	Source
A	Client-load per Ombudsman	80,000	80,000	80,000	Based on current contract data
B	Average Monthly Caseload	-	16,426	59,848	Table 3.1 (Annual average)
C	Required Ombudsman FTE	-	0.21	0.75	Row B / Row A
D	Cost per Ombudsman	$60,000	$60,000	$60,000	Based on current contract data
E	Percentage of Year in Operation	0%	67%	100%	Assumed
F	**Total Cost**	**$0**	**$8,400**	**$45,000**	Row C * Row D * Row E

Table 9.1: New Letternote Totals for Medical Services Premiums

Cash Funds Report						
Cash Fund	**FY 2009-10**			**FY 2010-11**		
	Spending Authority	**Request**	**Change**	**Spending Authority**	**Request**	**Change**
Health Care Expansion Fund	$82,475,369	$82,475,369	$0	$85,416,768	$85,401,320	$15,448
Total	**$82,475,369**	**$82,475,369**	**$0**	**$85,416,768**	**$85,401,320**	**$15,448**

Revised Letternote Text for FY 2010-11 only

(2) Medical Sevices Premiums (a)

Of this amount, **$85,401,320** shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.; $21,498,147 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program; $784,875 shall be from the Autism Treatment Fund created in Section 25.5-6-805, C.R.S.; $1,725,479 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a), C.R.S.; $27,040,854 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S.; $250,000 shall be from the Coordinated Care for People with Disabilities Fund; and, $212,806,547 shall be from Hospital Provider Fee Cash Fund.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✔	Budget Amendment FY 2010-11 ✔

Request Title: Federally Mandated CHP+ Program Changes
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew **Date:** January 4, 2010
Priority Number: S-7, BA-6 **OSPB Approval:** **Date:** 12-29-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	16,758,109	17,118,312	113,527	17,231,839	14,720,689	0	14,720,689	236,150	14,956,839	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	8,411,762	6,989,092	0	6,989,092	4,384,989	0	4,384,989	74,679	4,459,668	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(193,762)	2,502,059	39,734	2,541,793	2,687,536	0	2,687,536	46,661	2,734,197	0
	CFE/RF	66,563	31,995	0	31,995	25,009	0	25,009	135	25,144	0
	FF	8,473,546	7,595,166	73,793	7,668,959	7,623,155	0	7,623,155	114,675	7,737,830	0
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	Total	513,604	2,500,000	0	2,500,000	0	0	0	46,661	46,661	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	4,525,182	2,500,000	0	2,500,000	0	0	0	46,661	46,661	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(4,011,578)	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(4) Indigent Care Program; Children's Basic Health Plan Administration	Total	6,182,289	5,537,590	113,527	5,651,117	5,306,516	0	5,306,516	132,987	5,439,503	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	2,708,692	2,473,301	39,734	2,513,035	2,383,912	0	2,383,912	46,545	2,430,457	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,473,597	3,064,289	73,793	3,138,082	2,922,604	0	2,922,604	86,442	3,009,046	0

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐	**Base Reduction Item FY 2010-11** ☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☑	
Request Title:	Federally Mandated CHP+ Program Changes			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 4, 2010
Priority Number:	S-7, BA-6	**OSPB Approval:**		**Date:**

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	**Total**	10,062,216	9,080,722	0	9,080,722	9,414,173	0	9,414,173	56,502	9,470,675	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	3,886,580	4,489,092	0	4,489,092	4,384,989	0	4,384,989	28,018	4,413,007	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,109,124	28,758	0	28,758	303,624	0	303,624	116	303,740	0
	CFE/RF	66,563	31,995	0	31,995	25,009	0	25,009	135	25,144	0
	FF	4,999,949	4,530,877	0	4,530,877	4,700,551	0	4,700,551	28,233	4,728,784	0

Non-Line Item Request:	None.
Letternote Revised Text:	a Of this amount, $2,013,770 shall be from the Children's Basic Health Plan Trust Fund and $403,252 shall be from the Health Care Expansion Fund. b Of this amount, $2,020,231 shall be from the Children's Basic Health Plan Trust Fund, $403,252 shall be from the Health Care Expansion Fund, and $6,974 shall be from the Hospital Provider Fee Cash Fund. c Of this amount, $28,940 shall be from the Children's Basic Health Plan Trust Fund and $274,800 shall be from the Hospital Provider Fee Cash Fund.
Cash or Federal Fund Name and COFRS Fund Number:	CF: CBHP Trust Fund 11G; FF: Title XIX, Title XXI
Reappropriated Funds Source, by Department and Line Item Name:	Old Age Pension Fund, Department of Human Services
Approval by OIT?	**Yes:** ☐ **No:** ☐ **N/A:** ☑
Schedule 13s from Affected Departments:	Department of Human Services

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-7, BA-6
Change Request Title:	Federally Mandated CHP+ Program Changes

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☐ Base Reduction Item FY 2010-11
☒ Supplemental Request FY 2009-10
☒ Budget Request Amendment FY 2010-11

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 of Health Care Policy and Financing is requesting $113,527 total funds in FY 2009-10 and $236,150 total funds in FY 2010-11 to implement two federally mandated provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This funding is requested for the purposes of amending its current External Quality Review contract to comply with expanded requirements for managed care quality review in the Children's Basic Health Plan as well as for modifications to the Colorado Benefits Management System to comply with requirements regarding guaranteed coverage of newborns born to mothers enrolled in Medicaid or the Children's Basic Health Plan. There is not annualization into FY 2011-12.

This request also impacts the Department of Human Services due to the cost-sharing agreement between the two State departments for changes to the Colorado Benefits Management System. The Department of Human Services is requesting $150,150 total funds including $65,056 total General Fund in FY 2010-11. This portion of the request does not impact FY 2009-10.

Background and Appropriation History:

The Children's Basic Health Plan, marketed as the Child Health Plan Plus, is a program that provides affordable health insurance to children under the age of 19 in low-income families (up to 205% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration. The federal government originally implemented this program in 1997, giving states an enhanced match on State expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. The Plan also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization.

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) into law. This legislation reauthorized the Children's Health Insurance Program (CHIP). The law provides states with $35 billion over the next four and a half years, funded by a $0.61, per-pack increase in the federal tax on cigarettes and other tobacco products. The legislation increases Colorado's federal funding by 36% to $97.5 million in the 2009 federal fiscal year. The legislation included many provisions which will affect Colorado's Children's Basic Health Plan over the next four years.

Enhanced External Quality Review

Section 403 of CHIPRA applies select Medicaid law (42 U.S.C. 1396u-2 (a)(4),(a)(5), (b), (c), (d), and (e)) regarding managed care quality to CHIP, known in Colorado as the Children's Basic Health Plan. This section includes:

- Requirements for processes for enrollment and termination or change of enrollment, which includes allowing enrollees to terminate or change enrollment for cause at any time or at least once a year;
- Provisions outlining requirements related to information dissemination to enrollees or potential enrollees, which includes ease of understanding and availability of comparative information;

- Beneficiary protections such as coverage of emergency services, established grievance procedures, demonstration of adequate capacity and services, and antidiscrimination;
- Quality assurance standards, including access standards, monitoring procedures, external independent review of managed care activities, protections against fraud and abuse;
- Protections against fraud and abuse; and,
- Use of sanctions by the State to enforce requirements.

Regulations at 42 CFR, Part 438, Subparts D and E show how section 1932(c) of the Social Security Act ("the Act") is applied in Medicaid managed care. Effective July 1, 2009, States contracting with managed care organizations (MCOs) for delivery of care under separate CHIP programs, such as Colorado, must institute such a program for their CHIP-contracting MCOs.

Section 1932(c)(1) of the Act requires each State CHIP program that contracts with MCOs to develop and implement a Quality Assessment and Improvement Strategy. The strategy must address access to care standards, and other measures of care and service related to quality, such as grievance procedures, marketing information standards, monitoring procedures, and a process for periodic revision of the strategy.

Section 1932(c)(2) of the Act requires that a contract between an MCO and a State CHIP program include a mandatory annual external review of the quality of care provided by the MCO. This review must be conducted by a qualified and independent external quality review organization (EQRO), which means that the EQRO may not have a financial relationship with the MCO under review. The results of these reviews must be made public upon request, and must be conducted in accordance with protocols developed by the Centers for Medicare and Medicaid Services (CMS). The State must ensure that the EQRO produces a detailed technical report that describes the manner in which the data from all activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to the care furnished by the MCO.

External quality reviews shall include, at a minimum, three specific quality improvement activities for each MCO external quality review:

- Validation of performance measures reported by the MCO;
- Validation of performance improvement projects conducted by the MCO; and,
- Overall assessment of compliance by the MCO with the quality standards outlined in the State's quality strategy.

There are also five optional external quality review activities:

- Validation of MCO Encounter data;
- Administration of State-run patient satisfaction surveys;
- Calculation of State-established performance measures;
- Management of State-directed PIPs; and,
- Administration of focused studies.

Each of these eight activities, together with assessment of information systems, must have a governing protocol as required by 1932(c)(2)(a)(iii), which are used by EQROs for the external quality review of MCOs serving Medicaid beneficiaries. It should be noted that Section 401(c)(1) of CHIPRA requires each State to complete an annual report on its child health quality measures and other State-specific information, including information collected through external quality reviews. Beginning in 2010, the Secretary will analyze and publish information from these annual reports. In addition to the inclusion of external quality review information in CHIP annual reports, this information will be part of the Secretary's annual report to Congress on children's health care quality issues.

General Description of Request:

This request is for funding in FY 2009-10 and FY 2010-11 to implement two provisions of CHIPRA. First, the Department is requesting funding to amend its current External Quality Review contract to comply with expanded requirements for managed care quality review in the Children's Basic Health Plan. Second, the Department is requesting funding for modifications to the Colorado Benefits Management System to comply with requirements regarding guaranteed coverage of newborns born to mothers enrolled in Medicaid or the Children's Basic Health Plan.

To comply with the section of CHIPRA, noted above, the Department will have to amend its current EQRO contract to include additional duties. These include conducting on-site reviews to monitor the CHP+ health plan compliance with all contractual standards on an annual basis and production of reports detailing the monitoring process, documents reviewed, interviews and surveys conducted, individual findings and corrective actions for each health plan reviewed. The reports must be provided to the Department within forty-five (45) days of review completion.

In FY 2009-10, the EQRO will perform on-site review, produce plan specific reports, produce one aggregate statewide report, and develop corrective action plans for each of the Plan's five MCOs. The cost for these additional duties is $113,527 based on the current combined Medicaid and Children's Basic Health Plan EQRO contract. Beginning in FY 2010-11, the Department will require continuation funding plus $19,460 for preparing a combined report for all of the Plan's MCOs and to evaluate, assess and follow-up on corrective action plans for each of the MCOs, as these deliverables are due after the end of the fiscal year. The total FY 2010-11 cost is $132,987. While this request will result in additional expenditures in FY 2011-12, the Department is not requesting continuation funding at this time due to the projected insolvency of the Children's Basic Health Plan Trust Fund. The Department will address this funding need along with the insolvency of the Trust Fund in a future change request.

The Department is currently working with the Centers for Medicare and Medicaid Services (CMS) to fully determine the requirements to ensure compliance with CHIPRA. As the requirements are finalized, the Department may require additional funding for the EQRO contract to perform any additional duties as directed by CMS.

<u>Guaranteed Coverage of Newborns</u>

Section 2112(e) of the Act, as added by section 111 of CHIPRA, requires that newborns born to mothers enrolled in either Medicaid or the Children's Basic Health Plan must be deemed eligible for Medicaid or the Children's Basic Health Plan until age 1. Newborns born to teens or mothers covered in the Children's Basic Health Plan children's program (rather than the prenatal program) do not currently receive twelve months of guaranteed

coverage. While the Children's Basic Health Plan has twelve-month guaranteed eligibility, Medicaid does not. For purposes of eligibility determination for these newborns, the mother's income is normally not counted and the child becomes eligible for Medicaid. To comply with this section, modifications to the Colorado Benefits Management System will be necessary to provide twelve-month guaranteed enrollment to all newborns born to any mother enrolled in Medicaid or the Children's Basic Health Plan.

The Department's contractor, Deloitte Consulting LLP, estimates that these modifications will require 1,430 hours for requirement development, coding, and resting at $105 per hour, for a total cost of $150,150. There is little capacity to implement any new changes in the Colorado Benefits Management System in FY 2009-10 due to the recent vendor transition and the long queue of prioritized modifications. Therefore, the Department is requesting this funding in FY 2010-11 and anticipates that the modifications will be completed by April 2011.

The Department assumes that there will be a very small number of newborns who will be affected by this change. Under current policy, many of the babies born to Children's Basic Health Plan children are found eligible for Medicaid due to income calculations. While the Colorado Benefits Management System does not currently prevent these children from remaining in Medicaid or the Children's Basic Health Plan for twelve months, the Department assumes that most newborns currently retain eligibility for close to the full year. Therefore, the Department assumes that costs associated with the additional months of eligibility will be negligible.

Federally-Qualified Health Center and Rural Health Clinic Rates

Section 2107(e)(1)(D) of the Act, as added by section 503 of CHIPRA, applies Section 1902(bb) of the Act to CHIP. This particular section of the Act requires that federally-qualified health centers (FQHCs) and rural health clinics (RHCs) are paid according to a prospective payment system, which is a method of reimbursement in which Medicaid payments are made based on a predetermined, fixed amount. Alternatively, the legislation allows CHIP to pay FQHCs and RHCs through a payment methodology that results in reimbursement that is at least what the prospective payment system would yield, as long as

it receives the approval of the FQHCs and RHCs. Either change in payment methodology will lead to an increase in payments to FQHCs and RHCs from what the Children's Basic Health Plan currently pays, as the prospective payment system requires reimbursement to be set at 100% of the clinic's average cost of providing the service. The Department is currently working with the FQHCs and RHCs toward an agreement on an alternative payment methodology. Because the Department is still in negotiations and does not have actuarially certified rates for this new reimbursement methodology, the Department is not currently requesting funding for this requirement.

Required Dental Benefits

Section 2103(c)(5) of the Act, as added by section 501 of CHIPRA, requires that CHIP programs include "coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions". As outlined in the State Health Official Letter dated October 7, 2009, the dental benefits package offered to all children enrolled in Colorado's Children's Basic Health Plan must meet certain requirements in order to satisfy the CHIPRA provision. Due to the delayed guidance on the requirements of the dental package, the State's contracted actuary has just begun the process determining what benefits need to be changed to the capitated dental package. In order to implement the changes to the benefits once they are determined, actuarially certified rates would need to be developed. Because the Department does not yet have actuarially certified rates for the new dental benefit package, the Department is not currently requesting funding for this requirement.

Consequences if Not Funded:

This request is for funding to implement federally mandated changes. If this request is not funded, federal financial participation in the Children's Basic Health Plan will be at risk. The FY 2010-11 base request includes $139,306,703 federal funds for the Children's Basic Health Plan.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$113,527**	**$0**	**$39,734**	**$0**	**$73,793**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$113,527	$0	$39,734	$0	$73,793

Summary of Request FY 2010-11	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$236,150**	**$74,679**	**$46,661**	**$135**	**$114,675**
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	$46,661	$46,661	$0	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Administration	$132,987	$0	$46,545	$0	$86,442
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$56,502	$28,018	$116	$135	$28,233

Summary of Request FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$0**	**$0**	**$0**	**$0**	**$0**
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	$0	$0	$0	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Administration	$0	$0	$0	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$0	$0	$0	$0	$0

Cash Funds Projections: This request includes $39,734 from the Children's Basic Health Plan Trust Fund in FY 2009-10 and $46,661 in FY 2010-11. Because the Trust Fund is projected to be insolvent in FY 2010-11 after the impact of FY 2010-11 DI-3 Children's Basic Health Plan Medical Premium and Dental Benefit Costs, the Department is seeking a General Fund appropriation in FY 2010-11 to the Trust for the costs associated with this request.

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Children's Basic Health Plan Trust	11G	$32,626,199	$6,608,063	$817,042	$2,586,082	($7,626,685)

Assumptions for Calculations: Based on the Department's current EQRO contract for similar work performed in Medicaid, the Department assumes that the cost of compliance with the enhanced external quality review provision for FY 2009-10 will be $113,527 for on-site reviews and development of reports and corrective actions for each of the Plan's five MCOs. An additional $19,460 will be required beginning in year 2 (FY 2010-11) for preparing a combined report for all of the Plan's MCOs and to evaluate, assess and follow-up on corrective action plans for each of the MCOs, as these deliverables are due after the end of the fiscal year.

Estimates for the Colorado Benefits Management System modifications required for the provision regarding guaranteed coverage of newborns were provided by the Department's contractor, and assumes 1,430 hours at $105 per hour, for a total cost of $150,150 in FY 2010-11.

Because the Trust Fund is projected to be insolvent in FY 2010-11 after the impact of FY 2010-11 DI-3, the Department is seeking a General Fund appropriation to the Trust for the costs associated with this request in FY 2010-11, and will submit a separate change request for FY 2011-12.

Impact on Other Government Agencies: As modifications in the Colorado Benefits Management System are required, this request impacts the Department of Human Services. The total cost for modifications to the Colorado Benefits Management System is $150,150, of which $56,502 is from the Department and $93,648 is from the Department of Human Services per the cost-sharing agreement between the two State departments for changes to the Colorado Benefits Management System in FY 2010-11 only.

Summary of Department of Human Services Request FY 2010-11	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Medicaid Cash Funds**	**Medicaid General Fund**	**Federal Funds**
Total Request	**$150,150**	**$37,038**	**$6,993**	**$56,502**	**$56,502**	**$28,018**	**$49,617**
(2) Office of Information Technology, Colorado Benefits Management System (CBMS)	$150,150	$37,038	$6,993	$56,502	$56,502	$28,018	$49,617

Cost Benefit Analysis: Not applicable. This request is for funding to implement federally mandated changes.

Statutory and Federal Authority: Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) and amended by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). SEC. 2. *PURPOSE- It is the purpose of this Act to provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles.*

Section 2103(f) of Social Security Act (42 U.S.C. 1397bb(f)) as amended by P.L. 111-3, Sec. 403 *(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS- The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage,*

State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.

25.5-8-105 C.R.S. (2009) (1) *A fund to be known as the Children's Basic Health Plan Trust is hereby created… all monies deposited in the trust and all interest earned on the moneys in the Trust shall remain in the Trust for the purposes set forth…*

25.5-8-111 C.R.S. (2009) (1)(a)(I) *The department may… Pursuant to section 24-50-504 (2)(a), C.R.S., enter into personal services contracts for the administration of the children's basic health plan.*

Performance Measures:

By ensuring continued federal financial participation in the Children's Basic Health Plan, the Department would ensure continuity of care, and clients in the program would have better health outcomes and show a high level of satisfaction with their care. As such, the Department believes that this request supports the following Performance Measures:

- Expand coverage in the Children's Basic Health Plan.
- 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.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11 ✓

Request Title: Public School Health Services Administrative Claiming
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew **Date:** January 4, 2010 12/28/09
Priority Number: S-9, BA-7 **OSPB Approval:** **Date:** 1-4-10

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	21,073,892	22,488,434	529,968	23,018,402	23,856,681	0	23,856,681	4,087,324	27,944,005	4,087,324
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0.0	0.0
	GF	(743,608)	919,283	0	919,283	1,206,281	0	1,206,281	0	1,206,281	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	10,321,611	10,472,200	264,984	10,737,184	10,825,188	0	10,825,188	2,043,662	12,868,850	2,043,662
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	11,495,889	11,096,951	264,984	11,361,935	11,825,212	0	11,825,212	2,043,662	13,868,874	2,043,662
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration	Total	337,833	211,312	(61,312)	150,000	211,312	0	211,312	(61,312)	150,000	(61,312)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	337,833	211,312	(61,312)	150,000	211,312	0	211,312	(61,312)	150,000	(61,312)
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	Total	1,817,491	2,272,266	(433,700)	1,838,566	3,640,513	0	3,640,513	(433,700)	3,206,813	(433,700)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	836,446	919,283	0	919,283	1,206,281	0	1,206,281	0	1,206,281	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	72,300	0	0	0	352,988	0	352,988	0	352,988	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	908,745	1,352,983	(433,700)	919,283	2,081,244	0	2,081,244	(433,700)	1,647,544	(433,700)

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10**	☑	**Budget Amendment FY 2010-11**	☑				
Request Title:	Public School Health Services Administrative Claiming										
Department:	Health Care Policy and Financing			**Dept. Approval by:**	John Bartholomew			**Date:**	January 4, 2010		
Priority Number:	S-9, BA-7			**OSPB Approval:**				**Date:**			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(5) Other Medical Services; Public School Health Services	**Total**	18,918,568	20,004,856	499,780	20,504,636	20,004,856	0	20,004,856	3,782,636	23,787,492	3,782,636
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	(1,580,054)	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	10,249,311	10,472,200	264,984	10,737,184	10,472,200	0	10,472,200	2,043,662	12,515,862	2,043,662
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	10,249,311	9,532,656	234,796	9,767,452	9,532,656	0	9,532,656	1,738,974	11,271,630	1,738,974
(5) Other Medical Services, Public School Health Services Contract Administration *(new line item)*	**Total**	0	0	525,200	525,200	0	0	0	799,700	799,700	799,700
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	525,200	525,200	0	0	0	799,700	799,700	799,700

Non-Line Item Request:	None.			
Letternote Revised Text:	None.			
Cash or Federal Fund Name and COFRS Fund Number:		CF: Certified Public Expeditures; 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:		Department of Education		

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-9, BA-7
Change Request Title:	Public School Health Services Administrative Claiming

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☐ Base Reduction Item FY 2010-11
☒ Supplemental Request FY 2009-10
☒ Budget Request Amendment FY 2010-11

SELECT ONE (click on box):

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

Short Summary of Request: This request is for $264,984 cash funds and matching federal funds in FY 2009-10 and $2,043,662 cash funds and matching federal funds beginning in FY 2010-11 for the implementation of administrative cost claiming in the Public School Health Services Program. In addition, the Department is requesting a reorganization of the budget for the program such that contract-driven administrative funding appear explicitly in a single new line item in the Department's budget, (5) Other Medical Services, Public School Health Services Contract Administration. In order to implement the recently federally allowable administrative cost claiming process in the program, the Department would require the services of a contractor with experience in school-based Medicaid administrative cost claiming and additional spending authority for the certified public expenditures component of the Public School Health Services line item.

Background and Appropriation History: The Public School Health Services program was created in 1997 with the passage of SB 97-101 to fund the provision of medical services to Medicaid-eligible, uninsured, and

underinsured students in public school districts throughout the state[1]. Each contracting school district or Board of Cooperative Education Services (BOCES) uses funds received from the Department for direct provision of medical services in the way that best meets the needs of students based on a service delivery process established through the Local Services Plan. In cases where a student requires services included in their Individualized Education Plan (IEP) that cannot be reasonably accommodated on site at a school, districts may make arrangements for the services to be obtained at the client's home or at another site in the community from a qualified provider. The Department currently staffs 1.25 FTE paid through the (1) Executive Director's Office; (A) General Administration, Personal Services line item for the administration of the Public School Health Services program. Upon passage of SB 97-101, the Department entered into an interagency agreement with the Colorado Department of Education. The Department of Education receives and reviews all local plans, conducts on-site reviews, submits annual reports, and provides technical assistance to medical staff at participating school districts.

The Public School Health Services line item was appropriated $20,242,120 total funds in FY 2008-09. The Department was appropriated an additional $407,747 in FY 2008-09 for administration of this program in the (1) Executive Director's Office; Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration. During FY 2009-10 Figure Setting, the appropriation to the Public School Health Services line item, (and correspondingly, the appropriation to the (1) Executive Director's Office; (B) Transfers to Other Department, Transfer to Department of Education for Public School Health Services Administration) was reduced by $3,564 federal funds for Department of Education POTS Issues. In addition, the federal funds appropriation was reduced by $233,700 pursuant to the Department's November 3, 2008 FY 2009-10 DI-17, and this funding was transferred to the (1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts line item. The FY

[1] Per 25.5-5-318 (4) (b) C.R.S., (2009), each contracting school district or Board of Cooperative Education Services may spend an amount, not to exceed 30% of total federal funds received, on health care for low-income students, defined as students whose families are below one hundred eighty-five percent of the federal poverty level, as opposed to strictly Medicaid-eligible students.

2009-10 appropriation to the Public School Health Services line item is $20,004,856 total funds.

General Description of Request:

This request is for $264,984 cash funds and matching federal funds in FY 2009-10 and $2,043,662 cash funds and matching federal funds beginning in FY 2010-11 for the implementation of administrative cost claiming in the Public School Health Services Program. In addition, the Department is requesting a reorganization of the budget for the program such that contract-driven administrative funding appear explicitly in a single new line item in the Department's budget, (5) Other Medical Services, Public School Health Services Contract Administration. Currently, funds for the administration of contracts related to the Public School Health Services program appear in the (1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts line item. The Department is requesting the following:

- A reduction of $433,700 in federal funds from the (1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts line item in FY 2009-10 and FY 2010-11;
- A net increase of $499,780 total funds and $3,782,636 total funds in FY 2009-10 and FY 2010-11 respectively for the Public Schools Health Services line item as shown in the table on the follow page; and
- The creation of a new line item, (5) Other Medical Services, Public School Health Services Contract Administration with an appropriation of $525,200 total funds/federal funds and $799,700 total funds/federal funds in FY 2009-10 and FY 2010-11/2011-12, respectively. The funding for this proposed new line item is the total of the reductions from Provider Audits and Services (first bullet above) and from Public School Health Services (table on following page).

This request also seeks to reduce administrative funding associated with the program and appropriated to the Department of Education, much of which has gone unused in recent years. This would reduce the appropriation to the (1) Executive Director's Office; (B) Transfers to Department of Education for Public School Health Services program by $61,312 beginning in FY 2009-10. As the program is limited in administrative expenses to 10% of total federal funds appropriated to the program, these administrative funds would

be needed to obtain a contractor to assist the Department with the implementation of administrative claiming.

As described below in the request, the Department anticipates increased certified public expenditures due to the implementation of administrative claiming in the amounts of $264,984 in FY 2009-10 and $2,043,662 in FY 2010-11. The following table shows the impact to the appropriation in the Public School Health Services line item due to this request:

Calculation of Net Impact to Public School Health Services Line Item		
(5) Other Medical Services; Public School Health Services	FY 2009-10	FY 2010-11
Increased Certified Public Expenditures (Cash Funds)	$264,984	$2,043,662
Less Transfer to Public School Health Services Contract Administration line item for contractor costs	($91,500)	($366,000)
Savings from Reduction in Transfer to Department of Education (increase to the Public School Health Services appropriation)	$61,312	$61,312
Total Federal Funds Impact	**$234,796**	**$1,738,974**
New Certified Public Expenditures (Cash Funds)	$264,984	$2,043,662
Total Funds Impact	**$499,780**	**$3,782,636**

In accordance with the Department's goals of improving access to health care and ensuring that clients receive necessary services, the Department is requesting ongoing operational funding to implement and maintain the School Health Services Medicaid Administrative Claiming (MAC) program. On June 30, 2009, the Centers for Medicare and Medicaid Services (CMS) rescinded the federal school-based services rule that eliminated the ability of states to receive federal financial participation on administrative costs incurred by public school districts in the provision of health care to eligible students. The Department submitted an implementation guide to CMS in November 2009 to implement the administrative claiming program retroactive to October 1, 2009, and approval is anticipated by January 2010. The Department anticipates that in the long-run, the implementation of Medicaid Administrative Claiming will increase provider

participation in the Public School Health Services Program as the range of billable activities is expanded.

Were this request to be approved, the Department would be able to leverage federal funds to reimburse school districts and BOCES for activities necessary for the proper and efficient administration of the state Medicaid plan. The Medicaid Administrative Claiming program reimburses school districts for the time spent in administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid. Allowable administrative activities include the following:

- Medicaid Outreach;
- Facilitating Medicaid eligibility determination;
- Transportation-related activities in support of Medicaid-covered services;
- Translation related to Medicaid services;
- Program planning, policy development, and interagency coordination related to medical services;
- Medical/Medicaid-related training;
- Referral, coordination, and monitoring of Medicaid services; and,
- General administration.

Administrative claiming for the School Health Services program may involve all school district staff who, as part of their routine job duties, help students and their families learn about Medicaid, apply for Medicaid benefits, refer students to community medical and mental health providers or collaborate with other school staff or community agencies to better address the health care needs of students. Based on historical total administrative and direct services cost pools, adjusted to account for expected participation rates and implementation timeline, the Department estimates that utilization of administrative claiming would generate $264,984 and $2,043,662 in new certifications in FY 2009-10 and FY 2010-11 respectively, and an equal amount of federal matching revenue for reimbursement to participating providers, less the administrative costs of operating the program. These estimates assume that provider participation will increase in FY 2010-11,

as the administrative costs will now be billable. The calculation of this estimate is shown in Table 6 below. The Department also reviewed revenue figures generated by other states implementing MAC programs as a reasonableness test; relative to revenue earned by other states, the Department's estimates are conservative[2].

In order to implement and maintain the MAC program, the Department would require a contractor with specific experience in Medicaid administrative claiming (particularly with School Health Services programs) to perform the operational functions. These activities would consist of administering a quarterly random moment time study and quarterly cost report/reconciliation process for each participating school district. The contractor would provide and maintain the software for the electronic random moment time study and cost report, develop the quarterly random moment time study results for submission to CMS and participate with the Department in federal meetings. The contractor would also prepare each participating school district's cost report for claims submission for federal financial participation (FFP). Due to the amount of work required to generate revenue via the administrative claiming process, the Department anticipates an ongoing six month lag between the provision of services and receipt of federal funds by school districts. Operationally, this means that school districts would only be reimbursed for three months of administrative expenses in FY 2009-10. The remaining reimbursement for expenditures incurred in FY 2009-10 would be distributed in FY 2010-11.

Hiring a contractor with specialized experience in Medicaid administrative claiming would be more efficient and effective than hiring a significant number of FTE to administer the program, which would require extensive training in the processes related to administrative claiming before they could become effective administrators of the program. Additionally, it would be more cost effective to hire a contractor to perform this work as the Department possesses neither the software systems required to administer the random moment time study nor the resources to collect the corresponding financial data for the cost reports.

[2] See Table 7 for more information on outcomes experienced by other states implementing MAC programs relative to total Direct Services revenue associated with each State's school health program.

In discussions with entities that have implemented MAC programs in other states, the Department has determined that a contractor with the expertise necessary to implement the program would cost the Department $366,000 annually. This estimate is built from a detailed list of costs associated with a series of tasks that will be required for the implementation of Medicaid Administrative Claiming. Broadly, these functions can be separated into three major components:

- Tasks related to the operation and tracking of the Time Study results, which account for $180,000 annually;
- The distribution, collection, and reporting of quarterly administrative cost reports, expected to cost $164,000 annually; and,
- Technical assistance and consulting services for the Department and the Department of Education, expected to cost $22,000 annually.

This estimate cannot be meaningfully broken into an hourly rate and number of hours required, given the variation in skill and time required for each of the individual tasks for which a contractor would be responsible.

Consequences if Not Funded:

Were this request to be denied, the Department would forgo the opportunity to substantially increase reimbursement, at no cost to the State, to the 85[3] currently participating school districts. The Department would also lose the opportunity to incentivize increased participation in the Public School Health Services Program, which would improve access to health care and ensure that clients receive necessary services. School districts would continue to provide administrative services related to the operation of the program without associated administrative reimbursement, which the Department believes would discourage further participation in the program and may result in a reduced number of districts providing services.

[3] Participating School Districts or BOCES as of November 2009.

Calculations for Request:

Table 1: Summary of Request FY 2009-10

Summary of Request FY 2009-10	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	$529,968	$0	$264,984	$0	$264,984
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration	($61,312)	$0	$0	$0	($61,312)
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	($433,700)	$0	$0	$0	($433,700)
(5) Other Medical Services; Public School Health Services	$499,780	$0	$264,984	$0	$234,796
(5) Other Medical Services, Public School Health Services Contract Administration *(new line item)*	$525,200	$0	$0	$0	$525,200

Table 2: Summary of Request FY 2010-11 and FY 2011-12

Summary of Request FY 2010-11 and FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	$4,087,324	$0	$2,043,662	$0	$2,043,662
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration	($61,312)	$0	$0	$0	($61,312)
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	($433,700)	$0	$0	$0	($433,700)
(5) Other Medical Services; Public School Health Services	$3,782,636	$0	$2,043,662	$0	$1,738,974
(5) Other Medical Services, Public School Health Services Contract Administration *(new line item)*	$799,700	$0	$0	$0	$799,700

Table 3: Administration Only Revenue Estimates

Administration Total Cost Pool	Medicaid-Eligible Ratio	Administration Only - Administrative Time Study %	Effective Federal Medicaid Assistance Percentage	Administration Only - Net Federal Financial Participation (= Product of all columns)
$99,561,327	30%	7.00%	50%	$1,045,394
		8.00%		$1,194,736
		9.00%		$1,344,078
		10.00%		$1,493,420
		11.00%		$1,642,762
		12.00%		$1,792,104

1) All revenue estimates are exclusive of adjustments for partial year implementation and anticipated participation rates, which are detailed in Table 5.

Table 4: Increased Direct Services Revenue Estimate

Direct Services Total Cost Pool	Medicaid-Eligible Ratio	Direct Services Only - Administrative Time Study %	Effective Federal Medicaid Assistance Percentage	Direct Services Only - Net Federal Financial Participation (= Product of all columns)
$368,760,000	30%	1.00%	50%	$553,140
		2.00%		$1,106,280
		3.00%		$1,659,420
		4.00%		$2,212,560
		5.00%		$2,765,700
		6.00%		$3,318,840

1) All revenue estimates are exclusive of adjustments for partial year implementation and anticipated participation rates, which are detailed in Table 5.

Table 5: Estimate of Increased Certified Public Expenditures

FY 2009-10 for Costs Incurred In FY 2009-10	Total Cost Pool	Medicaid Eligibility Rate	Time Study Estimated Time Spent %	Percentage of Districts Participating	Percentage of Year Program is Active	% of Total Expenditures Certifiable	Total (Product of all Columns)
Administration	$99,561,327	30%	9.00%	35.29%	25%	50%	$118,581
Direct Services	$368,760,000	30%	3.00%	35.29%	25%	50%	$146,402
Grand Total New Certifications							**$264,984**

FY 2010-11 for Costs Incurred In FY 2009-10	Total Cost Pool	Medicaid Eligibility Rate	Time Study Estimated Time Spent %	Percentage of Districts Participating	Percentage of Year Program is Active	% of Total Expenditures Certifiable	Total (Product of all Columns)
Administration	$99,561,327	30%	10.00%	35.29%	50%	50%	$263,514
Direct Services	$368,760,000	30%	4.00%	35.29%	50%	50%	$390,406
Grand Total New Certifications							**$653,920**

FY 2010-11 for Costs Incurred In FY 2010-11	Total Cost Pool	Medicaid Eligibility Rate	Time Study Estimated Time Spent %	Percentage of Districts Participating	Percentage of Year Program is Active	% of Total Expenditures Certifiable	Total (Product of all Columns)
Administration	$99,561,327	30%	10.00%	75.00%	50%	50%	$560,032
Direct Services	$368,760,000	30%	4.00%	75.00%	50%	50%	$829,710
Grand Total New Certifications							**$1,389,742**

Table 6: Compliance with Administrative Cap

Compliance With Administrative Cap	Total Administrative Costs (External & Internal)	Total Program Federal Funds	Percentage of Total Federal Funds used for Administration
FY 2009-10	$969,733	$10,737,184	9.04%
FY 2010-11	$1,244,233	$12,515,862	9.95%
FY 2011-12	$1,244,233	$12,515,862	9.95%

Table 7: Sample of Regional States MAC Program Outcomes

STATE	Total Direct Service Revenue	Total MAC Revenue	Total Federal Revenue	Ratio of MAC Revenue to Total Revenue
Arizona (2002-2003)	$31,783,000	$25,253,419	$57,036,419	44%
(2003-2004)	$30,636,858	$23,161,606	$53,798,464	43%
(2004-2005)	$58,108,665	$11,944,163	$70,052,828	17%
Kansas (2002-2003)	$29,804,719	$3,030,000	$32,834,719	9%
(2003-2004)	$20,000,000	N/A	N/A	N/A
(2004-2005)	$23,000,000	$3,000,000	$26,000,000	12%
Nebraska (2002- 2003)	$7,263,483	$4,949,522	$12,213,005	41%
(2003-2004)	Not Available	N/A	N/A	N/A
(2004-2005)	Not Available	N/A	N/A	N/A
Wisconsin (2002-2003)	$20,132,579	$3,200,000	$23,332,579	14%
(2003-2004)	$18,700,000	$3,000,000	$21,700,000	14%
(2004-2005)	$21,600,000	$3,500,000	$25,100,000	14%
Colorado (Proposed FY 2010-11)	**$11,692,316**	**$823,546**	**$12,515,862**	**7%**

Source: The National Alliance for Medicaid in Education survey data.

Cash Funds Projections: Not applicable.

Assumptions for Calculations: Pertaining to the estimate of new revenue generated, the Department assumes that, for the first three months of operation, results of the time study required as a part of the operation of the MAC program would show "Time Spent Percentages" of 9.00% for Administrative Services and 3.00% for increased Direct Services. These figures determine the percentage

of total administrative and direct services cost pools which could be claimed under the MAC program, adjusted for the ratio of Medicaid eligible students to all students with an Individualized Education Plan (IEP). These percentages are conservative estimates based on data collected from various contractors that have implemented MAC in other states. See Tables 5 and 6 for more information on the base figures used to estimate potential revenue under the proposed MAC program. These figures were then adjusted downwards to account for the fact that initial participation in the program is expected to be lower than the long-run expectation of participation. After three months of operation, beginning in January of 2010, the Department assumes that increased familiarity with the administrative claiming process would increase the amount of revenue generated to amounts reflective of time study results of 10.00% and 4.00% for administration and direct services, respectively. The Department assumes partial participation for the first nine months of operation, equal to the proportion of school districts that have expressed certainty in their desire to participate in the administrative claiming program relative to the total number of all currently participating school districts or BOCES. Furthermore, the timeline of the proposal indicates that only 9 months of administrative costs will be claimable by school districts in FY 2009-10. Beginning in July 2010, the Department assumes that participation in the administrative claiming program will rise to 75% after it is demonstrated (by initial participants) that doing so would increase districts' total reimbursement.

Concerning the estimation of contract costs, the Department assumes that it will be able to obtain a contractor to perform the required tasks for $366,000 annually. This is based on a detailed estimate provided to the Department by a contractor that has implemented administrative claiming programs in other states, which outlines tasks and associated costs that would be required. Additionally, as the program would be operational for only 3 months in FY 2009-10, the Department assumes that contractor costs will be equal to 25% of the annual costs expected for FY 2010-11. Per 25.5-5-318 (8) (b) C.R.S., (2009), which limits total allowable state administrative costs to 10% of the federal funds reflected in the annual general appropriations bill, the Department assumes that the new revenue earned will be sufficient, given the new administrative expenses, to maintain compliance with this statute. Under the anticipated scenario, the administrative costs of the program

will be 9.04% of total federal funds in FY 2009-10 and 9.95% of total federal funds in FY 2010-11. In addition to the explicit administrative costs associated with contracts and services rendered by the Department of Education, the Department also incurs approximately $294,533 in internal administrative expenses composed of personal services, operating expenses, and Medicaid Management Information Systems costs. These costs must also be incorporated into the determination of compliance with section 25.5-5-318 (8) (b). See Table 6 for calculation of these percentages.

Impact on Other Government Agencies:

The Department has coordinated with the Department of Education to remove unused funding in the (1) Executive Director's Office; (B) Transfers to Other Line Items, Transfer to Department of Education for Public School Health Services Administration line item. Were the request to be approved, the Department believes that this action would be necessary to maintain compliance with 25.5-5-318 (8) (b) C.R.S., (2009) which limits total allowable state administrative costs to 10% of the federal funds reflected in the annual general appropriations bill. As the administrative costs of operating the program would increase if this request were approved, the Department would minimize administrative costs associated with the program to ensure continued compliance with this statute. The Department of Education has agreed to a permanent reduction of $61,312 to the appropriation to the (1) Executive Director's Office, (B) Transfers to Other Departments, Transfer to Department of Education for School Health Services Administration line item beginning in FY 2009-10. This funding is reflected in the Department of Education's budget in the (2) Assistance to Public Schools; (C) Grant Programs, Distributions, and Other Assistance; (I) Health and Nutrition, SB 97-101 Public School Health Services line item. A corresponding Schedule 13 from the Department of Education showing the impact of this proposal on that Department's budget has been included with this request.

Summary of Request FY 2009-10, FY 2010-11 and FY 2011-12	**Total Funds**	**Reappropriated Funds**
Total Request	($61,312)	($61,312)
(2) Assistance to Public Schools, (C) Grant Programs, Distributions, and Other Assistance, (V) Summer and After-school Programs, Dropout Prevention Activity Grant Program	($61,312)	($61,312)

Cost Benefit Analysis:

FY 2010-11 Cost Benefit Analysis	Costs	Benefits
Request	The requested funding consists entirely of federal funds and cash funds in the form of certified public expenditures, both of which can be increased without generating new costs for the State.	Increased reimbursement to school districts that are currently performing necessary administrative functions without reimbursement, further offsetting the cost of providing services and encouraging additional participation in the program.
Consequences if not Funded	The Department would forgo an opportunity to substantially increase reimbursement to the 85 school districts, at no cost to the State. School districts would continue to provide administrative services related to the operation of the program without reimbursement, which is expected to lower participation in the program and overall reimbursement to districts providing health services to Medicaid-eligible and other low-income students.	There are no benefits.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	July 2009 - April 2010
Written Agreement w/ Other State Agencies	September 2009
Contract Amendment for FY 2009-10[1]	April 2010-May 2010
Implementation Phase	May 2010-June 2010
Execute Contract Amendment for FY 2009-10	April 2010
Contract Amendment for FY2010-11	May – June 2010
Operations Phase	July 2010-Ongoing

1) A sole source was approved for the current contractor to implement the MAC component. The Department is awaiting expenditure authority to amend the contractor's current scope of work and contract.

Statutory and Federal Authority:

25.5-5-318 (1) - *(8) (a), C.R.S. (2009). Under the contract entered into pursuant to this section, a contracting school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.*

(b) Total allowable state administrative costs for contracts entered into under this section for both the state department and the department of education shall not exceed ten percent of the total annual amount of federal funds reflected by the general assembly for such contracts in the annual general appropriations bill. State administrative costs include costs incurred in evaluating the implementation of this section.

Performance Measures:

This request contributes to achievement of the following Department objective:

A. Assure delivery of appropriate, high-quality health care in the most cost-effective manner possible. Design programs that result in improved health status for clients served and improve health outcomes. Expand and preserve health care services through the purchase of services in the most cost-effective manner possible.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐
Supplemental FY 2009-10	☑	**Budget Amendment FY 2010-11**	☑

Request Title:	Acute Care Utilization Review Adjustments		
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew FB **Date:** January 4, 2010 12/28/09
Priority Number:	S-10, BA-8	**OSPB Approval:**	**Date:** 12-28-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	**Total**	4,586,288	4,576,355	85,400	4,661,755	5,204,383	0	5,204,383	149,560	5,353,943	149,560
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,142,390	1,359,148	3,379	1,362,527	1,470,343	0	1,470,343	19,419	1,489,762	19,419
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	54,949	54,949	0	54,949	86,596	0	86,596	0	86,596	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,388,949	3,162,258	82,021	3,244,279	3,647,444	0	3,647,444	130,141	3,777,585	130,141
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**Total**	4,586,288	4,576,355	85,400	4,661,755	5,204,383	0	5,204,383	149,560	5,353,943	149,560
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,142,390	1,359,148	3,379	1,362,527	1,470,343	0	1,470,343	19,419	1,489,762	19,419
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	54,949	54,949	0	54,949	86,596	0	86,596	0	86,596	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,388,949	3,162,258	82,021	3,244,279	3,647,444	0	3,647,444	130,141	3,777,585	130,141

Non-Line Item Request:	None.		
Letternote Revised Text:	None.		
Cash or Federal Fund Name and COFRS Fund Number:	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 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	S-10, BA-8
Change Request Title:	Acute Care Utilization Review Adjustments

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☐ Base Reduction Item FY 2010-11
☒ Supplemental Request FY 2009-10
☒ Budget Request Amendment FY 2010-11

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 $85,400 total funds and net General Fund of $3,379 in FY 2009-10 and $149,500 total funds and $19,419 General Fund in FY 2010-11 for additional acute care prior authorization reviews due to increasing Medicaid caseload. The amounts requested include an ongoing reduction of $17,971 General Fund due to a correction in fund splits to the Acute Care Utilization Review line item.

Background and Appropriation History:

On November 1, 2002 the Department submitted BRI-3, "Separation of Long Bill Line Items for Utilization Review and External Quality Review" as a change request for FY 2003-04 to replace the then Contractual Utilization Review line item with four line items to simplify administration and improve budgetary oversight. See Table 1 for a list of line items created and the corresponding fund splits.

With the exception of Acute Care Utilization Review, each line item was permitted to draw down 75% enhanced federal financial participation for the performance of medical and utilization review by a Quality Improvement Organization (QIO) under contract (42 CFR §433.15 (b)(6)(i), (2008)). The federal match rate for the Acute Care Utilization

Review line item was "adjusted by some administrative services by a few single entry point agencies in the Long Term Care contract that must be charged at 50% federal financial participation. As a result, the federal financial participation rate is 73% federal funds and 27% General Fund." (*BRI-3, "Separation of Long Bill Line Items for Utilization Review and External Quality Review", November 1, 2002 Change Request for FY 2003-04*)

Subsequent to the Department's submission of BRI-3 in November 2002, it sent a letter on February 7, 2003 to the Joint Budget Committee to propose several reductions to the utilization and quality review line items, in particular Acute Care and Long Term Care Utilization Review. The reductions were proposed in order to address the 4% budget balancing plan that occurred that fiscal year. The Joint Budget Committee approved the reductions and appropriated the amounts in the Department's Long Bill, SB 03-258. See Table 2 for the revised appropriations.

After the passage of HB 05-1262, Tobacco Tax Bill, the Acute Care Utilization Review line item was appropriated an additional $16,520 cash funds resulting in a total funds appropriation of $66,080. With this additional funding, the appropriation increased to $1,375,906 total funds and has remained at this level since the passage of the Department's FY 2006-07 Long Bill, HB 06-1385. In FY 2006-07, the Department also reduced the cash funds from the Breast and Cervical Cancer Treatment Fund by $2,174 but correspondingly increased General Fund by $2,174 pursuant to 25.5-5-308 (9), C.R.S. (2009). Under the same statute, the remaining $725 cash funds from the Breast and Cervical Cancer Treatment Fund was refinanced with General Fund and appropriated in the Department's FY 2008-09 Long Bill, HB 08-1375. As a result of this statutory requirement, the cash funds amount of $16,520 is appropriated entirely from the Health Care Expansion Fund and not the Breast and Cervical Cancer Treatment Fund.

Based on these changes and the passage of the Department's FY 2009-10 Long Bill, SB 09-259, the current appropriation for the Acute Care Utilization Review line item can be seen in Table 3.

Per Footnote #22 of the FY 2007-08 Long Bill SB 07-239, the Department submitted a plan for restructuring its Executive Director's Office long bill group appropriations into a more programmatic format. The Department's proposal was submitted to the Joint Budget Committee on November 9, 2007 and requested that 46 line items be placed into groups based on functional similarity. As a result of conversations during the Department's FY 2008-09 Figure Setting about the consolidation of these line items and the transfer of some to other long bill groups, the passage of HB 08-1375 resulted in 31 line items in long bill group (1) Executive Director's Office for FY 2008-09.

This action resulted in the Acute Care Utilization Review line item being consolidated under a new line item and subdivision under Long Bill Group (1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts.

General Description of Request:

Acute Care Prior Authorization Reviews

The Department's contractor for acute care utilization reviews is the Colorado Foundation for Medical Care (CFMC). By contract, CFMC conducts up to 12,500 prior authorization reviews per fiscal year or an average of 1,042 per month, and reviews all hospital readmissions to determine appropriateness of discharge for the initial admission.

During the first quarter of FY 2009-10 the Department experienced an increase in the number of acute care prior authorization reviews. See Table 4 for monthly totals. The Department attributes the growth in acute care prior authorization reviews to increasing Medicaid caseload. Although the data from the first quarter show a larger increase than what is requested, the Department believes the remaining months in FY 2009-10 would experience growth more in line with its annual estimates for caseload. If these trends continue throughout FY 2009-10, then CFMC would reach its contractual limit by May 2010. At that time the Department may need to instruct CFMC to completely suspend acute care prior authorization review activity due to insufficient funding.

In order to continue providing Medicaid clients with the services they require while ensuring the services and equipment are medically necessary, the Department requests

additional funding to increase the prior authorization review contract limit in FY 2009-10 and FY 2010-11. Using projected Medicaid caseload growth rates of 17.08% for FY 2009-10 and 10.96% for FY 2010-11, the Department would increase the number of prior authorization reviews by 2,135 in FY 2009-10 or $85,400 total funds and an additional 1,604 reviews in FY 2010-11 or $64,160 total funds. See Tables 6 and 7.

Adjust Fund Splits for Acute Care Utilization Review Line Item

Since July 1, 2005 the Department has been under contract with CFMC to perform acute care utilization reviews. The contractor qualifies as a QIO as defined in Section 1152 of the Social Security Act, and as such the Department is allowed to draw down enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a QIO (42 C.F.R. §433.15 (b)(6)(i), (2008)).

The Department no longer contracts with single entry point agencies to conduct acute care prior authorization reviews. Rather, the Department's contractor conducts all acute care prior authorization reviews, and as such the Department requests the fund splits developed under BRI-3 for FY 2003-04 be corrected to show 75% instead of 73% federal financial participation. This change would decrease General Fund by $17,971 in FY 2009-10 and FY 2010-11. See Table 8 for calculations.

Consequences if Not Funded:

If the request for additional funding is not approved and the number of acute care prior authorization reviews continues to exceed the estimated monthly average of 1,042 by 178 reviews, then the Department would need to reduce the number and type of prior authorization reviews conducted each month or instruct the contractor to completely suspend acute care prior authorization review activity in May 2010 or whenever the contract limit is reached. See Table 5. Should this occur it is estimated that the Department's contractor would not conduct acute care prior authorization reviews for at least two months. Using the monthly average of 1,220 prior authorization reviews and the estimated cost avoided per prior authorization review of $887 from CFMC's FY 2008-09 Annual Report, the Department estimates this could result in at least $2,164,280 in additional Medical Services Premiums cost in FY 2009-10. In FY 2010-11 the

Department estimates that its contractor would not conduct acute care prior authorization reviews for approximately three months which could result in $3,600,333 in additional Medical Services Premiums cost.

Calculations for Request:

Summary of Request FY 2009-10	Total Funds	General Fund	Federal Funds
Total Request	$85,400	$3,379	$82,021
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$85,400	$3,379	$82,021
Increased Funding For Additional Prior Authorization Reviews	*$85,400*	*$21,350*	*$64,050*
Correct Fund Splits For Acute Care Utilization Review Line Item	*$0*	*($17,971)*	*$17,971*
Request	*$85,400*	*$3,379*	*$82,021*

Summary of Request FY 2010-11 and FY 2011-12	Total Funds	General Fund	Federal Funds
Total Request	$149,560	$19,419	$130,141
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$149,560	$19,419	$130,141
Funding For Additional FY 2009-10 Prior Authorization Reviews	*$85,400*	*$21,350*	*$64,050*
Increased Funding For FY 2010-11 Prior Authorization Reviews	*$64,160*	*$16,040*	*$48,120*
Correct Fund Splits For Acute Care Utilization Review Line Item	*$0*	*($17,971)*	*$17,971*
Request	*$149,560*	*$19,419*	*$130,141*

Table 1: Proposed Appropriations For Utilization Review Line Items In BRI-3 for FY 2003-04

Line Item	TF	GF	CF*	FF	FFP Rate
Acute Care Utilization Review**	$1,147,326	$301,904	$2,899	$842,523	73%
Long Term Care Utilization Review	$2,557,752	$639,438	$0	$1,918,314	75%
External Quality Review	$812,193	$203,048	$0	$609,145	75%
Drug Utilization Review	$233,025	$58,256	$0	$174,769	75%
Total	$4,750,296	$1,202,646	$2,899	$3,544,751	

**Cash Funds from the Breast and Cervical Cancer Treatment Fund*

*** Manual calculation of federal funds does not equal listed FFP rate due to rounding.*

Table 2: Revised Appropriations For Utilization Review Line Items In Letter Dated February 7, 2003					
Line Item	**TF**	**GF**	**CF***	**FF**	**FFP Rate****
Acute Care Utilization Review	$1,309,826	$342,529	$2,899	$964,398	73%
Long Term Care Utilization Review	$1,668,108	$598,813	$0	$1,069,295	64%
External Quality Review	$812,193	$203,048	$0	$609,145	75%
Drug Utilization Review	$233,025	$58,256	$0	$174,769	75%
Total	$4,023,152	$1,202,646	$2,899	$2,817,607	

**Cash Funds from the Breast and Cervical Cancer Treatment Fund*

*** Manual calculation of federal funds does not equal listed FFP rate due to rounding.*

Table 3: Appropriation For Acute Care Utilization Review Per Long Bill, SB 09-259					
Line Item	**TF**	**GF**	**CF***	**FF**	**FFP Rate****
Acute Care Utilization Review	$1,375,906	$345,428	$16,520	$1,013,958	73%

**Cash Funds from the Health Care Expansion Fund*

*** Manual calculation of federal funds does not equal listed FFP rate due to rounding.*

Table 4: Number Of Prior Authorization Reviews Received During 1st Quarter FY 2009-10	
Month	**Prior Authorization Reviews**
July 2009	1,434
August 2009	1,746
September 2009	1,802
Monthly Average for 1st Quarter	1,661

Table 5.1: Number Of Months Before Prior Authorization Review Limit Is Reached in FY 2009-10		
Row	**Description**	
A	Prior Authorization Review Limit Per Contract	12,500
B	Estimated Annual Increase In FY 2009-10 (Table 6, Row C)	2,135
C	Estimated Monthly Average In FY 2009-10 (Row A + Row B) / 12	1,220
D	Number Of Months Before Prior Authorization Review Limit Is Reached (Row A / Row C)	10 months

Table 5.2: Number Of Months Before Prior Authorization Review Limit Is Reached in FY 2010-11		
Row	**Description**	
A	Prior Authorization Review Limit Per Contract	12,500
B	Estimated Annual Increase In FY 2009-10 (Table 6, Row C)	2,135
C	Estimated Annual Increase In FY 2010-11 (Table 7, Row C)	1,604
D	Estimated Monthly Average In FY 2010-11 (Row A + Row B + Row C) / 12	1,353
E	Number Of Months Before Prior Authorization Review Limit Is Reached (Row A / Row D)	9 months

Table 6: FY 2009-10 Funding Need For Additional Acute Care Prior Authorization Reviews		
Row	**Description**	
A	Base Number Of Prior Authorization Reviews	12,500
B	Projected Annual Increase In Medicaid Caseload	17.08%
C	Estimated Increase For Caseload (Row A * Row B)	2,135
D	Estimated Total Fund Need For FY 2009-10 (Row C * $40)	$85,400

Table 7: FY 2010-11 Funding Need For Additional Acute Care Prior Authorization Reviews		
Row	**Description**	
A	Base Number Of Prior Authorization Reviews (Table 6, Row A + Row C)	14,635
B	Projected Annual Increase In Medicaid Caseload	10.96%
C	Estimated Increase For Caseload (Row A * Row B)	1,604
D	Estimated Total Fund Need For FY 2010-11 (Row C * $40)	$64,160

Table 8: Correct Fund Splits For Acute Care Utilization Review in FY 2009-10 and FY 2010-11					
Description	**TF**	**GF**	**CF**	**FF**	**FFP Rate**
Appropriation For Acute Care Utilization Review Per SB 09-259*	$1,375,906	$345,428	$16,520	$1,013,958	73%
Adjust Federal Financial Participation To Reflect 75% FFP For Contractor Qualifying As A Quality Improvement Organization	$1,375,906	$327,457	$16,520	$1,031,929	75%
Difference (General Fund Savings)	$0	($17,971)	$0	$17,971	-

** Manual calculation of federal funds does not equal listed FFP rate due to rounding.*

Assumptions for Calculations: The Department assumes acute care utilization review services would be funded by enhanced federal financial participation of 75% for the performance of medical and utilization review by a quality improvement organization (42 C.F.R. §433.15 (b)(6)(i), (2008)).

The Department's contractor charges $40 per prior authorization review and assumes this rate in calculating cost for additional prior authorization reviews.

The Department used projected Medicaid caseload growth rates of 17.08% for FY 2009-10 and 10.96% for FY 2010-11 (Exhibits for Medical Services Premiums, FY 2010-11 Budget Request, November 6, 2009, Exhibit B, page EB-1).

Impact on Other Government Agencies: Not applicable.

Cost Benefit Analysis:

FY 2009-10 Cost Benefit Analysis	Benefit	Cost
Request	The Department gains the benefits of having a quality improvement organization conducting prior authorization reviews for acute care services to ensure that services are medically appropriate.	Net General Fund cost is $3,379 in FY 2009-10.
Consequences if not funded	No net General Fund cost of $3,379 in FY 2009-10.	The Department may incur additional Medical Services Premiums costs of $2,164,280 for the two months that prior authorization reviews for acute care services are suspended due to reaching the contract limit of 12,500 prior authorization reviews per fiscal year.

FY 2010-11 Cost Benefit Analysis	Benefit	Cost
Request	The Department gains the benefits of having a quality improvement organization conducting prior authorization reviews for acute care services to ensure that services are medically appropriate.	Net General Fund cost is $19,419 in FY 2010-11.
Consequences if not funded	No net General Fund cost of $19,419 in FY 2010-11.	The Department may incur additional Medical Services Premiums costs of $3,600,333 for the three months that prior authorization reviews for acute care services are suspended due to reaching the contract limit of 12,500 prior authorization reviews per fiscal year.

Implementation Schedule: Not applicable.

Statutory and Federal Authority: Sec. 1903. [42 U.S.C. 1396b] *(a) From the sums appropriated therefore, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—*

(3) an amount equal to—

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity which meets the requirements of section 1152, as determined by the Secretary, under a contract entered into under section 1902(d);

Sec. 1902. [42 U.S.C. 1396a] *(a) A State plan for medical assistance must—*

(d) If a State contracts with an entity which meets the requirements of section 1152, as determined by the Secretary, or a utilization and quality control peer review organization having a contract with the Secretary under part B of title XI for the performance of

medical or utilization review functions required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

Sec. 1152. [42 U.S.C. 1320c–1] *The term "utilization and quality control peer review organization" means an entity which—*

(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secretary under section 1153, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured;

(2) is able, in the judgment of the Secretary, to perform review functions required under section 1154 in a manner consistent with the efficient and effective administration of this part and to perform reviews of the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice; and

(3) has at least one individual who is a representative of consumers on its governing body.

Section 42 C.F.R. §433.15 (b)(6)(i), (2008) *Funds expended for the performance of medical and utilization review by a QIO under a contract entered into under section 1902(d) of the Act: 75 percent (section 1903(a)(3)(C) of the Act).*

Performance Measures:

Increasing funds for the acute care utilization review line item will help the Department achieve its performance measure to maintain or reduce the difference between the Department's spending authority and actual expenditures for Medical Services Premiums.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐	**Base Reduction Item FY 2010-11** ☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☑

Request Title: Refinance Colorado Benefit Management System Improvements
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew for SB 12/30/09 **Date:** January 4, 2010
Priority Number: S-11, BA-9 **OSPB Approval:** **Date:** 1-4-10

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	**Total**	1,185,057	5,495,100	(1,749,976)	3,745,124	2,995,100	0	2,995,100	(1,749,976)	1,245,124	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	4,850,960	3,933,260	(814,545)	3,118,715	1,433,260	0	1,433,260	(814,545)	618,715	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(4,011,578)	0	0	0	0	0	0	0	0	0
	CFE/RF	3,822	0	5,515	5,515	0	0	0	5,515	5,515	0
	FF	341,853	1,561,840	(940,946)	620,894	1,561,840	0	1,561,840	(940,946)	620,894	0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Colorado Benefits Management System Medical Assistance Project	**Total**	98,825	2,995,100	(2,995,100)	0	2,995,100	0	2,995,100	(2,995,100)	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	42,122	1,433,260	(1,433,260)	0	1,433,260	0	1,433,260	(1,433,260)	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	56,703	1,561,840	(1,561,840)	0	1,561,840	0	1,561,840	(1,561,840)	0	0
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	**Total**	513,604	2,500,000	2,543	2,502,543	0	0	0	2,543	2,543	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	4,525,182	2,500,000	2,543	2,502,543	0	0	0	2,543	2,543	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(4,011,578)	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10**	☑	**Budget Amendment FY 2010-11**	☑				
Request Title:	Refinance Colorado Benefit Management System Improvements										
Department:	Health Care Policy and Financing			**Dept. Approval by:**	John Bartholomew			**Date:**	January 4, 2010		
Priority Number:	S-11, BA-9			**OSPB Approval:**				**Date:**			
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System Client Services Improvement Project	**Total**	572,628	0	1,242,581	1,242,581	0	0	0	1,242,581	1,242,581	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	283,656	0	616,172	616,172	0	0	0	616,172	616,172	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	3,822	0	5,515	5,515	0	0	0	5,515	5,515	0
	FF	285,150	0	620,894	620,894	0	0	0	620,894	620,894	0
Non-Line Item Request:	The Department requests rollforward authority for up to $1,229,811 total funds in FY 2009-10 and up to $2,057,120 total funds in FY 2010-11.										
Letternote Revised Text:	Of this amount, $2,972 shall be from Old Age Pension Fund managed by the Department of Human Services and $2,543 shall be from the Children's Basic Health Plan Trust.										
Cash or Federal Fund Name and COFRS Fund Number:	FF: Title XIX, Title XXI										
Reappropriated Funds Source, by Department and Line Item Name:	Old Age Pension Fund managed by the Department of Human Services; Children's Basic Health Plan Trust										
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑								
Schedule 13s from Affected Departments:	Department of Human Services										

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Departments:	Health Care Policy and Financing and Human Services
Priority Number:	S-11, BA-9
Change Request Title:	Refinance Colorado Benefit Management System Improvements

SELECT ONE (click on box):

☐ Decision Item FY 2010-11
☐ Base Reduction Item FY 2010-11
☒ Supplemental Request FY 2009-10
☒ Budget Request Amendment FY 2010-11

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: Both the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Human Services (DHS) request that $2,995,100 for Colorado Benefits Management System Medical Assistance Project in FY 2009-10 appropriated to HCPF be refinanced and transferred to DHS in a new line item for the total amount of $3,302,100 total funds in FY 2009-10. Both Departments also request that $2,995,100 included in the base request for FY 2010-11 be refinanced and transferred to DHS for a total of $3,302,100. No additional General Fund is requested in both years. The purpose of this request is to allocate the costs to the programs and federal partners that will benefit from the project. No annualization is requested into FY 2011-12.

Background and Appropriation History: The Colorado Benefits Management System (CBMS) became operational in September 2004. At that time, it was the most technologically advanced eligibility determination and financial assistance calculation system to be used by HCPF and DHS. The system

supports interactive interviews with clients, assesses the eligibility of applicants, calculates benefits for clients, and provides ongoing case management and history tracking. Several programs for which CBMS determines eligibility include Aid to the Blind, Aid to the Needy Disabled, Adult Protective Services, Children's Basic Health Plan, Colorado Works (known as Temporary Assistance for Needy Families or TANF), Food and Nutrition Services (known as Food Stamps), Medicaid, Old Age Pension, and Old Age Pension State Medical Program. The programs supported by CBMS are State supervised but generally county administered.

The Colorado Benefits Management System Medical Assistance Project line item came about based on the initial prioritized request of S-1A and BA-A1A, titled "Building Blocks to Health Care Reform," submitted by HCPF on February 15, 2008 in the "Supplemental Requests and Budget Amendment Requests for Medical Services Premiums; Health Care Reform Building Blocks; Mental Health Programs; Children's Basic Health Plan; and Medicare Modernization Act State Contribution Payment". That request, in turn, had been the result of recommendations by the Blue Ribbon Commission for Health Care Reform, commonly referred to as the 208 Commission, authorized by SB 06-208. HCPF is committed to improving access to health care for low-income and uninsured Colorado residents, improving the quality of health care services its clients are receiving, and decreasing overall health care costs. As a result of those efforts, it is anticipated that the number of medical assistance applications likely would increase significantly in the coming years.

With the passage of the Colorado Health Care Affordability Act (HB 09-1293), health care coverage will be expanded to 100,000 additional previously uninsured Coloradans. To achieve our goal of enrolling these new populations, the operational capacity of CBMS needs to be addressed. Additionally, Medicaid federal regulations have requirements for eligibility determinations that sometimes differ considerably from regulations for the other assistance programs in CBMS. Of particular interest was finding a way to implement computer programming changes to CBMS in a manner that would not adversely affect the other State assistance programs also using the CBMS for eligibility determination. The original intention was to go forward with necessary steps to implement those

recommendations from the consultant, Solutions Consulting Group Inc. also know as Public Knowledge, for improvements to client services related to medical programs. Of course, all of the assistance programs included in CBMS would benefit from the planned client services improvements.

From an appropriated amount of $1,561,000 in FY 2008-09, HCPF transferred $1,462,175 to DHS that was leveraged with additional federal funding for total funding of $1,623,982 to be used for CBMS client services improvements, as approved by the Joint Budget Committee as a 1331 Supplemental Request submitted and reviewed June 22, 2009.

Colorado Benefits Management System Medical Assistance Project no longer adequately described the situation. Instead, a more encompassing name of Colorado Benefits Management System Client Services Improvement Project was implemented as a new line item name in FY 2008-09. A separate line item facilitates more effective project management and tracking of costs. Funding in this new line item was used for development costs to bring about client services improvements. This funding does not support the day-to-day maintenance and operational expenditures of CBMS as represented in the main CBMS budget line item. Development of a client-facing web portal that will allow applicants to apply for benefits online and computer software changes for intelligent data entry that will make it easier for eligibility workers to enter information into CBMS began in the latter months of FY 2008-09. Much progress has occurred, but these changes are far from finished. These projects are continuing the original intent of improving medical access for potential clients, but the projects also improve access to other nonmedical assistance programs for eligible clients.

General Description of Request: Both HCPF and DHS request to go forward with the full amount of $2,995,100 appropriated for FY 2009-10, to be leveraged into a larger total amount by adding in certain cash funds and increased federal funds that become available as part of the funding mix when all of the assistance programs in CBMS participate in the improvements project. No additional General Fund is needed because both Departments would share the amount

of General Fund currently appropriated only to HCPF. The increased available funding will be explained later in this request. Both Departments propose to transfer all current funding for FY 2009-10 to this arrangement while adding the additional funding gained through the arrangement. Although there have been expenditures already paid by the Department of Health Care Policy and Financing, both Departments request that all expenditures for this fiscal year be reallocated according to the Random Moment Sampling methodology detailed later in this request. For FY 2010-11, all related funding would be handled in the same manner according to Random Moment Sampling methodology.

Client Services Improvement Project

Two improvements currently are in progress: the Web Based Portal and Intelligent Data Entry. These two particular improvements relate to the intent of the original funding purpose by improving access for clients needing medical assistance, but the projects go beyond the original intent by improving the entire Colorado Benefits Management System usability for Colorado citizens.

Web Based Portal

Research indicates that a growing number of low-income residents have access to computers and the Internet. Many states have experienced great success in developing online tools that potential applicants can use to apply for benefits and that existing clients can use to manage their benefits and report changes. The ability for applicants and clients to use an online self-service application also reduces the workload of CBMS workers who no longer have to process the paper application. The CBMS vendor has developed a Web-based online application, that when fully implemented, will be integrated into CBMS. The new web portal system is called the Colorado Program Eligibility Application Kit, otherwise known as Colorado PEAK, and the first phase was implemented on October 26, 2009. The current functionality allows any person to screen for potential eligibility online for several assistance programs included in CBMS through a module called "Am I Eligible." A second module allows existing clients to check the status of their benefits through the "Check My Benefits" function. Potential applicants or existing clients can easily access PEAK through a computer at home, at a public library, at a workforce center

operated by other State agencies, or at any other location. Potential clients can begin the application process by entering certain personal information into the secure online application. Phase Two of PEAK will allow applicants to submit their application online and will permit clients to report changes to their status. It is anticipated that Phase Two of PEAK will be implemented in late Spring of 2010. Additional functionality will be implemented in Phase Three of PEAK, although the scope of work and timeline have not been finalized.

Work on the design of the web portal change began during FY 2008-09. The first phase, completed in October 2009 and the second phase to be completed in March 2010, is estimated to cost $1,207,166. Although a great majority of the functionality will be achieved by March 2010, additional upgrades to Colorado PEAK in order to ease the complexities of application processing for both potential clients and county eligibility determination workers will continue into the future and will require additional funding estimated to be $230,611.

Regular maintenance of Colorado PEAK by Deloitte personnel is estimated at $142,000 for ten months remaining in FY 2009-10 after the initial roll out in October 2009.

Computer environmental supports by an outside vendor for Colorado PEAK is estimated at $68,053 for ten months in FY 2009-10.

The above types of costs would continue into FY 2010-11. Continued upgrades for Colorado PEAK by Deloitte are conservatively estimated at $50,000. Regular maintenance of Colorado PEAK for 52 weeks is estimated at $208,000 during FY 2010-11. Other computer environmental supports for Colorado PEAK by an outside vendor are estimated conservatively at $79,264. The costs for maintenance would be ongoing; however, if additional funding is required for FY 2011-12 or beyond, the Departments would seek additional funding through the normal budget process.

Intelligent Data Entry also has continuing costs that are detailed below.

Intelligent Data Entry

The Intelligent Data Entry project focuses on making changes to CBMS that make it easier for eligibility workers to enter data into CBMS and navigate the screens within CBMS. Changes to the content and screen appearance in CBMS would simplify data entry and achieve greater worker efficiencies and reduce the time required to enter information into CBMS for the eligibility worker. CBMS training would also become more streamlined and user-friendly. It is also anticipated that worker satisfaction and morale will be improved by implementing intelligent data entry based on the experiences in other states. By reducing the number of screens required for data entry and streamlining the screens, the overall CBMS eligibility and enrollment data processing can be simplified. All required information currently needed for eligibility determination continues to be collected and maintained for historical reference. However, data fields not currently required or used would be eliminated and the remaining information would be consolidated in such a way to reduce the number of screens within CBMS. Eligibility workers would be able to navigate CBMS more easily and decrease the amount of time it takes for the data on the paper application to be entered into CBMS.

The first phase of intelligent data entry changes was contracted in FY 2008-09 for $141,930, and the work for that amount has been completed. Continuation of this work into FY 2009-10 is progressing, as contracted, for $605,070, within the current appropriation. The second phase of intelligent data entry also at $605,070 is anticipated to begin in the latter half of FY 2009-10 after the first phase has been completed.

It is estimated that $999,200 will be needed in FY 2009-10 to continue into the second phase of intelligent data entry. More funding to continue the second phase of development is estimated at $2,057,120 in FY 2010-11.

Both client services improvements drive needs for additional computer hardware and software, and $50,000 is estimated for the purchase of additional server equipment in FY 2009-10.

Deloitte, the CBMS vendor, has estimated that the second phase of development for intelligent data may take up to 12 months to complete. That time frame would push the completion date into FY 2010-11 and part of the payment for the development also into FY 2010-11 since payment for the work is not billable and payable until after the completion of the work actually occurs.

A third improvement to client services is anticipated to begin in FY 2010-11 and focuses on making improvements to the CBMS client correspondence. The goal of this initiative is to streamline the client correspondence by reducing the amount of correspondence a client receives and also to improve the overall readability of the client correspondence by eliminating seemingly contradictory and confusing language in the correspondence. The estimated cost for this improvement is $918,616.

Benefits

Benefits of the web based portal known as Colorado PEAK and intelligent data entry include the following:

- Any person can go online for a quick, anonymous self-assessment of potential eligibility.
- If the person chooses to go forward, the client can apply for multiple assistance programs that are covered by CBMS via a short series of web pages.
- Clients could check their assistance benefits by viewing their eligibility online.
- Clients could report changes in employment, other income, bills, and other household changes such as adding a new dependent, divorce, marriage, pregnancy, or disability by using the online resource.
- Online assessment of eligibility would be available in easy to read language at a fourth grade reading level to be inclusive of various clients' abilities.
- Potential clients can save and complete the application at a later time.
- The submission process would provide clients with application tracking information and a printable version of the application.
- Eligibility workers may log in and view the same information in CBMS as the client sees.

- The application process could be expedited by allowing the client to have already provided much of the information online before contact with an eligibility determination worker.
- Eligibility determination workers would notice a reduction in amount of paper needed because the same information would be available online.
- Clients would have reduced travel needs to eligibility determination offices because much of the needed information could be already available by their own online data entry. Reduced travel would be especially helpful for clients whose age or physical and mental abilities might make travel difficult.
- The improved online capabilities would enhance coordination and cooperation between agencies and contracted partners that provide services for the various assistance programs covered by CBMS.

To maintain computer security for both potential clients and eligibility determination workers, the above client services improvements would employ identification and authentication controls, session management and audit trails, encrypted communication channels, and infrastructure/network controls such as firewall separation and application monitoring for suspicious levels of usage.

Both Departments agree that there are unknowns associated with the Client Services Improvement Project. Additional improvements are being researched and are not yet available for inclusion at this time. As additional improvements become known, it is possible that the improvements may need to continue into the future beyond the FY 2009-10 and FY 2010-11 timeframe, possibly by one or two more years. Therefore, as shown in Table B the Department requests rollforward authority for certain line item amounts in FY 2009-10 and FY 2010-11.

Costs for the currently planned client services improvement processes, as well as additional processes to be formulated in the future, would be shared by both Departments based on Random Moment Sampling that allocates funding between the Departments as well as among the various assistance programs covered by CBMS. Within the various programs, the funding is further delineated among State funding and other sources such as

federal financial participation. The allocation depends on results reported from Random Moment Sampling that arrives at approximate shares of funding for each Department.

Consequences if Not Funded:

If this request were not approved, there would be continuation of inefficiencies and duplication of effort between the Departments as well as continued public frustration about the usability of CBMS. There would also be a failure to allocate the costs to the particular assistance programs for which the costs are associated, as well as failure to obtain federal financial participation properly for the particular assistance programs.

Without the increase in federal funding, the Departments will be forced to delay the Intelligent Data Entry project by at least 90 days. By doing so, the contractor staff currently assigned to the project would be reassigned, delaying the project further and potentially adding additional cost to the project. Additional delays may open the Department to further litigation related to eligibility determinations.

As described earlier in the request (page 8), the Intelligent Data Entry project creates large administrative efficiencies for county eligibility workers. By decreasing the amount of time it takes for the data on the paper application to be entered into CBMS, the Department may reduce the need for additional county administration funding in the future.

Calculations for Request:

Summary of Request FY 2009-10 and FY 2010-11 Department of Health Care Policy and Financing	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Total Net Request	($1,749,976)	($814,545)	$0	$5,515	($940,946)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Colorado Benefits Management System Medical Assistance Project	($2,995,100)	($1,433,260)	$0	$0	($1,561,840)
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	$2,543	$2,543	$0	$0	$0
(Reactivate line item used in FY 2008-09) Department of Health Care Policy and Financing; (6) Department of Human Services Medicaid-Funded Programs, (B) Office of Information Technology Services – Medicaid Funding, CBMS Client Services Improvement Project*	$1,242,581	$616,172	$0	$5,515	$620,894

The sources of Reappropriated Funds are $2,543 from the Children's Basic Health Plan and $2,972 from the Old Age Pension Fund managed by the Department of Human Services.

*The Department requests rollforward authority for up to $1,229,811 total funds in FY 2009-10 and up to $2,057,120 total funds in FY 2010-11(See Table B).

Table A: Calculation of the Request Amount and Fund Splits

Row	Description	Total Funds	General Fund	Cash Funds	Reappropri-ated Funds	Federal Funds	Medicaid Cash Fund	Medicaid General Fund	Net General Fund
A	Original HCPF Funding Split	$2,995,100	$1,433,260	$0	$0	$1,561,840	N/A	N/A	N/A
B	Estimated Random Moment Sampling percentages for HCPF.	37.63%	18.74%	0.00%	0.09%	18.80%	N/A	N/A	N/A
C	Estimated Random Moment Sampling percentages for the Department of Human Services	100.00%	24.67%	4.66%	37.63%	33.05%	37.63%	18.74%	43.40%
D	Estimated Total amount holding the Original General Fund constant (Row A General Fund divided by Row C Net General Fund percentage).	$3,302,100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E	Health Care Policy and Financing Fund Splits (Row D*Row B).	$1,242,581	$618,715	$0	$2,972	$620,894	N/A	N/A	N/A
F	Department of Human Services Fund Splits (Row D*Row C)	$3,302,100	$814,545	$153,795	$1,242,581	$1,091,179	$1,242,581	$618,715	$1,433,260

Note that the General Fund and reappropriated funds amounts and percentages reflect that the Children's Basin Health Plan Trust fund must be backfilled with General Fund (see Assumptions for Calculations). In this table, the amount required for the Children's Basic Health Plan Trust has been removed from the reappropriated funds and included in General Fund to avoid a double count. Some numbers may not add exactly due to rounding.

Table B: How the Funding Will Be Used		
Fiscal Year	**Use**	**Dollars**
FY 2009-10	Web Portal (Colorado PEAK) Continued Development that began in FY 2008-09	$1,207,166
	Continued Upgrades to Colorado PEAK *	$230,611
	Maintenance of Colorado PEAK for 35.5 Weeks by Deloitte - Estimated	$142,000
	Purchase of Additional Server Equipment - Estimated	$50,000
	Other Environmental Supports for Colorado PEAK by Outside Vendor - Estimated	$68,053
	Intelligent Data Entry Continued Development in Phase One that began in FY 2008-09(1)	$605,070
	Start Second Phase of Intelligent Data Entry Development – Estimated*	$999,200
	Total for FY 2009-10	**$3,302,100**
FY 2010-11	Continued Second Phase of Intelligent Data Entry Development - Estimated(1)*	$2,057,120
	Adjust Colorado PEAK to Remain Compatible with Intelligent Data Entry Changes - Estimated	$50,000
	Regular Maintenance of Colorado PEAK for 52 Weeks by Deloitte - Estimated	$208,000
	Other Environmental Supports for Colorado PEAK by Outside Vendor - Estimated	$79,264
	Development to Streamline Client Correspondence – Estimated	$918,616
	Total for FY 2010-11	**$3,302,100**

(1) If the incremental increase in funding is not granted, the program budget for the Intelligent Data Entry projects in anticipated to be reduced by the full amount, $307,100, in both FY 2009-10 and FY 2010-11. Please see the "Consequences if Not Funded" section of this request for additional details.

*The Department requests rollforward authority for up to $1,229,811 total funds in FY 2009-10 and up to $2,057,120 total funds in FY 2010-11.

Cash Funds Projections:

Cash Fund Name	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Children's Basic Health Plan Trust	11G	$32,626,199	$6,608,063	$817,042	$2,586,082	($7,626,685)
Old Age Pension Fund	See Note 2 Below					

Note 1: Children's Basic Health Plan Trust as reported in Schedule 9 of Budget Request for FY 2010-11 submitted by HCPF on November 2, 2009.

Note 2: Old Age Pension Fund, created in Article XXIV of the State Constitution, does not have a specific balance but is managed by the State Controller to have the amount needed for programs for eligible Old Age Pension clients.

Assumptions for Calculations:

For this request, the General Fund amount has been held constant by sharing the amount originally appropriated to HCPF between DHS and HCPF.

It is assumed that:

- The State share of the Children's Basic Health Plan related costs will be 35% and the federal funds will be 65%.
- The State share of costs related to Old Age Pension Fund will be 100%.
- Costs related to TANF (Colorado Works) will be 100% from the federal block grant.
- Costs associated with Food Stamps will be 50% for the State share and 50% for the federal share.
- Costs related to Foster Care will be 100% as the State share.
- Costs related to the Title XX Block Grant will be 100% as the State share.
- Costs related to Adult Protective Services will be 100% as the State share.
- Costs related to Medicaid will be 50% General Fund and 50% federal funds.

Children's Basic Health Plan costs will be first assigned to the Trust Fund but then transferred to General Fund for the State share because the Children's Basic Health Plan Trust Fund is struggling to maintain an adequate cash balance. This transfer has been

factored into the calculations to hold the General Fund amounts constant at the level originally appropriated. The federal funds to match the Children's Basic Health Plan costs will be drawn down at 65%, the usual level, and are included in the requested fund splits for federal funds.

The total funds to be available has been enhanced by adding the Old Age Pension Fund amount that was not originally included in the appropriation and by the increased federal funds amounts to be available by including all of the program sources rather than just the Medicaid program as a source for federal funds.

Random Moment Sampling (RMS), the methodology approved by federal Division of Cost Allocation, has been used to determine costs applicable to DHS programs and HCPF programs. Data for RMS is obtained by polling the county workers for the local departments of social services to determine what program the worker is dealing with at the time of the telephone call. The worker responses are tabulated and summed for reporting purposes on a quarterly schedule. The results of the quarterly reports are used for determining the total share of CBMS costs that DHS and HCPF share. When the results show important shifts in the percentages of work devoted to the different programs, both HCPF and DHS submit a budget request to realign the percentages of funding appropriated to each of the State departments. The last RMS adjustment occurred for funding in FY 2008-09 and has continued at the same level for FY 2009-10. Both Departments assume the current funding divisions would be used for this new line item as well. The allocation used for this request has been updated to 37.63% for HCPF programs and 62.37% for DHS programs. The HCPF appropriation for this line item would also be included as reappropriated funds in the total appropriation for DHS.

Whenever, the RMS allocations change, both Departments request adjustments accordingly. Such adjustments might occur annually and would be addressed through a separate budget request.

The previously used RMS percentages of 38.31% for HCPF and 61.69% for DHS under prior RMS results would have caused a higher leveraged amount of additional funding.

Analysis of the changes in percentages related to the various programs for each Department shows that the HCPF programs of Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program all had decreases in RMS results. Conversely, two DHS programs that do not receive federal matching, Adult Protective Services and Old Age Pension, showed increases in the in RMS percentage results, but without additional federal matching dollars, the overall gain in leveraged dollars is less, with a total funds gain of $307,000.

In order to calculate the total request amount the Department held the total General Fund amount constant at the already appropriated amount. To calculate the total amount of the request, the Department divided the current General Fund appropriation by the estimated RMS General Fund percentage. This calculated total fund amount is then split up based on the estimated RMS percentages for each of the funding sources. Details of the calculation are provided in Table A.

Impact on Other Government Agencies: The Department of Human Services is a co-requester.

Summary of Request FY 2009-10 and FY 2010-11 Department of Human Services	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropri-ated Funds**	**Federal Funds**	**Medicaid Cash Fund**	**Medicaid General Fund**	**Net General Fund**
(Reactivate line item used in FY 2008-09) Department of Human Services; (2) Office of Information Technology Services, CBMS Client Services Improvement Project*	$3,302,100	$814,545	$153,795	$1,242,581	$1,091,179	$1,242,581	$618,715	$1,433,260

*The Department requests rollforward authority for up to $1,229,811 total funds in FY 2009-10 and up to $2,057,120 total funds in FY 2010-11 (See Table B).

Cost Benefit Analysis:

Cost	Financial Benefits
$307,100 Additional Funding to be available in FY 2009-10 and FY 2010-11.	No additional General Fund is required. Additional funding is from adding cash funds and more federal funds.
	Appropriately allocates the costs to the various federal partners.
	Allows HCPF and DHS to share improvements and costs for improvements in CBMS.
	Currently planned new developments would allow potential clients to input personal data online which will save time and allow eligibility determination workers to concentrate on policy and case management that is a more cost effective use of their time.

Statutory and Federal Authority:

25.5-4-106 (3), C.R.S. (2009) *The State Department shall cooperate with the federal Department of Health and Human Services and other federal agencies in any reasonable manner in conformity with the laws of this state, which may be necessary to qualify for federal financial participation, including the preparation of State Plans, the making of reports in such form and containing such information as any federal agency may from time to time require, and the compliance with such provisions as the federal government may from time to time find necessary to assure the correctness and verification of the reports.*

25.5-4-204 (1) (b) and (d), C.R.S. (2009) *The General Assembly hereby finds and declares that the agency responsible for the administration of the State's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that would provide the following:*
(b) On-line eligibility determinations; (d) Electronic fund transfers.

Performance Measures:

Although the Department has no performance measure specifically related to the CBMS, the Department believes that the improvements to result from this request would improve access to health care, increase health outcomes from better access, and provide more cost effective services to clients by greater use of information technology, as well as expedite eligibility determination for financial assistance programs for needy Coloradans.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11

Request Title: CBMS Client Correspondence Caseload Increase
Department: Health Care Policy and Financing
Priority Number: S-13
Dept. Approval by: John Bartholomew BB **Date:** January 4, 2010 12/16/09
OSPB Approval: [signature] **Date:** 12-28-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	10,575,820	11,580,722	184,275	11,764,997	9,414,173	0	9,414,173	0	9,414,173	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	8,411,762	6,989,092	91,568	7,080,660	4,384,989	0	4,384,989	0	4,384,989	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(2,902,454)	28,758	0	28,758	303,624	0	303,624	0	303,624	0
	CFE/RF	66,563	31,995	816	32,811	25,009	0	25,009	0	25,009	0
	FF	4,999,949	4,530,877	91,891	4,622,768	4,700,551	0	4,700,551	0	4,700,551	0
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	Total	513,604	2,500,000	376	2,500,376	0	0	0	0	0	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	4,525,182	2,500,000	376	2,500,376	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(4,011,578)	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	10,062,216	9,080,722	183,899	9,264,621	9,414,173	0	9,414,173	0	9,414,173	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	3,886,580	4,489,092	91,192	4,580,284	4,384,989	0	4,384,989	0	4,384,989	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,109,124	28,758	0	28,758	303,624	0	303,624	0	303,624	0
	CFE/RF	66,563	31,995	816	32,811	25,009	0	25,009	0	25,009	0
	FF	4,999,949	4,530,877	91,891	4,622,768	4,700,551	0	4,700,551	0	4,700,551	0

Non-Line Item Request: None.
Letternote Revised Text: Of these funds, $32,435 shall be from moneys in the Old Age Pension Fund appropriated to the Department of Human Services, pursuant to Article 24 of the State Constitution and $376 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1), C.R.S.
Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX; Title XXI
Reappropriated Funds Source, by Department and Line Item Name: Old Age Pension Fund managed by the Department of Human Services; Children's Basic Health Plan Trust
Approval by OIT? Yes: No: N/A: ✓
Schedule 13s from Affected Departments: Department of Human Services

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐	Base Reduction Item FY 2010-11 ☐	Supplemental FY 2009-10 ☑	Budget Amendment FY 2010-11 ☐

Request Title: CBMS Client Correspondence Caseload Increase per HCP&F S-13
Department: Human Services
Dept. Approval by: Will Koh **Date:** 12-17-09
Priority Number: S-NP-3
OSPB Approval: [signature] **Date:** 12-28-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	26,078,109	23,416,655	488,702	23,905,357	23,893,959	0	23,893,959	0	23,893,959	0
	FTE	43.3	47.1	0.0	47.1	47.1	0.0	0.0	0.0	0.0	0.0
	GF	3,590,793	5,591,860	120,550	5,712,410	5,646,781	0	5,407,373	0	5,407,373	0
	CF	3,258,624	996,712	22,761	1,019,473	972,224	0	748,520	0	748,520	0
	RF	10,017,619	8,957,495	183,899	9,141,394	9,414,173	0	8,669,071	0	8,669,071	0
	FF	9,211,073	7,870,588	161,492	8,032,080	7,860,781	0	6,814,925	0	6,814,925	0
	MCF	10,017,619	8,957,495	183,899	9,141,394	9,414,173	0	8,669,071	0	8,669,071	0
	MGF	3,863,887	4,427,495	91,192	4,518,687	4,384,991	0	4,049,067	0	4,049,067	0
	NGF	7,454,680	10,019,355	211,742	10,231,097	10,031,772	0	9,456,440	0	9,456,440	0
(2) Office of Information Technology, Colorado Benefits Management System (CBMS)	Total	26,078,109	23,416,655	488,702	23,905,357	23,893,959	0	23,893,959	0	23,893,959	0
	FTE	43.3	47.1	0.0	47.1	47.1	0.0	0.0	0.0	0.0	0.0
	GF	3,590,793	5,591,860	120,550	5,712,410	5,646,781	0	5,407,373	0	5,407,373	0
	CF	3,258,624	996,712	22,761	1,019,473	972,224	0	748,520	0	748,520	0
	RF	10,017,619	8,957,495	183,899	9,141,394	9,414,173	0	8,669,071	0	8,669,071	0
	FF	9,211,073	7,870,588	161,492	8,032,080	7,860,781	0	6,814,925	0	6,814,925	0
	MCF	10,017,619	8,957,495	183,899	9,141,394	9,414,173	0	8,669,071	0	8,669,071	0
	MGF	3,863,887	4,427,495	91,192	4,518,687	4,384,991	0	4,049,067	0	4,049,067	0
	NGF	7,454,680	10,019,355	211,742	10,231,097	10,031,772	0	9,456,440	0	9,456,440	0

Non-Line Item Request: None
Letternote Revised Text: o. Of these amounts, it is estimated that $3,358,267 shall be from the Temporary Assistance for Need Families Block Grant, $4,723,718 shall be from Food Stamp funds
Cash or Federal Fund Name and COFRS Fund Number: Cash Fund - Old Age Pension $22,761; Reappropriated Funds - Medicaid $183,899; Federal Funds - TANF $66,024 and Food Stamps $95,468.
Reappropriated Funds Source, by Department and Line Item Name: Health Care Policy and Financing - (6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS (B) Office of Information Technology-Medicaid Funding, Colorado Benefits Mangement System
Approval by OIT? Yes: ☑ No: ☐ N/A: ☐
Schedule 13s from Affected Departments: Health Care Policy and Financing

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department(s):	Department of Health Care Policy and Financing and Department of Human Services
Priority Number:	S-13
Change Request Title:	CBMS Client Correspondence Caseload Increase

SELECT ONE (click on box):

☐ Decision Item FY 2009-10
☐ Base Reduction Item FY 2009-10
☒ Supplemental Request FY 2009-10
☐ 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: Both the Colorado Department of Health Care Policy and Financing and the Colorado Department of Human Services request $488,702 total funds, $212,118 General Fund ($91,568 for Health Care Policy and Financing and $120,550 for Human Services), for a needed increase in funding due to the increased volume of client correspondence that has resulted from unprecedented caseload growth. This request is necessary to prevent an overexpenditure during FY 2009-10.

Background and Appropriation History: The Colorado Benefits Management System (CBMS) became operational in September 2004. At that time, it was the most technologically advanced eligibility determination and financial assistance calculation system used by the Department of Human Services and the Department of Health Care Policy and Financing. The system supports interactive interviews with clients, assesses the eligibility of applicants, calculates benefits for clients, and provides ongoing eligibility case management and history tracking. Several programs for which CBMS determines eligibility include Aid to the Blind, Aid to the Needy

Disabled, Adult Protective Services, Children's Basic Health Plan, Colorado Works (known as Temporary Assistance for Needy Families or TANF), Food and Nutrition Services (known as Food Stamps), Medicaid , Old Age Pension (financial assistance), and Old Age Pension State Medical Program.

When CBMS makes the eligibility determination for applications for the above-referenced programs, CBMS automatically generates client correspondence notifying the client of their approval or denial for a program. When a client is no longer eligible for programs, CBMS automatically generates a notice to the client communicating the termination of their benefits. Applicants also receive client correspondence when additional information is needed to complete their application so that CBMS can make the eligibility determination. Client correspondence is also generated prior to a client's redetermination date notifying the client of the need to complete and return the redetermination packet. The United States Constitution and the federal Medicaid Act protect Medicaid applicants, as well as clients, seeking Medicaid services. Applicants may not be denied the opportunity to apply for Medicaid and clients must have their request for services acted upon in a reasonably prompt manner (42 U.S.C. § 1396a(a)(8); 42 CFR § 435.930). Notice of denials of eligibility or services must include the reasons for the action, the specific regulation supporting the action, and an explanation of the person's right to request a hearing (See 42 CFR § 435.912). State Medicaid agencies must inform applicants and clients of the right to request a hearing, the method to obtain a hearing, and the ability to be represented by an attorney or other representative. A fair hearing must be available to any individual whose application is denied or is not acted upon in a reasonably prompt manner. A hearing is also available when a state Medicaid agency seeks to deny, terminate, or suspend services. Case law has consistently upheld a client's due process rights in connection with the Medicaid program and has affirmed that the notice be in writing.

The Food Assistance Program administered by the Colorado Department of Human Services also is required by the federal government to provide notice of eligibility, reduction of benefits, or termination (See 7 CFR 273.10(g)(1)(i)(A)).

Consequently, applicants and clients receive correspondence throughout the eligibility determination and enrollment cycle. As a result of the economic downturn, application volumes have experienced a dramatic increase as evidenced by the historic number of clients now eligible for both medical and financial assistance programs. As the caseloads grow, there is a corresponding increase in the volume of client correspondence.

Client correspondence expenses include all costs associated with the printing and mailing of benefit notifications for CBMS programs. Client correspondence expenses include items such as postage, paper, envelopes, impression (printing) costs, and insertion of the notification into the envelope. CBMS has experienced increases in both the volume of correspondence, and the cost of some printing and mailing services over the past four years. Refer to Table 1 below.

Certain computerized actions in CBMS trigger client communications that are distributed to the clients. The process of printing, collating, inserting, and mailing these client correspondences and/or communications is a service provided by Integrated Document Solutions (IDS), a work unit within the Division of Central Services, Department of Personnel and Administration. The work by IDS is charged back to the CBMS project.

Managing the CBMS spending plan to absorb the annual increases during FY 2006-07, FY 2007-08, and FY 2008-09 for client correspondence has been a difficult struggle. Over this time period, both Departments and the Governor's Office of Information Technology have focused on ways to streamline and reduce client correspondence by eliminating unnecessary notices and reducing unnecessary verbiage to shorten the length of the mandatory notices. The Departments and the Governor's Office of Information Technology have achieved some reduction in costs as a result of these efforts. However, these efforts have been insufficient in terms of the offsetting increased costs associated with the increased volumes of client correspondence due to rising caseload. Therefore, both Departments believe that additional funding must be requested.

General Description of Request:

Both the Colorado Department of Human Services and the Colorado Department of Health Care Policy and Financing request $488,702 total funds, $212,118 General Fund ($91,568 for Health Care Policy and Financing and $120,550 for Human Services), for a needed increase in funding due to the increased volume of client correspondence that has resulted from unprecedented caseload growth. This request is necessary to prevent an overexpenditure during FY 2009-10.

Within CBMS, client correspondence is automated to send out specific "Notices of Action" as well as other correspondence required by Federal and State regulations, court actions, and county policies. A Notice of Action is a case-specific legal correspondence about actions being taken that will impact a client's eligibility and/or benefits. Other client correspondence includes all other non-Notice of Action correspondence such as letters and forms. A piece of client correspondence can be triggered within CBMS by actions taken by eligibility staff, CBMS interface updates, or other CBMS processes.

For many of the state programs that use CBMS, caseload is economically countercyclical. When economic hard times hit, more Coloradans are in need of the assistance that these programs provide. Some of these programs include Medicaid, the Children's Health Plan Plus, Food Stamps, and Temporary Need to Needy Families (TANF). Due to the severe economic downturn of the last several years, the caseload figures for most of these programs have significantly increased.

The official start of the recession in the United States was December 2007. The total Medicaid caseload for FY 2006-07 was 392,228 (Department of Health Care Policy and Financing, FY 2010-11 Budget Request, November 6, 2009, page EB-1). The Department of Health Care Policy and Financing estimates that Medicaid caseload will total 511,411 in FY 2010-11 (Department of Health Care Policy and Financing, FY 2010-11 Budget Request, November 6, 2009, page EB-1). This represents a caseload increase of approximately 30% over that period of time. Similarly, caseload for the Children's Health Plan Plus was 47,047 in FY 2006-07 and is estimated to equal 72,159 in FY 2009-10 (Department of Health Care Policy and Financing, FY 2010-11 Budget Request,

November 6, 2009, page C.6-1). This represents an increase in caseload of approximately 53% over that period of time.

In July 2007, prior to the start of the recession, the number of active Food Stamp clients reported in CBMS totaled 245,677. By July 2009, the number of active Food Stamp clients reported in CBMS totaled 339,341. This represents an increase of approximately 38% during that period. In July 2007, prior to the start of the recession, the number of active Colorado Works (TANF) clients reported in CBMS totaled 23,843. By July 2009, the number of active Colorado Works clients reported in CBMS totaled 24,402. This represents an increase of approximately 2% during that period. There are several smaller programs that also use CBMS; however, based on their size, the impact of changing caseloads of these smaller programs on CBMS client correspondence is estimated to be negligible.

Total client correspondence costs related to CBMS are directly correlated to the caseload figures for the programs that use CBMS. As more people apply for and enroll in these programs, more pieces of correspondence must be sent to clients and prospective clients. Correspondence to applicants and clients include but are not limited to notices of eligibility approval, eligibility denial, and enrollment termination.

As a result of the unprecedented increases in caseload for some programs, CBMS related client correspondence costs have increased from $3,674,220 in FY 2006-07 to $4,760,224 in FY 2008-09. This is approximately a 30% increase in client correspondence costs for CBMS over this period of time. This unprecedented financial burden has put a strain on the ability of CBMS to meet its client correspondence obligations and continue with system maintenance and scheduled enhancements.

If the State is unable to finance the increase in client correspondence costs driven by the unprecedented growth in caseload, there is a danger that the state will be unable to effectively distribute all of the required client correspondence. Such a failure could have

significant and far reaching consequences to the State's ability to continue to operate programs that provide assistance to some of Colorado's most vulnerable populations.

A failure to send client correspondence in a timely manner may create a perceived "more restrictive eligibility process". For example, a client who does not receive notification that they must provide specific documents may find that they are no longer enrolled or eligible for a program. By creating a perception of a "more restrictive eligibility process" the state is at risk of losing the enhanced Federal Medicaid Assistance Percentage (FMAP) that the State is receiving as a result of the American Recovery and Reinvestment Act of 2009 (ARRA). The Department of Health Care Policy and Financing estimates that the State will receive approximately $402.1 million in FY 2009-10 as a result of the ARRA enhanced FMAP. This increased federal funding has freed up approximately $342 million General Fund for purposes of balancing the FY 2009-10 state budget.

Additionally, without additional funding, the state risks potential litigation regarding the timeliness and legal sufficiency of the CBMS generated notices. On August 30, 2004 a lawsuit was filed in District Court, City and County of Denver, requesting a reversion to the legacy system because CBMS was not timely processing the eligibility for initial applications and for redeterminations for both medical and financial assistance programs. Faulty client correspondence was a key component of the plaintiff's allegations. A Stipulation and Order of Settlement was entered into by the parties on December 19, 2007. However, as a condition of the settlement agreement, the Colorado Department of Human Services had to ensure that each Food Stamp household receives a notice of expiration of its certification period prior to the start of the last month of its certification period advising the household that it must submit a new application in order to renew its eligibility for a new certification period.

Additionally, both Departments have received requests from various entities under the Colorado Open Records Act (CORA). The Department of Health Care Policy and Financing was required to submit documents relating to its corrective action plan for client notification related to the CBMS Post Implementation Review dated September 24, 2007.

A Supplemental Request was submitted by the Department of Human Services in February 2005 to request additional funding for several components needed to make improvements to CBMS which included the client correspondence component within CBMS. An Emergency Change Request for FY 2006-07 was also submitted to the Joint Budget Committee on June 20, 2006 to request additional funding to continue efforts on cases exceeding processing guidelines in CBMS.

As previously mentioned, both the Department of Human Services and the Department of Health Care Policy and Financing, working with the Governor's Office of Information Technology, have focused on efforts to streamline client correspondence within CBMS by reducing the amount of correspondence a client receives and improving the overall readability of the client correspondence by eliminating seemingly contradictory and confusing language in the correspondence. As part of S-11, BA-9 "Refinance Colorado Benefit Management System Improvements" Supplemental Change Request submitted by the Department of Health Care Policy and Financing, approximately $900,000 is requested to be allocated to the project to streamline CBMS client correspondence.

In order to find savings related to CBMS client correspondence, CBMS has already stopped sending optional forms and notices. Additionally, in November 2009, a statement of facts was removed from the Review, Recertification, and Redetermination packet. It is expected that this would reduce the number of pages of the Review, Recertification, and Redetermination package and save approximately $32,700 in FY 2009-10.

In addition, the Departments along with the Governor's Office of Information Technology are investigating other possible solutions to decrease the cost of CBMS client correspondence such as:

- Consolidating notification of several actions within a single day into a single piece of correspondence to the client.
- Ensuring that duplicate notices are not sent where the same action is taken more than once in a given day.

- Sending a single correspondence to clients to provide notice for all actions that have been taken in a day.
- Sending a single correspondence providing notice of all actions that have been taken over the course of a week rather than sending daily letters.
- Providing notification of actions by email for those clients who have used the web portal to indicate their desire to receive correspondence electronically.

While these efficiencies will reduce the costs associated with generating CBMS client correspondence, the savings will not be great enough to cover the increased costs associated with client correspondence because of the tremendous growth in caseload across all programs.

The total increase in client correspondence costs to CBMS as a result of the unprecedented increase in caseload, once per-unit cost changes have been factored out, is estimated to total $2,176,151 (see Table 1.1 below). Due to the implementation of various initiatives to decrease CBMS client correspondence costs, the expedited increase in client correspondence costs is estimated to total $1,086,004. However, as a consequence of the economic crisis in the state, the Department of Health Care Policy and Financing, the Department of Human Services, and the Governor's Office of Information Technology have identified additional efficiencies and savings that will allow the agencies to absorb a portion of the caseload driven increase in client correspondence costs for CBMS. As a result, the above agencies are requesting additional total funding of only 45% of the increase, or $488,702 total funds. This additional funding will allow the State to continue to meet its obligations as they pertain to client correspondence for programs using CBMS while allowing for the implementation of important and required system changes to ensure that CBMS meets all federal requirements.

Consequences if Not Funded:

Not funding the request will require the program to re-evaluate the entire client notification process and possibly limit client notifications. There would be significant and far reaching consequences to the State's ability to continue to operate programs that provide assistance to Colorado's vulnerable populations. There is risk of losing the

enhanced FMAP that the State is receiving from ARRA. The State would also risk federal sanctions from the federal Department of Agriculture for failure to comply with Food Stamp regulations. The State is required to comply with the federal due process notification requirements for the medical and financial assistance programs and failure to do so places the State at risk for its potential failure to comply with the provisions of the Stipulation and Order of Settlement agreement dated December 19, 2007.

Calculations for Request:

Summary of Request FY 2009-10 for Department of Human Services	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Medicaid Cash Funds**	**Medicaid General Funds**	**Net General Fund**
Colorado Department of Human Services (2) Office of Information Technology, Colorado Benefits Management System (CBMS)	$488,702	$120,550	$22,761	$183,899	$161,492	$183,899	$91,192	$211,742

Summary of Request FY 2009-10 Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Net Request	**$184,275**	**$91,568**	**$0**	**$816**	**$91,891**
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	$376	$376	$0	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology – Medicaid Funding, Colorado Benefits Management System	$183,899	$91,192	$0	$816	$91,891

The sources of Reappropriated Funds are $376 from the Children's Basic Health Plan and $440 from the Old Age Pension Fund managed by the Department of Human Services.

Table 1: Calculation of Increased Client Correspondence Costs Resulting from Increased Caseload							
IDS Job Type:	**FY 2006-07 Actual Volume:**	**FY 2006-07 Cost Per:**	**FY 2006-07 Total Cost:**	**FY 2008-09 Estimated Volume:**	**FY 2008-09 Cost Per:**	**FY 2008-09 Total Cost:**	**Annual Cost Increase:**
Presort Letters	4,831	$0.7370	$2,189	5,591	$0.4051	$2,265	$76
1st Class Flats	366,581	$1.3152	$490,331	444,631	$1.6314	$725,392	$235,061
1st Class Letters	5,076	$0.9350	$2,669	99	$0.6162	$61	($2,608)
Non-Qualifying Presort	76,328	$0.0871	$6,612	32,672	$0.1680	$5,489	($1,123)
Non-Automation	457	$0.5899	$294	515	$0.4214	$217	($77)
Postage Strip	263	$11.1389	$2,726	1,453	$0.3489	$507	($2,219)
CBMS 1 Ounce	3,165,472	$0.3378	$1,080,808	3,415,587	$0.3879	$1,324,748	$243,940
CBMS 2 Ounce	1,194,458	$0.5800	$670,307	1,515,238	$0.5650	$856,158	$185,851
CBMS 3 Ounce Inserting	74,831	$0.8355	$51,840	13,197	$0.0610	$805	($51,035)
CBMS 3 Ounce Metering	0	$0.0000	$0	13,197	$0.6787	$8,957	$8,957
CBMS Flat Inserting (Manual)	0	$0.0000	$0	448,677	$0.3840	$172,292	$172,292
Pre-Sort (PTI)	0	$0.0000	$0	4,936,417	$0.0230	$113,538	$113,538
In-Line Metering	0	$0.0362	$0	4,930,825	$0.0040	$19,724	$19,724
Number of Impressions	43,799,135	$0.0547	$1,121,705	53,399,295	$0.0229	$1,225,018	$103,313
Annual Purchase of Envelopes	0	$0.0000	$168,755	0	$0.0000	$206,094	$37,339
Sheets of Paper	10,854,892	$0.0070	$75,984	14,136,942	$0.0070	$98,959	$22,975
Grand Total Volume:	**59,542,324**		**$3,674,222**	**83,294,336**		**$4,760,224**	**$1,086,004**
			Volume Increase	**39.89%**		**Cost Increase**	**29.56%**

Note: Numbers may not add exactly due to rounding.

Table 1.1: Calculation of Increased Client Correspondence Costs Resulting from Increased Caseload Factoring Out Per-Unit Cost Changes			
IDS Job Type:	**FY 2006-07 Cost Per:**	**FY 2008-09 Estimated Volume:**	**FY 2008-09 Total Cost Factoring Out Per-Unit Cost Changes:**
Presort Letters	$0.7370	5,591	$4,121
1st Class Flats	$1.3152	444,631	$584,779
1st Class Letters	$0.9350	99	$93
Non-Qualifying Presort	$0.0871	32,672	$2,846
Non-Automation	$0.5899	515	$304
Postage Strip	$11.1389	1,453	$16,185
CBMS 1 Ounce	$0.3378	3,415,587	$1,153,785
CBMS 2 Ounce	$0.5800	1,515,238	$878,838
CBMS 3 Ounce Inserting	$0.8355	13,197	$11,026
CBMS 3 Ounce Metering	$0.0000	13,197	$0
CBMS Flat Inserting (Manual)	$0.0000	448,677	$0
Pre-Sort (PTI)	$0.0000	4,936,417	$0
In-Line Metering	$0.0362	4,930,825	$178,496
Number of Impressions	$0.0547	53,399,295	$2,920,941
Annual Purchase of Envelopes	$0.0000	0	$0
Sheets of Paper	$0.0070	14,136,942	$98,959
		Total:	**$5,850,373**
FY 2006-07 Total Cost (from Table 1)			**$3,674,222**
Estimated Cost Increase Due Only to Caseload			**$2,176,151**

Note: Numbers may not add exactly due to rounding.

Table 2: Historical Caseload for Major Assistance Programs with Eligibility Determination in CBMS					
Programs	**Fiscal Years**				
	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10 Estimated
Temporary Aid to Needy Families (Colorado Works)	13,939	11,555	9,093	8,938	10,037
% Change Year to Year		-17.10%	-21.31%	-1.70%	12.30%
Food and Nutrition (Food Stamps)	91,822	104,722	109,746	126,557	150,401
% Change Year to Year		14.05%	4.80%	15.32%	18.84%
Title XIX Medicaid	402,218	392,228	391,962	436,812	511,411
% Change Year to Year		-2.48%	-0.07%	11.44%	17.08%
Title XXI Children's Basic Health Plan	41,945	47,047	57,795	61,582	72,459
% Change Year to Year		12.16%	22.85%	6.55%	17.66%
Total Caseload	549,925	555,553	568,596	633,888	744,308
% Change Year to Year		1.02%	2.35%	11.48%	17.42%

Cash Funds Projections:

Cash Fund Name for Department of Health Care Policy and Financing	Cash Fund Number	FY 2008-09 Expenditures	FY 2008-09 End of Year Cash Balance	FY 2009-10 End of Year Cash Balance Estimate	FY 2010-11 End of Year Cash Balance Estimate	FY 2011-12 End of Year Cash Balance Estimate
Children's Basic Health Plan Trust	11G	$32,626,199	$6,608,063	$817,042	$2,586,082	($7,626,685)
Old Age Pension Fund	See Note 2 Below					

Note 1: Children's Basic Health Plan Trust as reported in Schedule 9 of Budget Request for FY 2010-11 submitted by HCPF on November 6, 2009.

Note 2: Old Age Pension Fund, created in Article XXIV of the State Constitution, does not have a specific balance but is managed by the State Controller to have the amount needed for programs for eligible Old Age Pension clients.

Assumptions for Calculations: It is assumed that:

- The State share of the Children's Basic Health Plan related costs will be 35% and the federal funds will be 65%.
- The State share of costs related to Old Age Pension Fund will be 100%.
- Costs related to TANF (Colorado Works) will be 100% from the federal block grant.
- Costs associated with Food Stamps will be 50% for the State share and 50% for the federal share.
- Costs related to Foster Care will be 100% State share.
- Costs related to the Title XX Block Grant will be 100% State share.
- Costs related to Adult Protective Services will be 100% State share.
- Costs related to Medicaid will be 50% General Fund and 50% federal funds.

It is also assumed that in the short term, there is no change of methodology available that would reduce the various processes performed by Integrated Document Solutions and listed with associated costs in a table presented earlier in this request, so that current per-unit costs would remain the same for the remainder of FY 2009-10.

For prior years, the total expenditures for client correspondence are actual amounts charged back to the CBMS project. For FY 2009-10, the estimated cost for client correspondence was provided by Integrated Document Solutions, and the Departments assume that estimate is reliable based on the knowledge and experience of staff at Integrated Document Solutions.

Between FY 2006-07 and FY 2008-09, there have been changes in both volume and costs related to CBMS client correspondence (see Table 1). The unprecedented increase in caseload during this time can not reasonably be expected to affect the per-unit costs of CBMS client correspondence. By multiplying the FY 2006-07 per unit costs by the FY 2008-09 estimated volume, an estimate of the increase in CBMS client correspondence costs related only to case load increases can be obtained. See Table 1.1. It is estimated that the historic increase in caseload would have increased total CBMS client correspondence costs by approximately $2,176,151 between FY 2006-07 and FY 2008-09 when changes to the per-unit costs are factored out. Due to the implementation of various initiatives to decrease CBMS client correspondence costs, the expected increase in CBMS client correspondence costs is only approximately $1,086,004.

Historical caseload numbers for the Medicaid program and the Children's Basic Health Plan are tracked by the Department of Health Care Policy and Financing. Both the historical caseload for prior years and the projected caseload for FY 2009-10 presented in this request are based on the numbers in the Department's November 6, 2009 budget submission. Caseload numbers for Temporary Aid to Needy Families (Colorado Works) and Food and Nutrition Services (Food Stamps) are based on the number of cases tracked in CBMS for each of these programs. Caseload for Medicaid and Children's Basic Health Plan represents the number of individuals served. Caseload for Colorado Works represents the number of family units served with a family unit including both the adults and children in the family unit. Caseload for Food Stamps represents the number of family units served, and the size of the family unit can vary from one person typical of elderly clients to several family members typical of younger clients. No attempt was made to capture the total number of unique individuals whose eligibility was determined in CBMS.

Even though there is a mixture of individuals and family units stated in the total caseload, the caseload, however it is comprised, still is a driver to trigger the mailing of correspondence so caseload information remains an important consideration.

Some clients receive assistance from more than one program. For example, a client may receive assistance from Colorado Works, Food Stamps, and Medicaid, all simultaneously. A client could be represented in the caseload of all three programs. However, it is assumed that counting a client in the caseload multiple times does not overstate the amount of correspondence because every program in which the client participates generates additional correspondence and, thus, higher client correspondence costs.

Random Moment Sampling (RMS), the methodology approved by federal Division of Cost Allocation, has been used to determine costs applicable to the Department of Human Services programs and the Department of Health Care Policy and Financing programs. Data for RMS is obtained by polling the county workers for the local departments of social services to determine what program the worker is dealing with at the time of the telephone call. The worker responses are tabulated and summed for reporting purposes on a quarterly schedule. The results of the quarterly reports are used for determining the total share of CBMS costs that the Department of Human Services and the Department of Health Care Policy and Financing share. When the results show important shifts in the percentages of work devoted to the different programs, both the Department of Health Care Policy and Financing and the Department of Human Services submit a budget request to realign the percentages of funding appropriated to each of the State departments. The last RMS adjustment occurred for funding in FY 2008-09 and has continued at the same level for FY 2009-10. Both Departments assume the current funding divisions would be used for this new line item as well. The allocation used for this request has been updated to 37.63% for the Department of Health Care Policy and Financing programs and 62.37% for the Department of Human Services programs. The Department of Health Care Policy and Financing appropriation for this line item would also be included as reappropriated funds in the total appropriation for the Department of Human Services.

Impact on Other Government Agencies:	Both the Department of Human Services and the Department of Health Care Policy and Financing as co-requesters.
Cost Benefit Analysis:	The benefits associated with the cost in FY 2009-10 point out the cost effectiveness of funding during the current fiscal year as opposed to possible future ill effects that may have more far reaching social, financial, and political costs to the State.

Cost	Benefits
$488,702 total funds, $212,118 General Fund ($91,568 for Health Care Policy and Financing and $120,550 for Human Services)	Allows client correspondence to continue uninterrupted through FY 2009-10.
	Alleviates the possibility of future lawsuits under the due process provisions of the U.S. Constitution if applicants and clients are not provided adequate notice when benefits are reduced or terminated. The costs associated with fully funding CBMS client correspondence outweigh any costs associated with potential litigation.
	Allows assistance programs to comply with the federal requirements for applicant and client noticing and enhances program participation when applicants and clients learn of their eligibility for those benefits.
	Prevents loss of federal funds for Medicaid, Children's Basic Health Plan, and Food Stamps because of sanctions against the Departments.
	Prevents the need to use funding for client correspondence that is intended for completing enhancements to CBMS that benefits CBMS workers and for completing the development and implementation of the online application for clients. The substantial investment made for the completion of these major CBMS strategic initiatives is jeopardized if not fully funded.
	Offers interim relief while requirements are identified, detailed impact analyses are completed, and computer programming coding is modified, tested, and implemented for planned future improvements to CBMS client correspondence. The improvements will take several months but are expected to result in future savings.
	Prevents a large increase of client calls to call centers in both Departments and in the county offices to inquire about outcomes of eligibility determinations if clients have received inadequate or no notification regarding the status of their eligibility and benefits.
	Allows better client relations for a State computer system that has had poor public relations in past years.

Statutory and Federal Authority: Federal: 45 CFR Part 95, Title XXI Social Security Act; 7 U.S.C. 2011-2036, Food Stamp Act of 1977; 42 U.S.C 601, 603, 604, 606-611, 619, 1308; 31 U.S.C. 7501 et seq.; 42 U.S.C. 654,1302,1308,1337

42 CFR § 435.912 Notice of agency's decision concerning eligibility. *The agency must send each applicant a written notice of the agency's decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing.*

42 CFR § 435.930 Furnishing Medicaid. *The agency must—*
(a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;
(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and
(c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.

42 U.S.C § 136a (a) (8) *A State plan for medical assistance must*
8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

24-102-202 C.R.S. (2009) *Authority of the executive director. (1) Consistent with the provisions of this code, the executive director may adopt operational procedures governing the internal functions of the department (2) except as otherwise specifically provided in this code, the executive director shall pursuant to rules: (a) Procure or supervise the procurement of all supplies and services needed by the state; (c) Establish and maintain programs for the inspection, testing and acceptance of supplies. (d) Examine each requisition submitted by a using agency and approve, disapprove, or revise it as to quantity or quality; (e) Develop and maintain programs and procedures to delegate purchasing authority in order to conserve resources for management of the statewide purchasing system; and (f) Develop programs to evaluate and reduce the administrative costs of the procurement function.*

25.5-4-204, C.R.S. (2009) *The General hereby finds and declares that the agency responsible for the administration of the State's medical assistance program would be more effective in its ability to streamline administrative implementation of an automated system that would provide the following: (b) On-line eligibility determinations; (d) Electronic fund transfers.*

25.5-4-204, C.R.S. (2009) *The State Department shall cooperate with the federal Department of Health and Human Services and other federal agencies in any reasonable manner in conformity with the laws of this state, which may be necessary to qualify for federal financial participation, including the preparation of State Plans, the making of reports in such form and containing such information as any federal agency may from time to time require, and the compliance with such provisions as the federal government may from time to time find necessary to assure the correctness and verification of the reports.*

Performance Measures:

Department of Human Services Performance Measures

Program	Performance Measure	Outcome	FY-2005-06 Actual	FY-2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Approp.
Food & Energy Assistance Programs	Increase the percentage of food stamp applications processed within the thirty-day federal guidelines.	**Benchmark**	80.00%	82.00%	85.00%	95.00%	95.00%
		Actual	70.00%	70.67%	70.49%	78.74% through March 2009*	TBD

*Most current Quality Assurance data available for records evaluated through March 2009.

The Department of Human Services has no performance measure specifically related to the CBMS, but the above performance measure for food stamp applications depends on the functionality of CBMS. Other financial assistance programs in the Department of Human Services have a similar reliance on CBMS, so the performance measures in the other programs are enhanced by all aspects of CBMS to function well.

Department of Health Care Policy and Financing Performance Measures

Although the Department of Health Care Policy and Financing has no performance measure specifically related to the CBMS, the Department believes that funding that would result from this request would improve access to health care by insuring that eligibility determination progresses timely, increase health outcomes from better access sooner after the eligibility determination is completed, and provide more cost effective services to clients by greater use of information technology beginning with all aspects of the eligibility determination processes including timely communications through client correspondence.

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11

Request Title: Statewide Furlough Impact
Department: Health Care Policy and Financing
Priority Number: NP-S2
Dept. Approval by: John Bartholomew JB **Date:** January 4, 2010 12/11/09
OSPB Approval: Peter J **Date:** 12·21·09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	21,227,364	25,174,723	(239,760)	24,934,963	27,376,728	0	27,376,728	0	27,376,728	0
	FTE	266.1	287.8	0.0	287.8	317.0	0.0	317.0	0.0	317.0	0.0
	GF	8,958,919	10,329,244	(109,884)	10,219,360	9,155,111	0	9,155,111	0	9,155,111	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	615,293	961,778	(13,626)	948,152	2,517,915	0	2,517,915	0	2,517,915	0
	CFE/RF	1,536,056	1,623,799	5,602	1,629,401	1,857,769	0	1,857,769	0	1,857,769	0
	FF	10,117,096	12,259,902	(121,852)	12,138,050	13,845,933	0	13,845,933	0	13,845,933	0
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	19,502,741	20,901,734	(247,918)	20,653,816	22,608,612	0	22,608,612	0	22,608,612	0
	FTE	266.1	287.8	0.0	287.8	317.0	0.0	317.0	0.0	317.0	0.0
	GF	8,010,994	8,645,285	(114,617)	8,530,668	7,505,041	0	7,505,041	0	7,505,041	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	604,469	618,917	(12,898)	606,019	1,884,880	0	1,884,880	0	1,884,880	0
	CFE/RF	1,501,807	1,579,589	6,302	1,585,891	1,830,045	0	1,830,045	0	1,830,045	0
	FF	9,385,471	10,057,943	(126,705)	9,931,238	11,388,646	0	11,388,646	0	11,388,646	0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	Total	22,621	23,588	(844)	22,744	27,568	0	27,568	0	27,568	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	9,538	9,630	(363)	9,267	11,869	0	11,869	0	11,869	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	568	722	(33)	689	889	0	889	0	889	0
	CFE/RF	1,795	1,917	(32)	1,885	998	0	998	0	998	0
	FF	10,720	11,319	(416)	10,903	13,812	0	13,812	0	13,812	0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	Total	275,961	332,946	(10,888)	322,058	487,925	0	487,925	0	487,925	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	114,941	136,054	(4,686)	131,368	183,788	0	183,788	0	183,788	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	6,983	9,778	(428)	9,350	44,306	0	44,306	0	44,306	0
	CFE/RF	22,096	26,026	(411)	25,615	15,456	0	15,456	0	15,456	0
	FF	131,941	161,088	(5,363)	155,725	244,375	0	244,375	0	244,375	0

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11 ☐			**Base Reduction Item FY 2010-11** ☐			**Supplemental FY 2009-10** ☑			**Budget Amendment FY 2010-11** ☐		
Request Title:	Statewide Furlough Impact										
Department:	Health Care Policy and Financing			**Dept. Approval by:**		John Bartholomew		**Date:**	January 4, 2010		
Priority Number:	NP-S2			**OSPB Approval:**				**Date:**			
		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	**Total**	127,446	204,850	(6,805)	198,045	341,823	0	341,823	0	341,823	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	51,968	82,732	(2,929)	79,803	134,013	0	134,013	0	134,013	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	3,273	6,111	(267)	5,844	25,340	0	25,340	0	25,340	0
	CFE/RF	10,358	16,267	(257)	16,010	11,270	0	11,270	0	11,270	0
	FF	61,847	99,740	(3,352)	96,388	171,200	0	171,200	0	171,200	0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	1,298,595	3,711,605	26,695	3,738,300	3,910,800	0	3,910,800	0	3,910,800	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	771,478	1,455,543	12,711	1,468,254	1,320,400	0	1,320,400	0	1,320,400	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	326,250	0	326,250	562,500	0	562,500	0	562,500	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	527,117	1,929,812	13,984	1,943,796	2,027,900	0	2,027,900	0	2,027,900	0

Non-Line Item Request:	None.		
Letternote Revised Text:	None.		
Cash or Federal Fund Name and COFRS Fund Number:	CF: HCPF Cash Fund 23G, Medicaid Nursing Facility Cash Fund 22X, Hospital Provider Cash Fund, Coordinated Care for People with Disabilities Cash Fund 19Z, Primary Care Fund 18L, Breast and Cervical Cancer Program Cash Fund 15D, Children's Basic Health Plan 11G, Short-term Innovative Health Program Cash Fund maintained by the Department of Public Health and Environment, Autism Treatment Fund 18A, Comprehensive Primary and Preventive Care Fund 14B, Health Care Expansion Fund 18K, FF: Medicaid Title XIX		
Reappropriated Funds Source, by Department and Line Item Name:	Department of Human Services, (2) Office of Information Technology Services, Colorado Benefits Management System (CBMS)		
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑
Schedule 13s from Affected Departments:	None.		

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11

Request Title: DHS - Statewide Furlough Impact
Department: Health Care Policy and Financing
Priority Number: NP-S3 (See also DHS N/A)
Dept. Approval by: John Bartholomew TB 12/11/09 **Date:** January 4, 2010
OSPB Approval: [signature] **Date:** 12-21-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	84,076,390	82,568,548	478,691	83,047,239	79,680,915	0	79,680,915	0	79,680,915	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	33,873,890	39,293,702	239,275	39,532,977	37,831,377	0	37,831,377	0	37,831,377	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,109,124	28,758	(15)	28,743	303,624	0	303,624	0	303,624	0
	CFE/RF	1,046,064	2,125,264	(2)	2,125,262	1,863,713	0	1,863,713	0	1,863,713	0
	FF	48,047,312	41,120,824	239,433	41,360,257	39,682,201	0	39,682,201	0	39,682,201	0
(6) Department of Human Services Medicaid-Funded Programs; (A) Executive Director's Office - Medicaid Funding	Total	4,007,340	13,011,981	(30,268)	12,981,713	12,814,719	0	12,814,719	0	12,814,719	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,841,600	6,659,567	(15,226)	6,644,341	6,558,690	0	6,558,690	0	6,558,690	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	388	0	388	388	0	388	0	388	0
	FF	2,165,740	6,352,026	(15,042)	6,336,984	6,255,641	0	6,255,641	0	6,255,641	0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	10,062,216	9,080,722	(13,375)	9,067,347	9,414,173	0	9,414,173	0	9,414,173	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	3,886,580	4,489,092	(6,665)	4,482,427	4,384,989	0	4,384,989	0	4,384,989	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,109,124	28,758	(15)	28,743	303,624	0	303,624	0	303,624	0
	CFE/RF	66,563	31,995	(2)	31,993	25,009	0	25,009	0	25,009	0
	FF	4,999,949	4,530,877	(6,693)	4,524,184	4,700,551	0	4,700,551	0	4,700,551	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☐
Request Title:	DHS - Statewide Furlough Impact			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	January 4, 2010
Priority Number:	NP-S3 (See also DHS N/A)	**OSPB Approval:**		**Date:**	

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Other Office of Information Technology Services line items	Total	442,190	399,192	(2,597)	396,595	442,479	0	442,479	0	442,479	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	183,721	199,597	(1,299)	198,298	221,240	0	221,240	0	221,240	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	258,469	199,595	(1,298)	198,297	221,239	0	221,239	0	221,239	0
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	5,627,497	5,345,364	(18,096)	5,327,268	5,189,221	0	5,189,221	0	5,189,221	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	2,291,160	2,672,682	(9,048)	2,663,634	2,594,610	0	2,594,610	0	2,594,610	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,336,337	2,672,682	(9,048)	2,663,634	2,594,611	0	2,594,611	0	2,594,611	0
(6) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding, Administration	Total	110,916	135,195	(1,776)	133,419	137,577	0	137,577	0	137,577	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	55,458	67,598	(888)	66,710	68,789	0	68,789	0	68,789	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	55,458	67,597	(888)	66,709	68,788	0	68,788	0	68,788	0

Schedule 13

Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☐
Request Title:	DHS - Statewide Furlough Impact			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	January 4, 2010
Priority Number:	NP-S3 (See also DHS N/A)	**OSPB Approval:**		**Date:**	

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 2008-09	Appropriation FY 2009-10	Supplemental Request FY 2009-10	Total Revised Request FY 2009-10	Base Request FY 2010-11	Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	Budget Amendment FY 2010-11	Total Revised Request FY 2010-11	Change from Base (Column 5) FY 2011-12
(6) Department of Human Services Medicaid-Funded Programs; (F) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Administration	Total	2,976,677	2,931,565	(24,187)	2,907,378	2,979,406	0	2,979,406	0	2,979,406	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,488,339	1,465,782	(12,093)	1,453,689	1,489,703	0	1,489,703	0	1,489,703	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,488,338	1,465,783	(12,094)	1,453,689	1,489,703	0	1,489,703	0	1,489,703	0
(6) Department of Human Services Medicaid-Funded Programs; (F) Services for People with Disabilities - Medicaid Funding, Regional Centers	Total	59,259,759	50,049,730	569,484	50,619,214	46,098,689	0	46,098,689	0	46,098,689	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	23,439,986	22,931,984	284,741	23,216,725	21,211,029	0	21,211,029	0	21,211,029	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	979,501	2,092,881	0	2,092,881	1,838,316	0	1,838,316	0	1,838,316	0
	FF	34,840,272	25,024,865	284,743	25,309,608	23,049,344	0	23,049,344	0	23,049,344	0
(6) Department of Human Services Medicaid-Funded Programs; (H) Division of Youth Corrections - Medicaid Funding	Total	1,589,795	1,614,799	(494)	1,614,305	2,604,651	0	2,604,651	0	2,604,651	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	687,046	807,400	(247)	807,153	1,302,327	0	1,302,327	0	1,302,327	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	902,749	807,399	(247)	807,152	1,302,324	0	1,302,324	0	1,302,324	0

Non-Line Item Request:	None.			
Letternote Revised Text:	None.			
Cash or Federal Fund Name and COFRS Fund Number:	CF: Children's Basic Health Plan Trust Fund 11G; FF: Title XIX, Title XXI			
Reappropriated Funds Source, by Department and Line Item Name:	RF: Old Age Pension Fund managed by Department of Human Services			
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑	
Schedule 13s from Affected Departments:	Department of Human Services			

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11

Request Title: DPHE - Statewide Furlough Impact
Department: Health Care Policy and Financing
Priority Number: NP-S4 (See also DPHE NP-13)
Dept. Approval by: John Bartholomew JB **Date:** January 4, 2010 12/21/09
OSPB Approval: **Date:** 12-22-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	4,546,609	5,001,243	9,970	5,011,213	5,070,684	0	5,070,684	0	5,070,684	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,660,998	1,502,513	3,390	1,505,903	1,526,123	0	1,526,123	0	1,526,123	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE RF	0	0	0	0	0	0	0	0	0	0
	FF	2,885,611	3,498,730	6,580	3,505,310	3,544,561	0	3,544,561	0	3,544,561	0
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Public Health and Environment Facility for Survey and Certification	Total	4,546,609	5,001,243	9,970	5,011,213	5,070,684	0	5,070,684	0	5,070,684	0
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,660,998	1,502,513	3,390	1,505,903	1,526,123	0	1,526,123	0	1,526,123	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE RF	0	0	0	0	0	0	0	0	0	0
	FF	2,885,611	3,498,730	6,580	3,505,310	3,544,561	0	3,544,561	0	3,544,561	0

Non Line Item Request: None
Letternote Revised Text: None
Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: No: N A: ✓
Schedule 13s from Affected Departments: Department of Public Health and Environment

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11 ✓

Request Title: Mail Equipment Upgrade Supplemental and Budget Amendment
Department: Health Care Policy and Financing
Dept. Approval by: John Bartholomew JB **Date:** January 4, 2010 12/21/09
Priority Number: NP-S5, NP-BA6
OSPB Approval: **Date:** 12/29/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	1,148,096	2,010,111	(15,442)	1,994,669	1,661,541	0	1,661,541	308	1,661,849	308
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	557,186	975,474	(7,721)	967,753	691,404	0	691,404	154	691,558	154
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	13,014	17,114	0	17,114	126,899	0	126,899	0	126,899	0
	CFE/RF	12,337	13,461	0	13,461	13,461	0	13,461	0	13,461	0
	FF	565,559	1,004,062	(7,721)	996,341	829,777	0	829,777	154	829,931	154
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	1,148,096	2,010,111	(15,442)	1,994,669	1,661,541	0	1,661,541	308	1,661,849	308
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	557,186	975,474	(7,721)	967,753	691,404	0	691,404	154	691,558	154
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	13,014	17,114	0	17,114	126,899	0	126,899	0	126,899	0
	CFE/RF	12,337	13,461	0	13,461	13,461	0	13,461	0	13,461	0
	FF	565,559	1,004,062	(7,721)	996,341	829,777	0	829,777	154	829,931	154

Non-Line Item Request: None.
Letternote Revised Text: None.
Cash or Federal Fund Name and COFRS Fund Number: 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~~ DPA

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11 ✓

Request Title: DHS - Annual Fleet Vehicle Replacements Technical True-up
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew JB **Date:** January 4, 2010 12/22/09
Priority Number: NP-S6 NP-BA7 (See also DHS S-NP-4, BA-NP-3) **OSPB Approval:** **Date:** 12/29/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	5,627,497	5,503,619	(12,707)	5,490,912	5,189,221	0	5,189,221	1,855	5,191,076	1,855
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	2,291,160	2,751,809	(6,353)	2,745,456	2,594,610	0	2,594,610	928	2,595,538	928
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,336,337	2,751,810	(6,354)	2,745,456	2,594,611	0	2,594,611	927	2,595,538	927
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	5,627,497	5,503,619	(12,707)	5,490,912	5,189,221	0	5,189,221	1,855	5,191,076	1,855
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	2,291,160	2,751,809	(6,353)	2,745,456	2,594,610	0	2,594,610	928	2,595,538	928
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,336,337	2,751,810	(6,354)	2,745,456	2,594,611	0	2,594,611	927	2,595,538	927

Non-Line Item Request: None.
Letternote Revised Text: None.
Cash or Federal Fund Name and COFRS Fund Number: 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: Department of Human Services

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	Base Reduction Item FY 2010-11	Supplemental FY 2009-10 ✓	Budget Amendment FY 2010-11 ✓

Request Title: DHS - Mail Equipment Upgrade Supplemental and Budget Amendment
Department: Health Care Policy and Financing
Dept. Approval by: John Bartholomew [illegible] **Date:** January 4, 2010 12/21/09
Priority Number: NP-S7 NP-BA8 (See also DHS S NP-5)
OSPB Approval: [illegible] **Date:** 12/30/09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	Total	77,926,149	67,565,636	(85,215)	67,480,421	63,681,489	0	63,681,489	29,668	63,711,157	29,668
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	31,106,065	31,638,667	(42,261)	31,596,406	29,680,331	0	29,680,331	14,714	29,695,045	14,714
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,109,124	28,758	(172)	28,586	303,624	0	303,624	60	303,684	60
	CFE/RF	1,046,064	2,124,876	(201)	2,124,675	1,863,325	0	1,863,325	70	1,863,395	70
	FF	44,664,896	33,773,335	(42,581)	33,730,754	31,834,209	0	31,834,209	14,824	31,849,033	14,824
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	10,062,216	9,080,722	(83,998)	8,996,724	9,414,173	0	9,414,173	29,245	9,443,418	29,245
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	3,886,580	4,489,092	(41,653)	4,447,439	4,384,989	0	4,384,989	14,502	4,399,491	14,502
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	1,109,124	28,758	(172)	28,586	303,624	0	303,624	60	303,684	60
	CFE/RF	66,563	31,995	(201)	31,794	25,009	0	25,009	70	25,079	70
	FF	4,999,949	4,530,877	(41,972)	4,488,905	4,700,551	0	4,700,551	14,613	4,715,164	14,613
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	5,627,497	5,503,619	(518)	5,503,101	5,189,221	0	5,189,221	180	5,189,401	180
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	2,291,160	2,751,809	(259)	2,751,550	2,594,610	0	2,594,610	90	2,594,700	90
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	3,336,337	2,751,810	(259)	2,751,551	2,594,611	0	2,594,611	90	2,594,701	90

Schedule 13
Change Request for FY 2010-11 Budget Request Cycle

Decision Item FY 2010-11	☐	**Base Reduction Item FY 2010-11**	☐	**Supplemental FY 2009-10** ☑	**Budget Amendment FY 2010-11** ☑
Request Title:	DHS - Mail Equipment Upgrade Supplemental and Budget Amendment			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	January 4, 2010
Priority Number:	NP-S7 NP-BA8 (See also DHS S NP-5)	**OSPB Approval:**		**Date:**	

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
(6) Department of Human Services Medicaid-Funded Programs; (F) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Administration	Total	2,976,677	2,931,565	(47)	2,931,518	2,979,406	0	2,979,406	17	2,979,423	17
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	1,488,339	1,465,782	(23)	1,465,759	1,489,703	0	1,489,703	9	1,489,712	9
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	1,488,338	1,465,783	(24)	1,465,759	1,489,703	0	1,489,703	8	1,489,711	8
(6) Department of Human Services Medicaid-Funded Programs; (F) Services for People with Disabilities - Medicaid Funding, Regional Centers	Total	59,259,759	50,049,730	(652)	50,049,078	46,098,689	0	46,098,689	226	46,098,915	226
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	23,439,986	22,931,984	(326)	22,931,658	21,211,029	0	21,211,029	113	21,211,142	113
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	979,501	2,092,881	0	2,092,881	1,838,316	0	1,838,316	0	1,838,316	0
	FF	34,840,272	25,024,865	(326)	25,024,539	23,049,344	0	23,049,344	113	23,049,457	113

Non-Line Item Request:	None.		
Letternote Revised Text:	None.		
Cash or Federal Fund Name and COFRS Fund Number:	CF: Children's Basic Health Plan Trust Fund 11G; FF: Title XIX, Title XXI		
Reappropriated Funds Source, by Department and Line Item Name:	RF: Old Age Pension Fund managed by Department of Human Services		
Approval by OIT?	**Yes:** ☐	**No:** ☐	**N/A:** ☑
Schedule 13s from Affected Departments:	Department of Human Services		