Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Heath Care Policy and Financing
Request Title: DHS Colorado Mental Health Institutes Revenue Adjustment
Priority Number: NP S-1, BA-1

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
		Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,775,751	221,994	4,775,751	221,994	221,994
	FTE	-	-	-	-	-
	GF	2,387,876	110,997	2,387,876	109,315	108,753
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,387,875	110,997	2,387,875	112,679	113,241
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Mental Health Institutes	**Total**	4,775,751	221,994	4,775,751	221,994	221,994
	FTE	-	-	-	-	-
	GF	2,387,876	110,997	2,387,876	109,315	108,753
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,387,875	110,997	2,387,875	112,679	113,241

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: Colorado Department of Human Services
Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CBMS Technology Improvement Workplan

Priority Number: NP S-2, NP BA-2

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	12,669,689	796,398	564,113	26,770,806	-
	FTE	-	-	-	-	-
	GF	1,886,059	388,014	282,058	7,102,544	-
	GFE	-	-	-	-	-
	CF	48,785	7,130	-	1,286,032	-
	RF	-	-	-	-	-
	FF	10,734,845	401,254	282,055	18,382,230	-
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services, CBMS Modernization Project	**Total**	12,669,689	796,398	564,113	26,770,806	-
	FTE	-	-	-	-	-
	GF	1,886,059	388,014	282,058	7,102,544	-
	GFE	-	-	-	-	-
	CF	48,785	7,130	-	1,286,032	-
	RF	-	-	-	-	-
	FF	10,734,845	401,254	282,055	18,382,230	-

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2013-14: Of this amount, ~~$36,136~~ $43,266 shall be from the Old Age Pension Health and Medical Care Fund moneys originally appropriated to the Old Age Pension State Medical Program and $12,649 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105(1), C.R.S.

FY 2014-15: Of this amount $125,665 shall be from the Old Age Pension Health and Medical Care Fund moneys originally appropriated to the Old Age Pension State Medical Program and $1,160,367 shall be from the Hospital Provider Fee created in Section 25.5-4-402.3 (4), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund 22X, Old Age Pension State Medical Cash Fund, FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes: ☑ No: ☐ **Not Required:** ☐

Schedule 13s from Affected Departments: Department of Human Services, Governor's Office of Information Technology

Other Information:

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: DPA's Annual Fleet Supplemental True-Up
Priority Number: NP-S-3

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,786,843	9,775	4,955,534	-	-
	FTE	-	-	-	-	-
	GF	2,393,422	4,888	2,477,767	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,393,421	4,887	2,477,767	-	-
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	**Total**	4,786,843	9,775	4,955,534	-	-
	FTE	-	-	-	-	-
	GF	2,393,422	4,888	2,477,767	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,393,421	4,887	2,477,767	-	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: Department of Human Services
Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Heath Care Policy and Financing
Request Title: DHS Amendment to Regional Center Capital Outlay
Priority Number: NP S-4, BA-4

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	47,499,561	-	49,010,457	(420,000)	-
	FTE	-	-	-	-	-
	GF	21,883,639	-	22,604,579	(210,000)	-
	GFE	-	-	-	-	-
	CF	1,866,142	-	1,866,142	-	-
	RF	-	-	-	-	-
	FF	23,749,780	-	24,539,736	(210,000)	-
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Regional Centers	**Total**	47,499,561	-	49,010,457	(420,000)	-
	FTE	-	-	-	-	-
	GF	21,883,639	-	22,604,579	(210,000)	-
	GFE	-	-	-	-	-
	CF	1,866,142	-	1,866,142	-	-
	RF	-	-	-	-	-
	FF	23,749,780	-	24,539,736	(210,000)	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: Colorado Department of Human Services
Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medical Services Premiums Request
Priority Number: S-1

Dept. Approval by: Josh Block 9/20/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,736,824,877	52,407,944	5,323,832,795	-	-
	FTE	-	-	-	-	-
	GF	1,036,017,966	17,580,433	1,035,822,319	-	-
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	61,442,739	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	(26,615,228)	3,132,627,039	-	-
(2) Medical Services Premiums	**Total**	4,736,824,877	52,407,944	5,323,832,795	-	-
	FTE	-	-	-	-	-
	GF	1,036,017,966	17,580,433	1,035,822,319	-	-
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	61,442,739	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	(26,615,228)	3,132,627,039	-	-

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** See Exhibit D

Cash or Federal Fund Name and COFRS Fund Number: See Exhibit D

Reappropriated Funds Source, by Department and Line Item Name: See Exhibit D

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Behavioral Health Request
Priority Number: S-2

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	385,638,470	(3,383,922)	461,739,445	-	-
	FTE	-	-	-	-	-
	GF	153,461,111	500,880	155,827,511	-	-
	GFE	-	-	-	-	-
	CF	2,033,883	9,145,504	12,646,178	-	-
	RF	-	-	-	-	-
	FF	230,143,476	(13,030,306)	293,265,757	-	-
(3)Behavioral Health Community Programs; Behavioral Health Capitation Payments	**Total**	380,837,424	(3,814,279)	456,935,528	-	-
	FTE	-	-	-	-	-
	GF	151,060,588	285,702	153,425,552	-	-
	GFE	-	-	-	-	-
	CF	2,033,883	9,145,504	12,646,178	-	-
	RF	-	-	-	-	-
	FF	227,742,953	(13,245,485)	290,863,799	-	-
(3)Behavioral Health Community Programs; Medicaid Mental Health Fee for Services Payments	**Total**	4,801,046	430,357	4,803,917	-	-
	FTE	-	-	-	-	-
	GF	2,400,523	215,178	2,401,959	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,400,523	215,179	2,401,958	-	-

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**
See Exhibit BB

Cash or Federal Fund Name and COFRS Fund Number: See Exhibit BB

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Children's Basic Health Plan Medical and Dental Costs
Priority Number: S-3

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	196,282,277	(17,385,723)	207,458,484	-	-
	FTE	-	-	-	-	-
	GF	22,825,770	(3,309,421)	26,649,625	-	-
	GFE	438,300	-	438,300	-	-
	CF	46,413,329	(2,569,185)	46,579,118	-	-
	RF	-	-	-	-	-
	FF	126,604,878	(11,507,117)	133,791,441	-	-
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**Total**	196,282,277	(17,385,723)	207,458,484	-	-
	FTE	-	-	-	-	-
	GF	22,825,770	(3,309,421)	26,649,625	-	-
	GFE	438,300	-	438,300	-	-
	CF	46,413,329	(2,569,185)	46,579,118	-	-
	RF	-	-	-	-	-
	FF	126,604,878	(11,507,117)	133,791,441	-	-
(4) Indigent Care Program; Children's Basic Health Plan Administration	**Total**	4,319,079	-	4,319,079	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	2,019,582	-	2,019,582	-	-
	RF	-	-	-	-	-
	FF	2,299,497	-	2,299,497	-	-

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** See Exhibit C2

Cash or Federal Fund Name and COFRS Fund Number: See Exhibit C2

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicare Modernization Act of 2003 State Contribution Payment
Priority Number: S-4

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	107,173,869	(4,917,552)	107,173,869	-	-
	FTE	-	-	-	-	-
	GF	82,492,862	(16,805,357)	82,492,862	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	24,681,007	11,887,805	24,681,007	-	-
(5) Other Medical Services, Medicare Modernization Act of 2003 State Contribution Payment	**Total**	107,173,869	(4,917,552)	107,173,869	-	-
	FTE	-	-	-	-	-
	GF	82,492,862	(16,805,357)	82,492,862	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	24,681,007	11,887,805	24,681,007	-	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: Federal funds: CHIPRA Bonus
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Enhanced Federal Medical Assistance Percentages
Priority Number: BA-10

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 1/2/14 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☐ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	5,813,285,256	-	6,917,800,117	78,607,116	93,133,162
	FTE	-	-	-	-	-
	GF	1,271,639,596	-	1,482,380,897	-	(9,434,989)
	GFE	470,280,384	-	470,280,384	-	-
	CF	827,588,988	-	958,819,076	5,616,233	(15,297,970)
	RF	4,441,892	-	3,505,000	(22,801)	(30,401)
	FF	3,239,334,396	-	4,002,814,760	73,013,684	117,896,522
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	8,492,552	-	6,660,552	150,000	150,000
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	75,000	75,000
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	75,000	75,000
(1) Executive Director's Office; (B) Transfers to Other Departments; Transfer from Department of Human Services for Nurse Home Visitor Program (NEW LINE)	**Total**	3,010,000	-	3,010,000	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	1,505,000	-	1,505,000	(22,801)	(30,401)
	FF	1,505,000	-	1,505,000	22,801	30,401
NEW ITEM (1) Executive Director's Office; (I) State of Health Projects, Transfer from General Fund to State of Health Cash Fund	**Total**	-	-	-	17,089,710	-
	FTE	-	-	-	-	-
	GF	-	-	-	17,089,710	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	-	-	-
NEW ITEM (1) Executive Director's Office; (I) State of Health Projects, State of Health Projects	**Total**	-	-	-	17,089,710	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	17,089,710	-
	RF	-	-	-	-	-
	FF	-	-	-	-	-

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
(2) Medical Services Premiums	Total	4,736,824,877	-	5,323,832,795	44,277,696.0	92,983,162
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	(9,269,545)	1,016,898
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	(8,831,948)	(11,775,931)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	62,379,189	103,742,195
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	Total	380,837,424	-	456,935,528	-	-
	FTE	-	-	-	-	-
	GF	151,060,588	-	153,425,552	(2,476,051)	(3,301,401)
	GFE	-	-	-	-	-
	CF	2,033,883	-	12,646,177	(36,993)	(49,324)
	RF	-	-	-	-	-
	FF	227,742,953	-	290,863,799	2,513,044	3,350,725
(4) Indigent Care Programs; Safety Net Provider Payments	Total	311,296,186	-	311,296,186	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	155,648,093	-	155,648,093	(2,340,619)	(3,120,825)
	RF	-	-	-	-	-
	FF	155,648,093	-	155,648,093	2,340,619	3,120,825
(4) Indigent Care Programs; Clinic Based Indigent Care	Total	6,119,760	-	6,119,760	-	-
	FTE	-	-	-	-	-
	GF	3,059,880	-	3,059,880	(46,357)	(61,809)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	3,059,880	-	3,059,880	46,357	61,809
(4) Indigent Care Program; Pediatric Specialty Hospital	Total	11,799,938	-	11,799,938	-	-
	FTE	-	-	-	-	-
	GF	5,899,969	-	5,899,969	(89,385)	(119,180)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	5,899,969	-	5,899,969	89,385	119,180
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	196,282,277	-	207,458,484	-	-
	FTE	-	-	-	-	-
	GF	22,825,770	-	26,649,625	(891,849)	(1,189,132)
	GFE	438,300	-	438,300	-	-
	CF	46,413,329	-	46,579,118	-	-
	RF	0	-	-	-	-
	FF	126,604,878	-	133,791,441	891,849	1,189,132
(5) Other Medical Services; Commission on Family Medicine Residency Training Programs	Total	3,371,077	-	3,371,077	-	-
	FTE	-	-	-	-	-
	GF	1,685,538	-	1,685,538	(25,536)	(34,048)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	1,685,539	-	1,685,539	25,536	34,048

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
(5) Other Medical Services; State University Teaching Hospitals - Denver Health and Hospital Authority	Total	1,831,714	-	1,831,714	-	-
	FTE	-	-	-	-	-
	GF	915,857	-	915,857	(13,875)	(18,500)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	915,857	-	915,857	13,875	18,500
(5) Other Medical Services; State University Teaching Hospitals - University of Colorado Hospital Authority	Total	633,314	-	633,314	-	-
	FTE	-	-	-	-	-
	GF	316,657	-	316,657	(4,797)	(6,396)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	316,657	-	316,657	4,797	6,396
(5) Other Medical Services; Public School Health Services	Total	54,353,956	-	54,353,956	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	27,176,978	-	27,176,978	(257,496)	(343,328)
	RF	-	-	-	-	-
	FF	27,176,978	-	27,176,978	257,496	343,328
(6) Department of Human Services Medicaid-Funded Programs; (A) Executive Director's Office - Medicaid Funding	Total	17,535,090	-	17,289,499	-	-
	FTE	-	-	-	-	-
	GF	8,767,545	-	8,644,750	(129,724)	(172,965)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	8,767,545	-	8,644,749	129,724	172,965
(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	572,374	-	526,461	-	-
	FTE	-	-	-	-	-
	GF	286,187	-	263,231	(4,478)	(5,971)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	286,187	-	263,230	4,478	5,971
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	4,786,843	-	4,955,534	-	-
	FTE	-	-	-	-	-
	GF	2,393,422	-	2,477,767	(37,679)	(50,239)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,393,421	-	2,477,767	37,679	50,239
(6) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	Total	14,579,137	-	14,797,824	-	-
	FTE	-	-	-	-	-
	GF	7,289,569	-	7,398,913	(112,095)	(149,460)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	7,289,568	-	7,398,911	112,095	149,460

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
(6) Department of Human Services Medicaid-Funded Programs; (New Line) (D.5) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	Total	4,582,485	-	4,582,485	-	-
	FTE	-	-	-	-	-
	GF	2,291,243	-	2,291,243	(37,832)	(50,443)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,291,242	-	2,291,242	37,832	50,443
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Residential Treatment for Youth (H.B. 99-1116)	Total	118,593	-	118,593	-	-
	FTE	-	-	-	-	-
	GF	59,297	-	59,297	(911)	(1,215)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	59,296	-	59,296	911	1,215
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Mental Health Institutes	Total	4,775,751	-	4,775,751	-	-
	FTE	-	-	-	-	-
	GF	2,387,876	-	2,387,876	(36,177)	(48,236)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,387,875	-	2,387,875	36,177	48,236
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	Total	1,429,133	-	1,429,133	-	-
	FTE	-	-	-	-	-
	GF	714,567	-	714,567	(10,988)	(14,651)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	714,566	-	714,566	10,988	14,651
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding; Regional Centers	Total	47,499,561	-	49,010,457	-	-
	FTE	-	-	-	-	-
	GF	21,883,639	-	22,604,579	(372,783)	(497,044)
	GFE	-	-	-	-	-
	CF	1,866,142	-	1,866,142	-	-
	RF	-	-	-	-	-
	FF	23,749,780	-	24,539,736	372,783	497,044
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	Total	1,187,825	-	1,187,825	-	-
	FTE	-	-	-	-	-
	GF	593,913	-	593,913	(8,998)	(11,997)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	593,912	-	593,912	8,998	11,997

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
(6) Department of Human Services Medicaid-Funded Programs; (I) Division of Youth Corrections - Medicaid Funding	Total	1,365,389	-	1,369,878	-	-
	FTE	-	-	-	-	-
	GF	682,695	-	684,940	(10,233)	(13,644)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	682,694	-	684,938	10,233	13,644
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	Total	-	-	338,015,700	-	-
	FTE	-	-	-	-	-
	GF	-	-	153,608,493	(2,672,803)	(3,563,737)
	GFE	-	-	-	-	-
	CF	-	-	30,798,715	(6,421)	(8,562)
	RF	-	-	-	-	-
	FF	-	-	153,608,492	2,679,224	3,572,299
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	Total	-	-	47,042,236	-	-
	FTE	-	-	-	-	-
	GF	-	-	27,481,475	(521,107)	(694,809)
	GFE	-	-	0	-	-
	CF	-	-	0	-	-
	RF	-	-	0	-	-
	FF	-	-	19,560,761	521,107	694,809
NEW ITEM (7) Office of Community Living; (A) Program Costs, Children's Extensive Support Services for 659 Medicaid FPE	Total	-	-	18,785,189	-	-
	FTE	-	-	-	-	-
	GF	-	-	9,392,594	(145,238)	(193,651)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	9,392,595	145,238	193,651
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	Total	-	-	26,610,248	-	-
	FTE	-	-	-	-	-
	GF	-	-	14,454,444	(246,269)	(328,359)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	12,155,804	246,269	328,359

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** See appendix A for details by cash fund.

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX; CF: See appendix A for details by cash fund.

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests an increase of $78,607,116 total funds, including an increase of $5,616,233 cash funds, a decrease of $22,801 Reappropriated Funds and an increase of $73,013,684 in federal funds for FY 2014-15 due to an increase in the Federal Medical Assistance Percentage (FMAP) for Colorado and repurposing of funds.

Current Program

- FMAP is determined by the Secretary of Health and Human Services each year; historically, Colorado's FMAP has been 50%, with the exception of years when the FMAP was temporarily increased to combat the effects of recession.
- Pursuant to Section 1905(b) of the Social Security Act, a state's FMAP is a function of the state's per capita personal income relative to national per capita personal incomes.

Problem or Opportunity

- Colorado will receive an increase of 1.01% to its FMAP and 0.71% to its Enhanced FMAP (applicable to the Children's Basic Health Plan) for total FMAPs of 51.01% and 65.71% respectively. These increases will be effective October 2014 through September 2015.
- The Department received an informal notice from the Centers for Medicare and Medicaid Services (CMS) in November 2013 indicating that Colorado's FMAP rates would be increasing. Consequently, the Department's November 1, 2013 budget requests did not account for the increased FMAP and overstate General Fund and cash funds need while understating federal funds need.
- The offset General Fund creates an opportunity to address long term systemic issues that would not otherwise be funded.

Consequences of Problem

- Because the Department's November 2013 requests overstate General Fund and cash funds need, funding is available for other purposes.

Proposed Solution

- The Department request to repurpose the offset General Fund to continue provider rate increases implemented under Section 1202 of the Affordable Care act, and to create a cash fund to fund future projects related to critical access issues and support of the "State of Health".

Department Priority: BA-10
Request Detail: Enhanced Federal Medical Assistance Percentages

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Enhanced Federal Medical Assistance Percentage	$78,607,116	$0

Problem or Opportunity:

Currently, the Federal Medical Assistance Percentage (FMAP) is 50% for most Medicaid programs, and is 65% for the Children's Basic Health Plan and the Breast and Cervical Cancer Prevention and Treatment program, which receive an enhanced FMAP (eFMAP). Pursuant to section 1905(b) of the Social Security Act, a state's FMAP is a function of the state's per capita personal income relative to national per capita personal incomes. Each state's FMAP is evaluated annually and can range from 50% to 83%.

The State's eligibility for the higher FMAP rates is primarily due to the income losses experienced during the recession. According to data released in September 2013, Colorado experienced a larger per capita personal income decline in 2009 than the nation overall, and a smaller growth rate in 2010. This caused the gap between Colorado's per capita personal income and the national per capita personal income to shrink; although Colorado's per capita personal income has grown faster than the national average in 2011 and 2012, the declines from prior years were enough to trigger an increase in FMAP.

Per Capita Personal Income 2006-2012				
Year	National	Percent Change	Colorado	Percent Change
2006	$38,127		$40,627	
2007	$39,804	4.40%	$42,199	3.87%
2008	$40,873	2.69%	$43,406	2.86%
2009	$39,357	-3.71%	$41,515	-4.36%
2010	$40,163	2.05%	$41,717	0.49%
2011	$42,298	5.32%	$44,179	5.90%
2012	$43,735	3.40%	$45,775	3.61%

Source: Bureau of Economic Analysis, SA1-3 Personal Income Summary

As a result of the changes in per capita personal income, the Department estimates that the State's FMAP rate for federal fiscal year 2014-2015 (October 1, 2014 through September 30, 2015) will be 51.01%; the State's eFMAP rate will be 65.71%.[1]

The Department received an informal notice from the Centers for Medicare and Medicaid Services (CMS) in November 2013 indicating that Colorado's FMAP rates would be increasing. Consequently, the Department's November 1, 2013 budget requests did not account for the increased FMAP and overstate General Fund and cash funds need while understating federal funds need.

Because additional General Fund is now available in FY 2014-15, an opportunity exists to rectify critical Medicaid provider access issues as well as to make strategic long term investments.

Proposed Solution:

The Department requests to repurpose General Fund offset by the increase in FMAP to make several strategic investments that contribute to fulfilling Colorado's promise to become the healthiest state in the nation, the "State of Health".

State of Health

The enhanced federal funding in federal fiscal year (FFY) 2015 creates new opportunity to invest in the long term success of Colorado through strategic initiatives that meet the goals contained in the State of Health, which outlines Colorado's commitment to become the healthiest state.[2] The Department proposes that the available funding would be utilized to provide grants for projects that support the four strategic initiatives of the State of Health. These initiative include the following:

- Promoting Prevention and Wellness;
- Expanding Coverage, Access and Capacity;
- Improving Health System Integration and Quality; and
- Enhancing Value and Strengthening Sustainability.

[1] The formula for FMAP is: $\text{FMAP}_{state} = 1 - \left[\left(\frac{Per\ Capita\ Income_{Colorado}{}^{2}}{Per\ Capita\ Income_{U.S.}{}^{2}}\right) \times 0.45\right]$. The per capita income statistics are the average of the most recent 3 years of data published by the Bureau of Economic Analysis.

[2] http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22The+State+of+Health+Full+Report.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251854683211&ssbinary=true

Targeted Investments

Program	General Fund
Continuation of Section 1202 of the Affordable Care Act (Primary Care Rates)	$18,490,366
Network Adequacy Study	$75,000
Dental Provider Network Adequacy	$3,000,000
After Hours Primary Care Incentive Program	$5,000,000
Colorado Plan to Reduce Prescription Drug Abuse – Primary Care Physician Pain Management Training	$1,000,000
Social-Emotional Learning Program for Early Childhood Health	$8,089,710
Total	**$35,655,076**

Continuation of Section 1202 of the Affordable Care Act (Primary Care Rates)

The Department requests $44,277,696 total funds, including $18,490,366 General Fund in FY 2014-15 in order to maintain physician rates at the equivalent Medicare rate beginning January 1, 2015. The Department also requests $150,000 total funds, including $75,000 General Fund, to engage a contractor to study the effect of the rate increase in order to determine whether the rate increases are successfully improving access for Medicaid clients.

Section 1202 of the Affordable Care Act (ACA) requires states to increase Medicaid reimbursement for a number of codes designated as primary care services; Medicaid rates are required to be set at the same level as Medicare (traditionally a higher level of reimbursement). The federal government provided 100% of the funding for the majority of the increase. However, this enhanced federal funding is only available in CY 2013 and CY 2014. In order to continue the rate increase beyond CY 2014, a new funding source is required.

The Section 1202 rate increase is intended to expand access for Medicaid clients during a time when Medicaid eligibility and caseload is expanding in many states. Given the magnitude of the rate increases, the Department believes that the amount of federal investment has been sufficient to achieve this goal. Consequently, allowing the rate increase to sunset may have the opposite effect; primary care access would likely be reduced following a return to standard Medicaid reimbursement. Given that the State has opted to expand Medicaid in SB 13-200, any reductions in access to primary care services could have potentially large negative fiscal implications for the state as clients could seek care in less appropriate settings, such as the emergency room. Health outcomes for clients could suffer as well. Continuing the Section 1202 rate increases in FY 2014-15 and FY 2015-16 is an important step in ensuring sufficient Medicaid network adequacy for a growing Medicaid population.

Under Section 1202, federal requirements have limited the number of providers eligible to receive the increased reimbursement. Providers are currently required to self-attest that they are eligible for the increase and belong to specific specialties. The self-attestation process is administratively burdensome for both providers and the Department. Further, it restricts the number of providers that could potentially benefit from

the rate increase. Consequently, the Department requests that the rate increase would be continued in FY 2014-15 and FY 2015-16 without the requirement of self-attestation by providers. This would allow non-primary care providers that are providing a medical home for clients to obtain the increase (for example, nephrologists or HIV doctors may be the primary provider for certain clients) and allow advanced practice nurses who independently practice to get the increase. The Department believes this is the optimal solution as this creates an incentive for a broader spectrum of providers to increase their Medicaid panels and allows for the greatest amount of Medicaid provider network growth.

Because Colorado's FMAP is likely to fluctuate over time, the availability of funds to perpetuate the ACA Section 1202 rate increase indefinitely using this financing mechanism is uncertain. Because Colorado's income has been growing relative to national income for the last two years (2011 and 2012), the Department believes that sufficient funding would be available only through FY 2015-16. Consequently, the Department requests to continue the rate increases through FY 2015-16 only, and would address the issue through the regular budgetary process moving forward.

The Department would continue to study the impact of the rate increase on network capacity to inform future decisions regarding the increase. In order to accomplish this, the Department's request includes funding to engage a contractor to study the effect of the rate increase in order to determine whether the rate increases are successfully improving access for Medicaid clients.

Continuation of the Section 1202 rate increases directly contributes to achieving the State of Health by promoting expanded coverage, access and capacity.

Dental Provider Network Adequacy

The Department proposes that $3 million General Fund would be utilized to promote growth of the Medicaid dental provider network. Anecdotally, active enrolled dental providers in Medicaid totaled 771 as of November 2013; this compares to 4,992 statewide licensed dental provides, or a Medicaid participation rate of only 15.44%. The low participation rate highlights the need for strategic recruitment and additional financial incentives for participation.

Implementation of an adult dental benefit and continuous strong growth in children's caseload necessitates a robust Medicaid dental provider network. Coupled with the across-the-board rate increases of FY 2013-14 and the proposed rate increases for FY 2014-15, the Department believes that targeted incentive payments to dental providers for total Medicaid volume, increases in volume relative to a benchmark, or a combination thereof, could achieve much needed network growth.

Further development of the Medicaid dental provider network advances the State of Health by promoting expanded coverage, access and capacity.

Afterhours Primary Care Incentive Program

The Department requests $5 million General Fund to implement a program to incentivize primary care providers to offer extended office hours. Statewide, emergency room utilization rates continue to rise

annually. This occurs despite multiple interventions and efforts to promote utilization of primary care services. While there are many factors that contribute to growth in utilization of emergency rooms, one likely factor is that the emergency room can be the only setting to get access to care in the evenings and on weekends. By providing additional resources to primary care providers to extend their office hours, the Department would seek to reduce the growth rate of emergency room utilization while simultaneously growing Medicaid provider network adequacy.

The Department would evaluate the impact of the program and request additional funds to continue providing incentives to providers should the program prove to be effective.

By strengthening sustainability, expanding coverage, access and capacity, this request moves Colorado toward the State of Health.

Colorado Plan to Reduce Prescription Drug Abuse – Primary Care Physician Pain Management Training

The Department requests $1 million General Fund to implement a primary care physician pain management training program. Colorado is ranked second worst in the nation in prescription painkiller abuse.[3] In the Governor's September 2013 Colorado Plan to Reduce Prescription Drug Abuse, it was noted that this area is "a crucial part of our commitment to make Colorado the healthiest state". The enhanced FMAP has created an opportunity to begin implementation of the plan and to take action to address Colorado's prescription drug abuse problem.

Evidence has shown that an effective strategy for reducing abuse of pain medications is to provide training to primary care physicians.[4] A training program for primary care physicians is an important step towards addressing misuse of prescription pain killers, and the associated costs, in Colorado. Further, training programs have shown to improve clinical outcomes, client satisfaction, and even provider satisfaction when faced with managing the care of clients with chronic pain. Should the program demonstrate efficacy, the Department could request additional funding to provide ongoing training for physicians through the regular budgetary process.

The proposal supports not only the Colorado Plan to Reduce Prescription Drug Abuse, but also the State of Health by both improving quality for clients and strengthening sustainability through cost containment.

Social-Emotional Learning Program for Early Childhood Health

The Department requests $8,089,710 General Fund to implement a social-emotional learning program for early childhood health. Funding social-emotional learning programs for early childhood health would support Colorado youth by providing skills necessary to become fully productive members of the workforce as adults. Early intervention and support is key. The State must continue to invest in programs that provide long term benefits to its citizens. This investment would do so by providing early intervention to children with behavioral health issues, in order to prevent childhood conditions from continuing on into adulthood.

[3] http://www.mcw.edu/Releases/2013-News-Releases/Pain-Training-for-Primary-Care.htm
[4] http://www.samhsa.gov/data/2k12/NSDUH115/sr115-nonmedical-use-pain-relievers.htm

In terms of health care costs, this program has the longest term return on investment of the proposed programs. However, it is likely that noticeable returns will be observed in other areas such as test performance and other indicators of childhood success. These short term results can be utilized to evaluate the programs efficacy; should the program produce results, additional funding to continue the program can be requested through the normal budgetary process.

This proposal supports the State of Health by promoting system integration and quality, and strengthening sustainability.

Creation of the State of Health Cash Fund to Address Systemic Issues and Long Term Strategic Opportunities

While continuation of the Section 1202 primary care rate increases can be implemented in FY 2014-15 and continued in 2015-16, implementation of the other four projects will likely occur over several fiscal years. To take advantage of the enhanced FMAP in such a way that promotes the State's long term strategic health care objectives and achieve the State of Health, the Department believes that utilization of a cash fund is the most appropriate mechanism of funding for the later four projects.

The Department requests that the Joint Budget Committee sponsor legislation to create the State of Health Cash Fund; further, the Department requests that the cash fund receives an appropriation of $17,089,710 General Fund, in order to address systemic issues and fund long term strategic opportunities in order to improve the health of Coloradoans. Further, the Department requests an appropriation from the cash fund to a new line item. Because it is not yet certain that the Department can receive a federal match, the Department requests that committee not apply the "H" headnote to this appropriation, to allow the Department to maximize the amount of funding available.

Colorado's per capita personal income has grown relative to the national statistics for the last two years; if this trend continues, the State's FMAP would begin to shrink as early as FFY 2016. As a result, the Department believes that investment opportunities that would require ongoing funding are not sustainable. The Department estimates that there would be sufficient General Fund made available by the increased FMAP in FY 2014-15 to both fully fund the continuation of Section 1202 rate increases, and fund approximately $17 million General Fund in additional projects. However, in FY 2015-16, the Department estimates the enhanced FMAP would offset only enough General Fund to finance the continuation of Section 1202 rate increases, with no additional funding for other projects. Because of the one-time nature of the surplus General Fund in FY 2014-15, the Department proposes creation of a cash fund that could be utilized to address systemic issues and long term strategic projects that would otherwise lack a funding source. Utilization of a cash fund to address these systemic needs would allow the flexibility with implementation timelines to actively engage stakeholders, establish a vetting process for utilization of funds, and partner with the General Assembly on key statewide issues prior to pursuing implementation of projects. The focus of issues proposed to be addressed would require interdepartmental coordination and planning such that implementation timelines would likely cross multiple fiscal years; by placing the surplus funding in a cash fund, the funding would not revert to the General Fund at the end of a fiscal year, allowing the Department to fund projects across multiple years.

Assumptions and Calculations:

The Department assumes that only medical assistance payments will be eligible for the increased FMAP; expenditure classified as administration is ineligible. It is unclear how the relationship between Colorado's per capita personal income and national personal per capita income may change in the future. Therefore, the Department anticipates that it would use the regular budget process in subsequent years to account for any changes to FMAP.

The Department's request contains four major components. First, the Department has recalculated its funding needs for its base budget as submitted on November 1, 2013 for its existing line items which are affected by the change in FMAP. Second, the Department has included the incremental impact of the FMAP increase for FY 2014-15 decision items submitted in November 2013 in this request. Third, the Department requests continuation of the Section 1202 primary care rate increases under the assumption that all attestation requirements are removed. Lastly, the Department requests any remaining General Fund offset is transferred to a newly created cash fund to fund critical access issues and long term strategic investments supporting the State of Health. In the event that any of these requests are not approved or are modified, the impact of this request would need to be modified as well.

Please see the Appendix for detailed calculations.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This supplemental funding request is the result of new information resulting in a substantive change in funding need. The Department was informally notified of the increase to federal fiscal year 2015 FMAP in November 2013.

Table A.1 - FY 2014-15 Impact of Increased FMAP by Long Bill Group						
Summary of Request FY 2014-15	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(1) Executive Director's Office	$34,329,420	$17,164,710	$0	$17,089,710	($22,801)	$97,801
(2) Medical Services Premiums	$44,756,701	($9,032,692)	$0	($8,831,948)	$0	$62,621,341
(3) Behavioral Health Community Programs	$0	($2,476,051)	$0	($36,993)	$0	$2,513,044
(4) Indigent Care Program	$0	($1,027,591)	$0	($2,340,619)	$0	$3,368,210
(5) Other Medical Services	$0	($44,208)	$0	($257,496)	$0	$301,704
(6) Department of Human Services Medicaid-Funded Programs	$0	($761,898)	$0	$0	$0	$761,898
(7) Office of Community Living	$0	($3,585,417)	$0	($6,421)	$0	$3,591,838
Total Impact	**$79,086,121**	**$236,853**	**$0**	**$5,616,233**	**($22,801)**	**$73,255,836**

Table A.2 Summary of HCPF Funding Request's R-1 though R-17 FY 2014-15 Incremental FMAP "True-up"						
Long Bill Group	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(2) Medical Services Premiums	$479,005	($27,523,058)	$0	($8,831,948)	$0	$36,834,011
(3) Behavioral Health Community Programs Total	$0	($2,476,051)	$0	($36,993)	$0	$2,513,044
(4) Indigent Care Programs; Children's Basic Health Plan Medical and Dental Costs Total	$0	($891,849)	$0	$0	$0	$891,849
(7) Office of Community Living	$0	($173,108)	$0	($6,421)	$0	$179,529
Total Impact	**$479,005**	**($31,064,066)**	**$0**	**($8,875,362)**	**$0**	**$40,418,433**

Table A.3 Summary of FY 2014-15 Incremental Fund Split Impact due to Increase FMAP and eFMAP by Long Bill Group (Excluding Incremental Impact of R-1 through R-17)						
Long Bill Group	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(1) Executive Director's Office	$0	$0	$0	$0	($22,801)	$22,801
(4) Indigent Care Program	$0	($135,742)	$0	($2,340,619)	$0	$2,476,361
(5) Other Medical Services	$0	($44,208)	$0	($257,496)	$0	$301,704
(6) Department of Human Services Medicaid-Funded Programs	$0	($761,898)	$0	$0	$0	$761,898
(7) Office of Community Living	$0	($3,412,309)	$0	$0	$0	$3,412,309
Total Impact	**$0**	**($4,354,157)**	**$0**	**($2,598,115)**	**($22,801)**	**$6,975,073**

Table A.4 Summary of FY 2014-15 Continuation of Section 1202 Primary Care Rate Increase Fiscal Impact						
Long Bill Group	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(2) Medical Services Premiums	$44,277,696	$18,490,366	$0	$0	$0	$25,787,330
Total Impact	**$44,277,696**	**$18,490,366**	**$0**	**$0**	**$0**	**$25,787,330**

Table A.5 Summary of FY 2014-15 Creation of State of Health Cash Fund						
Long Bill Group	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(New Line) General Fund Transfer to State of Health Cash Fund	$17,089,710	$17,089,710	$0	$0	$0	$0
(New Line) General Fund Transfer to State of Health Cash Fund	$17,089,710	$0	$0	$17,089,710	$0	$0
Total Impact	**$34,179,420**	**$17,089,710**	**$0**	**$17,089,710**	**$0**	**$0**

Table A.6 Summary of FY 2014-15 Contractor Funding Need						
Long Bill Group	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(1) Executive Director's Office	$150,000	$75,000	$0	$0	$0	$75,000
Total Impact	**$150,000**	**$75,000**	**$0**	**$0**	**$0**	**$75,000**

Table 2.1 - FY 2014-15 Long Bill Group (2) Medical Service Premiums Funding Requests - New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
R-1 Medical Service Premiums	$479,005	($27,144,773)	($8,820,706)	$0	$36,444,484
R-7 Adult Supported Living Services Waitlist Reduction and Service Plan Authorization Limits Increase	$0	($19,897)	$0	$0	$19,897
R-8 Developmental Disabilities New Full Program Equivalents	$0	$14,648	$0	$0	($14,648)
R-9 Medicaid Community Living Initiatives	$0	($3,944)	$0	$0	$3,944
R-10 Primary Care Specialty Collaboration	$0	($2,291)	($108)	$0	$2,399
R-11 Community Provider Rate Increase	$0	($366,801)	($11,134)	$0	$377,935
(2) Medical Services Premiums Total Impact	**$479,005**	**($27,523,058)**	**($8,831,948)**	**$0**	**$36,834,011**

Table 2.2 - FY 2014-15 Long Bill Group (3) Behavioral Health Community Programs Funding Requests - New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
R-2 Behavioral Health	$0	($2,470,530)	($36,993)	$0	$2,507,523
R-7 Adult Supported Living Services Waitlist Reduction and Service Plan Authorization Limits Increase	$0	($4,716)	$0	$0	$4,716
R-8 Developmental Disabilities New Full Program Equivalents	$0	($109)	$0	$0	$109
R-11 Community Provider Rate Increase	$0	($696)	$0	$0	$696
(3) Behavioral Health Community Programs Total Impact	**$0**	**($2,476,051)**	**($36,993)**	**$0**	**$2,513,044**

Table 2.3 - FY 2014-15 Long Bill Group (4) Indigent Care Programs; Children's Basic Health Plan Medical and Dental Costs Funding Requests- New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(4) Indigent Care Programs; Children's Basic Health Plan Medical and Dental Costs Total Impact (R-3 CHP+)	**$0**	**($891,849)**	**$0**	**$0**	**$891,849**

Table 2.4- FY 2014-15 NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE) Funding Requests - New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
R-8 Developmental Disabilities New Full Program Equivalents	$0	($31,073)	$0	$0	$31,073
R-11 Community Provider Rate Increase	$0	($32,452)	($6,421)	$0	$38,873
(7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid FPE Total Impact	**$0**	**($63,525)**	**($6,421)**	**$0**	**$69,946**

Table 2.5 - NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE Funding Requests - New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
R-7 Adult Supported Living Services Waitlist Reduction and Service Plan Authorization Limits Increase	$0	($74,899)	$0	$0	$74,899
R-8 Developmental Disabilities New Full Program Equivalents	$0	($2,868)	$0	$0	$2,868
R-11 Community Provider Rate Increase	$0	($6,512)	$0	$0	$6,512
(7) Office of Community Living; (A) Program Costs, Children's Extensive Support Services for 659 Medicaid FPE Total Impact	**$0**	**($84,279)**	**$0**	**$0**	**$84,279**

Table 2.6 - FY 2014-15 NEW ITEM (7) Office of Community Living; (A) Program Costs, Children's Extensive Support Services for 659 Medicaid FPE Funding Requests - New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE Total Impact (R-11 Community Provider Rate Increase)	**$0**	**($2,135)**	**$0**	**$0**	**$2,135**

Table 2.7 - FY 2014-15 NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE Funding Requests - New Fund Split Incremental Amounts

Requests	Total Funds	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
R-7 Adult Supported Living Services Waitlist Reduction and Service Plan Authorization Limits Increase	$0	($17,692)	$0	$0	$17,692
R-8 Developmental Disabilities New Full Program Equivalents	$0	($2,156)	$0	$0	$2,156
R-11 Community Provider Rate Increase	$0	($3,321)	$0	$0	$3,321
(7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE Total Impact	**$0**	**($23,169)**	**$0**	**$0**	**$23,169**

(1) Executive Director's Office
Calculation of Total Enhanced FMAP

Line Item	FY 2014-15 Total Appropriated Funds	Proportion of Funds Eligible for Enhanced FMAP	Funding Eligible For Enhanced FMAP	Estimated Federal Funds at Base FMAP	Enhanced FMAP	New FMAP for Eligible Funding	Increase in Federal Funds due to FMAP	Federal Funds Not Qualified for Enhanced FMAP	Revised Total Federal Funds	Original State Funds	Total Remaining State Funds
(B) Transfers to Other Departments; Transfer to Department of Public Health and Environment for Nurse Home Visitor Program	**$3,010,000**	**100.00%**	**$2,257,500**	**$1,128,750**	**51.01%**	**$1,151,551**	**$22,801**	**$376,250**	**$1,527,801**	**$1,505,000**	**$1,482,199**

(4) Indigent Care Program
Calculation of Total Enhanced FMAP

Line Item	FY 2014-15 Total Appropriated Funds	Proportion of Funds Eligible for Enhanced FMAP	Funding Eligible For Enhanced FMAP	Estimated Federal Funds at Base FMAP	Enhanced FMAP	New FMAP for Eligible Funding	Increase in Federal Funds due to FMAP	Federal Funds Not Qualified for Enhanced FMAP	Revised Total Federal Funds	Original State Funds	Total Remaining State Funds
Safety Net Provider Payments	$311,296,186	99.26%	$231,744,446	$115,872,223	51.01%	$118,212,842	$2,340,619	$39,775,870	$157,988,712	$155,648,093	$153,307,474
Clinic Based Indigent Care	$6,119,760	100.00%	$4,589,820	$2,294,910	51.01%	$2,341,267	$46,357	$764,970	$3,106,237	$3,059,880	$3,013,523
Pediatric Specialty Hospital	$11,799,938	100.00%	$8,849,954	$4,424,977	51.01%	$4,514,362	$89,385	$1,474,992	$5,989,354	$5,899,969	$5,810,584
Appropriation from Tobacco Tax Cash Fund to the General Fund	$438,300	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$438,300	$438,300
Primary Care Fund Program	$27,759,000	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$27,759,000	$27,759,000
Children's Basic Health Plan Administration	$5,127,772	0.00%	$0	$0	0.00%	$0	$0	$2,723,737	$2,723,737	$2,404,035	$2,404,035
(4) Indigent Care Program Totals (minus CHP+)	**$362,540,956**		**$245,184,220**	**$122,592,110**		**$125,068,471**	**$2,476,361**	**$44,739,569**	**$169,808,040**	**$195,209,277**	**$192,732,916**

(5) Other Medical Services
Calculation of Total Enhanced FMAP

Line Item	FY 2014-15 Total Appropriated Funds	Proportion of Funds Eligible for Enhanced FMAP	Funding Eligible For Enhanced FMAP	Estimated Federal Funds at Base FMAP	Enhanced FMAP	New FMAP for Eligible Funding	Increase in Federal Funds due to FMAP	Federal Funds Not Qualified for Enhanced FMAP	Revised Total Federal Funds	Original State Funds	Total Remaining State Funds
Old Age Pension State Medical Program	$4,504,973	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$4,504,973	$4,504,973
Commission on Family Medicine Residency Training Programs	$3,371,077	100.00%	$2,528,308	$1,264,154	51.01%	$1,289,690	$25,536	$421,385	$1,711,075	$1,685,538	$1,660,002
State University Teaching Hospitals - Denver Health and Hospital Authority	$1,831,714	100.00%	$1,373,786	$686,893	51.01%	$700,768	$13,875	$228,964	$929,732	$915,857	$901,982
State University Teaching Hospitals - University of Colorado Hospital Authority	$633,314	100.00%	$474,986	$237,493	51.01%	$242,290	$4,797	$79,164	$321,454	$316,657	$311,860
Medicare Modernization Act of 2003 State Contribution Payment	$100,807,053	0.00%	$0	$0	0.00%	$0	$0	$4,362,801	$4,362,801	$96,444,252	$96,444,252
Public School Health Services Contract Administration	$2,491,722	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$2,491,722	$2,491,722
Public School Health Services[1]	$54,353,956	62.54%	$25,494,723	$12,747,362	51.01%	$13,004,858	$257,496	$14,429,616	$27,434,474	$27,176,978	$26,919,482
(5) Other Medical Services Totals	**$167,993,809**		**$29,871,803**	**$14,935,902**		**$15,237,606**	**$301,704**	**$19,521,930**	**$34,759,536**	**$133,535,977**	**$133,234,273**

(1)The remaining 37.46% is done as a prior period adjustment certified public expenditure (which is refunded at the FMAP available at the time of expense). This portion should lag the rest of the annual percentage rate.

(6) Department of Human Services Medicaid-Funded Programs
Calculation of Total Enhanced FMAP

Line Item	FY 2014-15 Total Appropriated Funds	Proportion of Funds Eligible for Enhanced FMAP	Funding Eligible For Enhanced FMAP	Estimated Federal Funds at Base FMAP	Enhanced FMAP	New FMAP for Eligible Funding	Increase in Federal Funds due to FMAP	Federal Funds Not Qualified for Enhanced FMAP	Revised Total Federal Funds	Original State Funds	Total Remaining State Funds
(A) Executive Director's Office - Medicaid Funding	$17,289,499	99.05%	$12,843,937	$6,421,968	51.01%	$6,551,692	$129,724	$2,222,781	$8,774,473	$8,644,750	$8,515,026
(B) Office of Information Technology Services - Medicaid Funding; Colorado Benefits Management System	$8,408,583	0.00%	$0	$0	0.00%	$0	$0	$4,200,905	$4,200,905	$4,207,678	$4,207,678
(B) Office of Information Technology Services - Medicaid Funding; Colorado Benefits Management System - HCPF Only	$611,520	0.00%	$0	$0	0.00%	$0	$0	$305,760	$305,760	$305,760	$305,760
(B) Office of Information Technology Services - Medicaid Funding; CBMS SAS-70 Audit	$55,204	0.00%	$0	$0	0.00%	$0	$0	$27,580	$27,580	$27,624	$27,624
(B) Office of Information Technology Services - Medicaid Funding; Office of Information Technology Services - Medicaid Funding, CBMS Modernization Project	$564,113	0.00%	$0	$0	0.00%	$0	$0	$282,055	$282,055	$282,058	$282,058
(B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line items	$591,113	100.00%	$443,335	$221,667	51.01%	$226,145	$4,478	$73,889	$300,034	$295,557	$291,079
(C) Office of Operations - Medicaid Funding	$4,974,114	100.00%	$3,730,586	$1,865,293	51.01%	$1,902,972	$37,679	$621,764	$2,524,736	$2,487,057	$2,449,378
(D) Division of Child Welfare - Medicaid Funding; Administration	$137,306	0.00%	$0	$0	0.00%	$0	$0	$68,653	$68,653	$68,653	$68,653
(D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	$14,797,824	100.00%	$11,098,368	$5,549,183	51.01%	$5,661,278	$112,095	$1,849,728	$7,511,006	$7,398,913	$7,286,818
(New Line) (D.5) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$4,994,334	100.00%	$3,745,751	$1,872,876	51.01%	$1,910,708	$37,832	$624,291	$2,534,999	$2,497,167	$2,459,335
(E) Office of Self Sufficiency - Medicaid Funding; Systematic Alien Verification for Eligibility	$33,951	0.00%	$0	$0	0.00%	$0	$0	$33,951	$33,951	$0	$0
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Administration	$404,350	0.00%	$0	$0	0.00%	$0	$0	$202,175	$202,175	$202,175	$202,175
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Residential Treatment for Youth (H.B. 99-1116)	$120,372	100.00%	$90,279	$45,140	51.01%	$46,051	$911	$15,046	$61,097	$60,186	$59,275
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Mental Health Institutes	$4,775,751	100.00%	$3,581,813	$1,790,906	51.01%	$1,827,083	$36,177	$596,969	$2,424,052	$2,387,876	$2,351,699
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	$1,450,570	100.00%	$1,087,928	$543,964	51.01%	$554,952	$10,988	$181,321	$736,273	$725,285	$714,297
(G) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Administration	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0
(G) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Program Costs	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0
(G) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Early Intervention	$0	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$0	$0
(G) Services for People with Disabilities - Medicaid Funding; Regional Centers	$49,430,457	99.54%	$36,902,308	$18,476,916	51.08%	$18,849,699	$372,783	$6,272,820	$25,122,519	$24,680,721	$24,307,938
(G) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$1,187,825	100.00%	$890,869	$445,434	51.01%	$454,432	$8,998	$148,478	$602,910	$593,913	$584,915
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	$1,800	0.00%	$0	$0	0.00%	$0	$0	$900	$900	$900	$900
(I) Division of Youth Corrections - Medicaid Funding	$1,389,674	97.20%	$1,013,072	$506,535	51.01%	$516,768	$10,233	$188,301	$705,069	$694,838	$684,605
(J) Other; Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	$500,000	0.00%	$0	$0	0.00%	$0	$0	$500,000	$500,000	$0	$0
(6) Department of Human Services Medicaid-Funded Programs Totals	**$111,718,360**		**$75,428,246**	**$37,739,882**		**$38,501,780**	**$761,898**	**$18,417,367**	**$56,919,147**	**$55,561,111**	**$54,799,213**

(7) Office of Community Living
Calculation of Total Enhanced FMAP

Line Item	FY 2014-15 Total Appropriated Funds	Proportion of Funds Eligible for Enhanced FMAP	Funding Eligible For Enhanced FMAP	Estimated Federal Funds at Base FMAP	Enhanced FMAP	New FMAP for Eligible Funding	Increase in Federal Funds due to FMAP	Federal Funds Not Qualified for Enhanced FMAP	Revised Total Federal Funds	Original State Funds	Total Remaining State Funds
(A) Program Costs; Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	$347,249,465	67.75%	$235,277,210	$117,405,627	51.01%	$120,014,905	$2,609,278	$40,588,757	$160,603,662	$189,255,081	$186,645,803
(A) Program Costs; Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$58,168,084	64.24%	$37,369,328	$18,625,266	51.01%	$19,062,094	$436,828	$6,439,013	$25,501,107	$33,103,805	$32,666,977
(A) Program Costs; Children's Extensive Support Services for 659 Medicaid FPE	$19,066,967	99.08%	$14,168,663	$7,084,332	51.01%	$7,227,435	$143,103	$2,449,152	$9,676,587	$9,533,483	$9,390,380
(A) Program Costs; Preventive Dental Hygiene	$65,203	99.08%	$48,452	$0	0.00%	$0	$0	$0	$0	$65,203	$65,203
(A) Program Costs; Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$29,668,921	68.58%	$20,348,394	$10,156,616	51.01%	$10,379,716	$223,100	$3,511,284	$13,891,000	$16,001,021	$15,777,921
(A) Program Costs; Family Support Services	$6,762,095	0.00%	$0	$0	0.00%	$0	$0	$0	$0	$6,762,095	$6,762,095
(A) Program Costs; Eligibility Determination and Waitlist Management	$3,032,242	0.00%	$0	$0	0.00%	$0	$0	$19,655	$19,655	$3,012,587	$3,012,587
(B) Administrative Costs; Community and Contract Management System	$137,480	0.00%	$0	$0	0.00%	$0	$0	$48,118	$48,118	$89,362	$89,362
(B) Administrative Costs; Support Level Administration	$57,368	0.00%	$0	$0	0.00%	$0	$0	$28,684	$28,684	$28,684	$28,684
(7) Office of Community Living Totals	**$464,207,825**		**$307,212,047**	**$153,271,841**		**$156,684,150**	**$3,412,309**	**$53,084,663**	**$209,768,813**	**$257,851,321**	**$254,439,012**

(1) Executive Director's Office Base Appropriation						
Line Item	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(B) Transfers to Other Departments; Transfer from Department of Human Services for Nurse Home Visitor Program (new line)	**$3,010,000**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**

(4) Indigent Care Program Base Appropriation						
Line Item	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Safety Net Provider Payments	$311,296,186	$0	$0	$155,648,093	$0	$155,648,093
Clinic Based Indigent Care	$6,119,760	$3,059,880	$0	$0	$0	$3,059,880
Pediatric Specialty Hospital	$11,799,938	$5,899,969	$0	$0	$0	$5,899,969
Appropriation from Tobacco Tax Cash Fund to the General Fund	$438,300	$0	$0	$438,300	$0	$0
Primary Care Fund Program	$27,759,000	$0	$0	$27,759,000	$0	$0
Children's Basic Health Plan Administration	$5,127,772	$0	$0	$2,404,035	$0	$2,723,737
(4) Indigent Care Program Totals (minus CHP+)	**$362,540,956**	**$8,959,849**	**$0**	**$186,249,428**	**$0**	**$167,331,679**

(5) Other Medical Services Base Appropriation						
Line Item	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Old Age Pension State Medical Program	$4,504,973	$0	$0	$4,504,973	$0	$0
Commission on Family Medicine Residency Training Programs	$3,371,077	$1,685,538	$0	$0	$0	$1,685,539
State University Teaching Hospitals - Denver Health and Hospital Authority	$1,831,714	$915,857	$0	$0	$0	$915,857
State University Teaching Hospitals - University of Colorado Hospital Authority	$633,314	$316,657	$0	$0	$0	$316,657
Medicare Modernization Act of 2003 State Contribution Payment[(1)]	$100,807,053	$96,444,252	$0	$0	$0	$4,362,801
Public School Health Services Contract Administration	$2,491,722	$0	$0	$0	$2,491,722	$0
Public School Health Services	$54,353,956	$0	$0	$27,176,978	$0	$27,176,978
(5) Other Medical Services Totals	**$167,993,809**	**$99,362,304**	**$0**	**$31,681,951**	**$2,491,722**	**$34,457,832**

(1) While increases to FMAP impact the Medicare Modernization Act contribution payments, the extent of the impact is not yet known. Additional federal guidance is required to properly account for a Medicare Modernization Act impact.

(6) Department of Human Services Medicaid-Funded Programs Base Appropriation						
Line Item	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(A) Executive Director's Office - Medicaid Funding	$17,289,499	$8,644,750	$0	$0	$0	$8,644,749
(B) Office of Information Technology Services - Medicaid Funding; Colorado Benefits Management System	$8,408,583	$4,175,198	$0	$13,671	$18,809	$4,200,905
(B) Office of Information Technology Services - Medicaid Funding; Colorado Benefits Management System - HCPF Only	$611,520	$0	$0	$305,760	$0	$305,760
(B) Office of Information Technology Services - Medicaid Funding; CBMS SAS-70 Audit	$55,204	$27,416	$0	$89	$119	$27,580
(B) Office of Information Technology Services - Medicaid Funding; Office of Information Technology Services - Medicaid Funding, CBMS Modernization Project	$564,113	$282,058	$0	$0	$0	$282,055
(B) Office of Information Technology Services - Medicaid Funding; Other Office of Information Technology Services line items	$591,113	$295,557	$0	$0	$0	$295,556
(C) Office of Operations - Medicaid Funding	$4,974,114	$2,487,057	$0	$0	$0	$2,487,057
(D) Division of Child Welfare - Medicaid Funding; Administration	$137,306	$68,653	$0	$0	$0	$68,653
(D) Division of Child Welfare - Medicaid Funding; Child Welfare Services	$14,797,824	$7,398,913	$0	$0	$0	$7,398,911
(New Line) (D.5) Office of Early Childhood - Medicaid Funding; Division of Community and Family Support, Early Intervention Services	$4,994,334	$2,497,167	$0	$0	$0	$2,497,167
(E) Office of Self Sufficiency - Medicaid Funding; Systematic Alien Verification for Eligibility	$33,951	$0	$0	$0	$0	$33,951
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Administration	$404,350	$202,175	$0	$0	$0	$202,175
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Residential Treatment for Youth (H.B. 99-1116)	$120,372	$60,186	$0	$0	$0	$60,186
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Mental Health Institutes	$4,775,751	$2,387,876	$0	$0	$0	$2,387,875
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding; Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	$1,450,570	$725,285	$0	$0	$0	$725,285
(G) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Administration	$0	$0	$0	$0	$0	$0
(G) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Program Costs	$0	$0	$0	$0	$0	$0
(G) Services for People with Disabilities - Medicaid Funding; Community Services for People with Developmental Disabilities, Early Intervention	$0	$0	$0	$0	$0	$0
(G) Services for People with Disabilities - Medicaid Funding; Regional Centers	$49,430,457	$22,814,579	$0	$1,866,142	$0	$24,749,736
(G) Services for People with Disabilities - Medicaid Funding; Regional Center Depreciation and Annual Adjustments	$1,187,825	$593,913	$0	$0	$0	$593,912
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	$1,800	$900	$0	$0	$0	$900
(I) Division of Youth Corrections - Medicaid Funding	$1,389,674	$694,838	$0	$0	$0	$694,836
(J) Other; Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	$500,000	$0	$0	$0	$0	$500,000
(6) Department of Human Services Medicaid-Funded Programs Totals	**$111,718,360**	**$53,356,521**	**$0**	**$2,185,662**	**$18,928**	**$56,157,249**

(7) Office of Community Living Base Appropriation						
Line Item	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
(A) Program Costs; Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	$347,249,465	$157,994,385	$0	$31,260,696	$0	$157,994,384
(A) Program Costs; Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$58,168,084	$33,103,805	$0	$0	$0	$25,064,279
(A) Program Costs; Children's Extensive Support Services for 659 Medicaid FPE	$19,066,967	$9,533,483	$0	$0	$0	$9,533,484
(A) Program Costs; Preventive Dental Hygiene	$65,203	$61,506	$0	$3,697	$0	$0
(A) Program Costs; Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$29,668,921	$16,001,021	$0	$0	$0	$13,667,900
(A) Program Costs; Family Support Services	$6,762,095	$6,762,095	$0	$0	$0	$0
(A) Program Costs; Eligibility Determination and Waitlist Management	$3,032,242	$3,012,587	$0	$0	$0	$19,655
(B) Administrative Costs; Community and Contract Management System	$137,480	$89,362	$0	$0	$0	$48,118
(B) Administrative Costs; Support Level Administration	$57,368	$28,684	$0	$0	$0	$28,684
(7) Office of Community Living Totals	**$464,207,825**	**$226,586,928**	**$0**	**$31,264,393**	**$0**	**$206,356,504**

Table B.1: Continuation of Section 1202 Primary Care Rate Increases

Row	Item	Fiscal Year		Notes
		FY 2014-15	FY 2015-16	
A	Average Increase in Total Reimbursement per Provider per Quarter	$1,914	$2,009	Based on FY 2012-13 MMIS data and CY 2013 Medicare rates.
B	Number of providers	11,569	11,569	Assumes self-attestation is no longer required.
C	Applicable Quarters	2	4	Assumes January 1, 2014 implementation and a direct rate increase rather than supplemental payments.
D	**Total Funds Impact**	**$44,277,696**	**$92,983,162**	**Row A * Row B * Row C**
E	Estimated Federal Match Rate	58.24%	59.10%	Based on forecast of percentage of clients qualifying for 100% FMAP, 50.75% base FMAP in FY 2013-14, and 51.01% base FMAP in FY 2014-15.
F	General Fund Portion	$18,490,366	$38,030,113	Row D * Row E
G	Federal Funds Portion	$25,787,330	$54,953,049	Row D - Row F

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Alignment of CHP+ Oral Health Care Benefits to CHIPRA

Priority Number: BA-11

Dept. Approval by: Josh Block 12/14 Date

OSPB Approval by: 12/31/13

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☐ Supplemental FY 2014-15
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	196,282,277	-	207,458,484	5,332,745	6,518,592
	FTE	-	-	-	-	-
	GF	22,825,770	-	26,649,625	1,334,347	-
	GFE	438,300	-	438,300	-	-
	CF	46,413,329	-	46,579,118	503,850	1,110,768
	RF	-	-	-	-	-
	FF	126,604,878	-	133,791,441	3,494,548	5,407,824
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**Total**	196,282,277	-	207,458,484	5,332,745	6,518,592
	FTE	-	-	-	-	-
	GF	22,825,770	-	26,649,625	1,334,347	-
	GFE	438,300	-	438,300	-	-
	CF	46,413,329	-	46,579,118	503,850	1,110,768
	RF	-	-	-	-	-
	FF	126,604,878	-	133,791,441	3,494,548	5,407,824

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

See tables 1 and 2 for incremental changes by cash fund source.

Cash or Federal Fund Name and COFRS Fund Number: Children's Basic Health Plan Trust Fund

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: BA-11
Alignment of CHP+ Oral Health Care Benefits to CHIPRA
FY 2014-15 Budget Amendment

Cost and FTE

- The Department requests $5,332,745 total funds; $1,334,347 General Fund, $503,850 in cash funds, and $3,494,548 federal funds in FY 2014-15. The Department also requests continuation funding of $6,518,591 total funds; $1,110,768 cash funds and $5,407,823 federal funds in FY 2015-16.

Current Program

- The Department promotes oral health and is trying to increase the number of children receiving dental services. Preventive dental care can mitigate more expensive treatment in the future.

Problem or Opportunity

- The current oral health care benefit plan for the Child Health Plan *Plus* (CHP+) is not in compliance with federal law. Current coverage lacks periodontic care, orthodontic care, prosthodontic care and required coverage of all medically necessary oral health care.

Consequences of Problem

- Because CHP+ is currently out of compliance with federal law, the State is at risk for a significant loss of federal financial participation.
- CHP+ clients are not currently receiving adequate oral health care benefits; this can result in higher utilization of emergency rooms, greater dental expenses over the long-run, and other indirect health issues associated with poor oral health.

Proposed Solution

- The Department requests ongoing funding to expand CHP+ oral health care benefits to include periodontic care, orthodontic care, prosthodontic care, and increase the program's current $600 annual maximum per member to $1,000 per member per year.
- Adding benefits to the program would satisfy federal requirements and reduce or eliminate the risk of loss of federal financial participation in the program, while improving health outcomes for clients.
- Although an annual maximum of $1,000 is not explicitly required in federal regulations, the Department believes that increase the annual maximum is necessary to ensure access to all benefits that are required to be covered; adequate access is a requirement in federal regulations.

Department Priority BA-11
Request Detail: Alignment of CHP+ Oral Health Care Benefits to CHIPRA

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Alignment of CHP+ Oral Health Care Benefits to CHIPRA (2009)	$5,332,745	$1,334,347

Problem or Opportunity:

Colorado is currently out of compliance with federal regulations requiring a certain dental benefits package for clients enrolled in Children's Health Insurance Program (CHIP), known in Colorado as the Child Health Plan *Plus* (CHP+).

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, reauthorized the Children's Health Insurance Program under title XXI of the Social Security Act. Section 2103(c)(5) of the Social Security Act, as added by section 501 of CHIPRA, requires that "child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."

The Centers for Medicare and Medicaid Services (CMS) issued State Health Official (SHO) letter #09-012 in October 2009 further detailing dental coverage requirements. This letter describes several categories of service that must be covered in any CHP+ dental benefit package. Additionally, these services must be provided in a manner consistent with the statutory requirement to include coverage necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Colorado's CHP+ program currently lacks periodontic care, orthodontic care, prosthodontic care and required coverage of all medically necessary oral health care as mandated in CHIPRA and the SHO letter. Due to funding limitations due to the recession, the Department did not request funding to implement the expanded benefits. However, compliance with the requirements in CHIPRA is mandatory, and the Department must comply or potentially lose federal financial participation for the CHP+ program.

Proposed Solution:

The Department requests $5,332,745 total funds, including $1,334,347 in General Fund, $503,850 in cash funds, and $3,494,548 in federal funds, to expand CHP+ oral health care benefits to include periodontic care,

orthodontic care, and prosthodontic care and to raise the limits on an annual dollar limit to account for these additional services.

There are several components that are required for Colorado to be in compliance with this federal statute which include:

- Increasing the dental benefit package to two routine or periodontal maintenance cleanings in a 12 month period.
- Including coverage of up to four routine or periodontal maintenance cleanings in a 12 month period for patients with certain health conditions such as diabetes, cardiovascular diseases, kidney failure and suppressed immune systems;
- Covering all medically necessary oral health services to prevent disease and promote oral health, treat emergency conditions and restore oral structures using the least invasive services available to establish health functionality; and,
- Allowing certain procedure codes, not currently within the dental benefits package in CHP+, to be covered to ensure that Delta Dental provides necessary periodontic care, orthodontic care, and prosthodontic care.[1]

Due to the increased costs and utilization of adding these required services, the Department proposes increasing the annual limit on CHP+ expenditures per client from $600 to $1,000. CHP+ is modeled after insurance plans and needs to maintain comparability with other insurance providers. The Department reached out to the State's Dental Coalition, Oral Health Colorado, and the largest dental commercial carrier in the state, Delta Dental, and found that the majority of insurance plans offered an annual maximum of $1,000. Alabama, Iowa, Michigan, and Wyoming have approved SPA's for the proposed CHP+ dental benefit changes and offer annual maximums ranging from $1,000 to $1,500. The $1,000 annual limit would be consistent with what is offered by commercial insurance providers and other CHP+ programs, as well as allow clients to access the necessary services so that CHP+ is in compliance with CHIPRA regulations.

Anticipated Outcomes:

Expanding the CHP+ oral health care benefits package will not only bring Colorado into compliance with federal regulations, but will ensure that children in CHP+ have coverage for medically necessary dental services.

Continuing to disallow these services puts clients at risk for more serious and costly procedures in the future and puts the State at risk for losing federal financing.

Assumptions and Calculations:

The Department's contracted actuary performed an analysis on the costs of implementing this change and supplied the adjusted rates to account for the increase in benefits. Two separate analyses were supplied, one assuming annual maximum of $600 and on with an annual maximum of $1,000. The adjusted rates were multiplied by the predicted caseload in the applicable fiscal years. The original estimated dental costs were

[1] See the appendix for required dental coverage as outlined by SHO 09-012

subtracted from these estimates to get the cost of implementation. The request amount listed above assumes an increase to a $1,000 annual maximum for both FY 2014-15 and FY 2015-16.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This budget amendment is due to the CHP+ dental plan being out of compliance with CHIPRA legislation of 2009. This request meets budget amendment criteria as it brings CHP into federal compliance.

Appendix:

List of Required Covered Services

The following categories of services must be covered in the CHP+ dental benefit package.

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D799)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

Table 1: Alignment of CHP+ Dental to CHIPRA, FY 2014-15						
Item	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds[2]**	**FTE**
Total Request	**$5,332,745**	**$1,334,347**	**$503,850**	**$0**	**$3,494,548**	**$0**
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	$5,332,745	$1,334,347	$503,850	$0	$3,494,548	$0

[1]This amount is from the Hospital Provider Fee.

[2]Federal match is calculated as 65% match for the first quarter of the fiscal year, and 65.71% match for the remainder of the fiscal year. This weighted average is a 65.53% match for the entire fiscal year.

Table 2: Alignment of CHP+ Dental to CHIPRA, FY 2015-16						
	Total Funds	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds[2]**	**FTE**
Total Request	**$6,518,592**	**$0**	**$1,110,768**	**$0**	**$5,407,824**	**$0**
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	$6,518,592	$0	$1,110,768	$0	$5,407,824	$0

[1]Of this amount, $842,295 is from the CBHP Trust Fund and $268,473 is from the Hospital Provider Fee.

[2]Federal match is calculated as 65.71% match for the first quarter of the fiscal year, and 88.71% match for the remainder of the fiscal year (assuming the additional 0.71 percentage increas on FMAP remains constant). This weighted average is a 82.96% match for the entire fiscal year.

Table 3
Calculation of Increased Expenditure due to CHIPRA Dental Benefit
FY 2014-15

	Age Range	0-1	0-1	0-1	2-5	2-5	2-5	6-18	6-18	6-18	Total	Formula/Source
Row	FPL Level	Less than 101%	101%-200%	201%-250%	Less than 101%	101%-200%	201%-250%	Less than 101%	101%-200%	201%-250%		
A	Adjusted Rate Lower Bound	$4.96	$4.96	$4.96	$18.03	$17.35	$17.42	$24.64	$23.51	$23.83		Based on actuarial analysis
B	Adjusted Rate Upper Bound	$5.97	$5.97	$5.97	$20.88	$20.02	$20.21	$29.17	$27.62	$28.11		Based on actuarial analysis
C	Estimated Adjusted Rate	$5.47	$5.47	$5.47	$19.46	$18.69	$18.82	$26.91	$25.57	$25.97		(Row A + Row B) / 2
D	FY 2013-14 Rate	$3.35	$3.35	$3.35	$14.31	$13.98	$13.65	$18.10	$17.76	$17.67		Current rate
E	Incremental Increase to Rate	$2.12	$2.12	$2.12	$5.15	$4.71	$5.17	$8.81	$7.81	$8.30		Row C - Row D
F	FY 2014-15 Member Months	17,062	38,023	17,781	24,754	97,892	41,893	73,414	335,255	133,495		CHP+ Caseload estimate[1]
G	**Incremental Request**	$36,171	$80,609	$37,696	$127,483	$461,071	$216,587	$646,777	$2,618,342	$1,108,009	**$5,332,745**	Row E * Row F

(1) The CHP+ caseload is taken from the Department's November 1, 2013 R-3 request, multiplied by 12 to convert to member months.

Table 4
Calculation of Increased Expenditure due to CHIPRA Dental Benefit
FY 2015-16

	Age Range	0-1	0-1	0-1	2-5	2-5	2-5	6-18	6-18	6-18	Total	Formula/Source
Row	FPL Level	Less than 101%	101%-200%	201%-250%	Less than 101%	101%-200%	201%-250%	Less than 101%	101%-200%	201%-250%		
A	Estimated FY 2014-15 Increase to Rate	$2.12	$2.12	$2.12	$5.15	$4.71	$5.17	$8.81	$7.81	$8.30		Table 3, Row E
B	Estimated Trend	2.48%	2.48%	2.48%	2.48%	2.48%	2.48%	2.48%	2.48%	2.48%		CHP+ Trend estimate[1]
C	Estimated FY 2015-16 Rate	$2.17	$2.17	$2.17	$5.28	$4.83	$5.30	$9.03	$8.00	$8.51		Row A * (1 + Row B)
D	FY 2015-16 Member Months	20,353	45,356	21,211	29,528	116,771	49,972	87,572	399,913	159,240		CHP+ Caseload estimate[2]
E	**Incremental Request**	$44,166	$98,423	$46,028	$155,908	$564,004	$264,852	$790,775	$3,199,304	$1,355,132	**$6,518,592**	Row E * Row F

(1) The estimated trend is taken from the Department's November 1, 2013 R-3 request.
(2) The CHP+ caseload is taken from the Department's November 1, 2013 R-3 request, multiplied by 12 to convert to member months.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees
Priority Number: BA-12

Dept. Approval by: Josh Block 12/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☐ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,786,598,993	-	5,376,558,327	206,332	486,724
	FTE	-	-	-	-	-
	GF	1,052,524,920	-	1,053,246,934	173,111	313,803
	GFE	469,842,084	-	469,842,084	-	-
	CF	597,673,815	-	687,658,001	-	-
	RF	4,697,644	-	3,792,823	-	-
	FF	2,661,860,530	-	3,162,018,485	33,221	172,921
(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	**Total**	5,523,166	-	5,760,824	73,980	211,330
	FTE	-	-	-	-	-
	GF	2,575,246	-	2,543,792	73,980	142,655
	GFE	-	-	-	-	-
	CF	186,338	-	336,620	-	-
	RF	-	-	-	-	-
	FF	2,761,582	-	2,880,412	-	68,675
(1) Executive Director's Office (E) Utilization and Quality Review Contracts Professional Services Contracts	**Total**	9,382,809	-	10,053,110	12,500	62,500
	FTE	-	-	-	-	-
	GF	2,279,886	-	2,298,646	12,500	37,500
	GFE	-	-	-	-	-
	CF	305,844	-	461,089	-	-
	RF	-	-	-	-	-
	FF	6,797,079	-	7,293,375	-	25,000
(1) Executive Director's Office (A) General Administration General Professional Services and Special Projects	**Total**	8,492,552	-	6,660,552	21,475	82,375
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	21,475	51,925
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	-	30,450

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
(1) Executive Director's Office	Total	1,764,066	-	1,738,183	2,407	7,919
	FTE	-	-	-	-	-
(A) General Administration Operating Expenses	GF	733,525	-	789,074	2,407	5,163
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	-	2,756
(1) Executive Director's Office	Total	24,611,523	-	28,512,863	18,020	60,100
	FTE	-	-	-	-	-
(A) General Administration Personal Services	GF	8,410,879	-	10,245,685	18,020	39,060
	GFE	-	-	-	-	-
	CF	2,599,660	-	2,693,382	-	-
	RF	1,736,842	-	1,768,913	-	-
	FF	11,864,142	-	13,804,883	-	21,040
(2) Medical Services Premiums	Total	4,736,824,877	-	5,323,832,795	77,950	62,500
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	44,729	37,500
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	33,221	25,000

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- The Department requests $206,332 total funds, $173,111 General Fund, in FY 2014-15 and $486,724 total funds, $313,803 General Fund, in FY 2015-16.

Current Program

- Full benefit Medicare-Medicaid enrollees are individuals enrolled in Medicare Parts A and B and eligible for Part D, who receive full Medicaid State Plan benefits, receive or are eligible for Medicaid waiver services, and have no other comprehensive private or public health insurance.

Problem or Opportunity

- Full benefit Medicare-Medicaid enrollees are not currently passively enrolled in the Accountable Care Collaborative (ACC).
- The Department is receiving a federal grant to partially fund the State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) within the ACC to provide care coordination for approximately 40,000 individuals.
- The State has been awarded federal grant funds that would cover all program expenses in the first grant year (CY 2014) and 75% of administrative and contractor costs in the second grant year (CY 2015).
- Although federal funding is insufficient to cover the full cost of the program, a significant opportunity exists to improve health outcomes and client experience while reducing expenditure.
- Full participation in the Demonstration would allow the State to share in cost reductions experienced by Medicare.

Consequences of Problem

- Without State investment for administrative costs, the Department would not realize increased savings by coordinating care for Medicare-Medicaid enrollees.
- Many full benefit Medicare-Medicaid enrollees have complex health needs that would not be adequately addressed without care coordination.

Proposed Solution

- The Department requests funding to supplement the federal grant to fully implement this program by covering the State's share of contractor costs for the second grant year, allowing the State to realize savings through care coordination of the full benefit Medicare-Medicaid population.
- Over three years, the Department estimates that the Demonstration would be at least budget-neutral, due to savings achieved from reduced costs through management of service utilization, reducing unnecessary use of emergency services and redundant use of services.

Department Priority: BA-12
Request Detail: State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees	$206,332	$173,111

Problem or Opportunity:

The Department was informed by the Centers for Medicare and Medicaid Services (CMS) that it would be receiving a federal grant to partially fund the State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) using the Accountable Care Collaborative (ACC) to provide care coordination for approximately 40,000 individuals receiving both Medicare and Medicaid benefits. Extensive analysis has revealed a significant opportunity to improve health outcomes and client experience while reducing both Medicare and Medicaid expenditure.

Full benefit Medicare-Medicaid enrollees are those individuals who are enrolled in Medicare Parts A and B and eligible for Part D, receive full Medicaid State Plan benefits, receive or are eligible for Medicaid waiver services, and have no other comprehensive private or public health insurance. Full benefit Medicare-Medicaid enrollees are currently not passively enrolled in the ACC, though this population has complex health needs that are not adequately addressed in the current continuum of care, exacerbated by lack of coordination between Medicare and Medicaid providers and services. Passive enrollment of these clients into the ACC would provide an avenue for care coordination for this population that would alleviate the difficulties in ensuring that all provided care is appropriate and meets client needs, while still allowing clients the ability to opt out of the Demonstration if they so choose. The different systems of care that are currently available create further challenges with client navigation and provider care coordination, resulting in lower health outcomes, less positive client experiences, and increased costs. These outcomes could be improved through the care management and pay-for-performance incentives offered in the ACC's per-member per-month (PMPM) payments to Regional Collaborative Care Organizations (RCCOs) and primary care medical providers (PCMPs).

Passively enrolling the full benefit Medicare-Medicaid enrollees into the ACC would be inefficient for the State to attempt alone, as care coordination between Medicare and Medicaid would require extensive contractor analysis, access to Medicare beneficiary information, and infrastructure investment. However, savings would initially favor Medicare while the preliminary service utilization changes would increase costs

for the State, creating incentives for the State to be averse to undertaking such a task on its own. Care coordination initially transitions clients from emergency department services utilization to primary care services utilization and primarily lowers Medicare costs while at the same time increasing State costs. The grant funding available through the Demonstration alleviates the problems that have historically existed when considering care coordination programs for this population, creating an opportunity for the State to achieve savings as service utilization changes lower State costs over time.

The Demonstration would fund collaboration between Medicare and Medicaid programs and services through the ACC to provide full benefit Medicare-Medicaid enrollees with care coordination, a focal point of care, and data analytics through an existing program, all of which would result in better aligned services, alleviated fragmentation, enhanced quality of care, and reduced costs. The ACC creates a focal point for care management through the RCCOs, which coordinate care through the PCMPs and target benchmarks designed to reduce emergency service utilization, hospital readmissions, unnecessary high cost imaging usage, etc. while focusing on the proper utilization of health care services.

However, grant funding is insufficient to fully fund contractor costs necessary to achieve these gains. Additional funding for the State's share of contractor expenses in FY 2014-15 and FY 2015-16 would allow the State to realize net savings while improving client outcomes and experience through care management and the reduction in use of costly, avoidable services such as hospital readmissions and unnecessary emergency service usage, as well as potential movement from nursing facilities to home- and community-based services (HCBS). Further, eligibility to accept the federal grant is contingent upon a commitment from the State to provide a portion of the needed funding in the second grant-funded year of the Demonstration. As much as $14 million in federal grant funding is contingent upon the State contributing to administrative expenses in the second grant-funded year of the Demonstration.

Proposed Solution:

The Department requests $206,332 total funds, $173,111 General Fund, in FY 2014-15 and $486,724 total funds, $313,803 General Fund, in FY 2015-16 to proceed with the implementation of the Demonstration, using federal grant funding supplemented by state funds for contractor costs. The federal grant funding would last for two consecutive calendar years, beginning January 2014. In calendar year (CY) 2014, federal grant funds would cover all contractor expenditure associated with the Demonstration. For CY 2015, the State would need to provide 25% of contractor funding. Once the grant funding years are completed, the State's expenditures would be eligible for a 50% federal financial participation rate, and so would be responsible for 50% of contractor costs for the latter half of FY 2015-16 and beyond. Because the Department would front load resources to establish adequate infrastructure and processes in the first year when the 100% federal funding is in effect, the need for state-funded administration is minimized.

Enrollment of full benefit Medicare-Medicaid enrollees into the ACC would begin on July 1, 2014. The first Demonstration year would comprise July 1, 2014 to December 31, 2015. Thereafter, the second Demonstration year would encompass CY 2016 and the third Demonstration year would encompass CY 2017. CMS and the State could choose to stop the Demonstration at any time, should the desired results not be accomplished. At the end of the third Demonstration year, CMS and the State could mutually agree to continue the Demonstration. Should CMS choose not to continue the Demonstration, the State could make

the decision to continue the program without the Demonstration, if it would be in the State's best interest to do so.

The Department would also reinvest a portion of Demonstration-generated savings achieved through service utilization changes to offset the ACC's PMPM costs, payments made by the State to the RCCOs and PCMPs to compensate them for the costs of care management and coordination, as well as to offer incentives for benchmark achievement, in the second and third years. Therefore, the Department estimates that the Department's services cost for the Demonstration would be negligible from its onset, and budget neutral by FY 2015-16, due to savings achieved from reduced costs through management of service utilization and reduction of inefficiencies such as unnecessary and duplicative use of services. By FY 2016-17, savings achieved through the program would be expected to cover administrative costs as well as incentive payments to RCCOs and PCMPs.

Without funding for the State's portion of the administrative costs, the State would be ineligible for the Demonstration and would lose the opportunity to use federal grant funds to build the infrastructure necessary to enroll full benefit Medicare-Medicaid enrollees into the ACC and achieve savings and improved patient outcomes through care coordination. Duplicative and unnecessary use of costly services would continue to occur without appropriate care management for this medically complex population. The State would struggle to manage the complex care needs of full benefit Medicare-Medicaid enrollees in a disjointed Medicare and Medicaid delivery system that lacks integration of benefits and services from client and provider perspectives and that also lacks integration of data and payment from provider and payer perspectives.

Anticipated Outcomes:

Leveraging the opportunity presented by partnering with federal counterparts would allow the Department to align Medicare and Medicaid incentives through the ACC, placing emphasis on outcomes-driven preventive care and effective management of chronic conditions over volume-driven sick care to achieve better health outcomes and cost reduction.

Care coordination between Medicare and Medicaid providers and services would reduce costs for the State. For instance, the Department expects to achieve savings and improved client outcomes through reduced hospital admissions and readmissions, increased incidences of client movement from skilled nursing facilities to HCBS through early intervention, reduced nursing home admissions, process improvement, reduced emergency department utilization, comprehensive medication management and improved medication reconciliation, greater use of health homes, reductions in unnecessary or duplicative services such as radiology testing, and more judicious use of specialists. These outcomes align with the Department's Strategic Plan objectives of lower costs and improved health outcomes and client experience and would be incentivized through PMPM payments rewarding RCCOs and PCMPs for the achievement of benchmarks and performance goals, to ensure appropriate care management.

Assumptions and Calculations:

See Appendix A for detailed calculations of contractor and administrative costs.

The Department would require a core team of dedicated staff to manage the Demonstration to assure CMS that it has the capacity to implement and oversee the program and provide the best opportunity for program success possible. In the first year, any FTE would be 100% federal grant funded. Thereafter, the Department expects that it would absorb the necessary workload within its existing budget. For this reason, additional FTE have not been included in the calculation of this request, and are not requested at this time.

The Department estimates that net savings realized through the program due to changes in service utilization would reach over $4 million total funds by FY 2016-17. Consequently, the State's initial investment of less than $500,000, when coupled with the federal grant funding opportunity, represents a long term investment with a potentially significant return. Further, Medicare shared savings are not included in this estimate as the Department and CMS are currently negotiating the provisions of the Demonstration; the net savings estimate could potentially increase if Medicare expenses are reduced and subsequent savings shared with the State. For this analysis, the Department does assume that savings in the program would be at least equal to the additional costs of enrollment; this assumption is supported by the Department's analysis of the ACC program.[1]

Stakeholder Engagement

One important factor for the success of the Demonstration is stakeholder engagement, which provides education and outreach to stakeholders to ensure continuity in program comprehension and provides a foundation for optimum care management. The Department assumes two statewide two-day conferences and seven regional one-day conferences (one for each RCCO) throughout the duration of the Demonstration. Both the statewide and the regional conferences' total costs are estimated based on conference costs and participant travel assistance costs from past conferences of comparable scope, with statewide conference costs also including two keynote speakers' travel and per diem costs. Travel assistance for participants is especially critical for stakeholder and provider attendance and the success of the conferences.

Stakeholder engagement also includes the cost of education and outreach material development, production, and dissemination. These costs are estimated based on the Department's Medicaid Infrastructure Grant application and experience, and it is assumed that there would no longer be a need to develop new material by the third grant year, though production and dissemination of the previously developed material would still be necessary. The Department estimated costs for stakeholder meetings based on its federal grant application for the Money Follows the Person program.

The Department's estimates for stakeholder engagement costs are contained in table 2.

Conference Travel

One of the terms of the grant funding contract is that CMS requires two Demonstration project management team members to attend one out-of-state conference per quarter throughout the Demonstration. Per diem,

[1] For example, see the Department's response to the FY 2013-14 Legislative Request for Information #2, available on the Department's website:
http://www.colorado.gov/cs/Satellite?c=Page&childpagename=HCPF%2FHCPFLayout&cid=1251647685492&pagename=HCPFWrapper

incidental, airfare, transportation and lodging costs are each estimated based on current travel payments and the assumption that each conference has a duration of three days.

Because the statewide stakeholder engagement conferences would take place in Denver, no travel costs are associated with the attendance of Demonstration project management team members. However, travel costs would apply to the regional stakeholder engagement conferences. The Department assumes that three members of the Demonstration project management team would attend the regional conferences to provide training and present information to stakeholders, and their mileage reimbursement rate and per diem, incidental, and lodging costs are all based on current travel reimbursement rates and assume a two-day duration to remain conservative to account for travel times and safety considering that some conferences would be distant from Denver. The Department assumes that participants would travel 750 miles roundtrip on average for each conference. This figure is based on the approximate distance from Denver to Durango; however, the actual number of miles travelled would vary for each conference.

The Department's estimates for travel costs are contained in tables 3 and 4.

Enrollment Broker Contractor

Enrollment broker services comprise the development of new client packets in the first grant year and design updates in later years, as well as the production and dissemination of packets. To calculate the cost of new client packets, the Department first estimates the number of enrolled clients per month based on an 8% monthly attrition rate assumption and the goal of 40,000 total enrollment. The Department expects higher monthly enrollment in the first six months as enrollment ramps up to the 40,000 enrollment goal, and so the estimated number of enrolled clients per month is higher in the first grant year than in later years. The Department then estimates the cost of production and dissemination of demonstration program enrollment packets, which is based on current costs. These estimates are multiplied together, and then multiplied by the number of months of enrollment for each grant year, assuming that enrollment begins July 1, 2014, halfway through the first grant year. The costs of designing and updating packets are based on current costs for two letters, a frequently asked questions document, and different handbook inserts for each RCCO.

The Department's estimates for enrollment broker services are contained in table 5.

Beneficiary Rights and Protection Alliance Contractor

Ombudsman services would be required to guarantee fundamental beneficiary rights, including the right to be treated with respect, to receive information on available treatment options in an appropriate manner, to participate in decisions regarding individual health care, to request and receive copies of a client's own medical records, to request that records be amended or corrected, and to have access to complaints, grievances, and appeals processes. Costs associated with these services include salary and benefits for one ombudsman contractor position, estimated based on the current contract and assuming that a supplemental grant would fund the contractor position in the third grant year; training and materials for staff and volunteers, estimated based on the number of staff/volunteers assumed to require training as well as the costs of training and training materials with the assumption that refresher training would be less intensive than new training after the first grant year; beneficiary rights packets, estimated based on current costs for similar materials being sent to the full number of target enrollees in the first grant year and then tapering off thereafter; and

quarterly ombudsman meetings with RCCOs, with meeting costs estimated based on the costs of past meetings of similar scope.

The Department's estimates for beneficiary rights and protections are contained in table 6.

Statewide Data and Analytics Contractor

The statewide data and analytics contractor (SDAC) maintains the web portal that allows RCCOs and PCMPs to access client health information, utilization, and benchmark comparison for the clients attributed to the ACC, all of which are necessary for care management. The existing web portal does not have uptake capacity with Medicare data, though such capacity would be necessary for complete client health status information and care coordination. Costs under the Demonstration include the scope of work necessary for the SDAC to coordinate Medicare data and to add data for Medicare-Medicaid enrollees to analysis and reports. Costs are assumed to be front loaded to reflect the majority of infrastructure being put in place within the first grant year.

The Department's estimates for the SDAC are contained in table 7.

Actuarial Analysis and Rate Reform Contractor

Actuarial analysis and rate reform services are necessary to evaluate benchmarks to determine program success to calculate Medicare shared savings, and required by CMS. Costs include alignment and support of Medicare payment reform, estimated based on state fiscal notes for similarly scoped projects and assumed to no longer be necessary in the third grant year of the Demonstration, and actuary services, which are also estimated based on state fiscal notes for similarly scoped projects.

The Department's estimates for actuarial analysis and rate reform services are contained in table 8.

Evaluation and Program Improvement Contractor

Evaluation and program improvement services facilitate public forums and provide documentation and follow-up to evaluate the Demonstration with respect to the ACC as a whole and to other health care reforms in the State. These evaluations would not duplicate support already offered by CMS and its contractors. These costs are estimated based on current evaluation contractor costs, including funding for program monitoring and tracking.

The Department's estimates for evaluation and program improvement services are contained in table 9.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This budget amendment meets the criteria of new data resulting in substantive changes in funding needs. The Department recently learned it is receiving a federal grant to partially fund the Demonstration. Prior to this information, the Department did not know if it would receive a federal grant or, if it did, what the details of the grant would be.

Table 1.1: FY 2013-14 Demonstration Costs Summary

FY 2013-14[1]	Line Item	Total Funds from All Sources	Demonstration Grant[2]	State Budget Total Funds	State Budget General Fund	State Budget Federal Funds (Title XIX)
Stakeholder Engagement	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$247,208	$247,208	$0	$0	$0
Out-of-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$5,512	$5,512	$0	$0	$0
In-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$5,490	$5,490	$0	$0	$0
Enrollment Broker (MAXIMUS)	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$134,356	$134,356	$0	$0	$0
Beneficiary Rights and Protection Alliance	(1) Executive Director's Office (A) General Administration Personal Services	$113,700	$113,700	$0	$0	$0
Statewide Data and Analytics Contractor (Treo)	(2) Medical Services Premiums	$167,500	$167,500	$0	$0	$0
Actuarial Analysis and Rate Reform (Optumas)	(1) Executive Director's Office (A) General Administration General Professional Services and Special Projects	$106,200	$106,200	$0	$0	$0
Evaluation and Program Improvement	(1) Executive Director's Office (E) Utilization and Quality Review Contracts Professional Services Contracts	$50,000	$50,000	$0	$0	$0
Service Utilization/PMPM Impact	(2) Medical Services Premiums	$0	$0	$0	$0	$0
FY 2013-14 Total		**$829,966**	**$829,966**	**$0**	**$0**	**$0**

(1) FY 2013-14 encompasses half of Grant Year 1 (100% grant funding).
(2) The Demonstration Grant is calculated as: (Total Cost for Grant Year 1)/2.

Table 1.2: FY 2014-15 Demonstration Costs Summary

FY 2014-15[3]	Line Item	Total Funds from All Sources	Demonstration Grant[4]	State Budget Total Funds	State Budget General Fund[5]	State Budget Federal Funds (Title XIX)
Stakeholder Engagement	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$436,774	$389,382	$47,392	$47,392	$0
Out-of-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$11,024	$9,646	$1,378	$1,378	$0
In-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$9,607	$8,578	$1,029	$1,029	$0
Enrollment Broker (MAXIMUS)	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$240,706	$214,118	$26,588	$26,588	$0
Beneficiary Rights and Protection Alliance	(1) Executive Director's Office (A) General Administration Personal Services	$185,780	$167,760	$18,020	$18,020	$0
Statewide Data and Analytics Contractor (Treo)	(2) Medical Services Premiums	$217,500	$205,000	$12,500	$12,500	$0
Actuarial Analysis and Rate Reform (Optumas)	(1) Executive Director's Office (A) General Administration General Professional Services and Special Projects	$192,100	$170,625	$21,475	$21,475	$0
Evaluation and Program Improvement	(1) Executive Director's Office (E) Utilization and Quality Review Contracts Professional Services Contracts	$100,000	$87,500	$12,500	$12,500	$0
Service Utilization/PMPM Impact[6]	(2) Medical Services Premiums	$10,475,690	$10,410,240	$65,450	$32,229	$33,221
FY 2014-15 Total		**$11,869,181**	**$11,662,849**	**$206,332**	**$173,111**	**$33,221**

(3) FY 2014-15 encompasses half of Grant Year 1 (100% grant funding) and half of Grant Year 2 (75% grant funding).
(4) The Demonstration Grant is calculated as: (Total Cost for Grant Year 1)/2 + (Total Cost for Grant Year 2 * 0.75)/2.
(5) The State Budget General Fund is calculated as: (Total Cost for Grant Year 2 * 0.25)/2.
(6) Service Utilization/PMPM Impact is calculated directly by fiscal year in Table 10.

Table 1.3: FY 2015-16 Demonstration Costs Summary

FY 2015-16[7]	Line Item	Total Funds from All Sources	Demonstration Grant[8]	State Budget Total Funds	State Budget General Fund[9]	State Budget Federal Funds (Title XIX)[10]
Stakeholder Engagement	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$220,567	$142,175	$78,392	$62,892	$15,500
Out-of-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$11,024	$4,134	$6,890	$4,134	$2,756
In-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$4,117	$3,088	$1,029	$1,029	$0
Enrollment Broker (MAXIMUS)	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$212,701	$79,763	$132,938	$79,763	$53,175
Beneficiary Rights and Protection Alliance	(1) Executive Director's Office (A) General Administration Personal Services	$114,160	$54,060	$60,100	$39,060	$21,040
Statewide Data and Analytics Contractor (Treo)	(2) Medical Services Premiums	$100,000	$37,500	$62,500	$37,500	$25,000
Actuarial Analysis and Rate Reform (Optumas)	(1) Executive Director's Office (A) General Administration General Professional Services and Special Projects	$146,800	$64,425	$82,375	$51,925	$30,450
Evaluation and Program Improvement	(1) Executive Director's Office (E) Utilization and Quality Review Contracts Professional Services Contracts	$100,000	$37,500	$62,500	$37,500	$25,000
Service Utilization/PMPM Impact[11]	(2) Medical Services Premiums	$0	$0	$0	$0	$0
FY 2015-16 Total		**$909,369**	**$422,645**	**$486,724**	**$313,803**	**$172,921**

(7) FY 2015-16 encompasses half of Grant Year 2 (75% grant funding) and half of Grant Year 3 (50% federal financial participation rate).
(8) The Demonstration Grant is calculated as: (Total Cost for Grant Year 2 * 0.75)/2.
(9) The State Budget General Fund is calculated as: (Total Cost for Grant Year 2 * 0.25)/2 + (Total Cost for Grant Year 3 * 0.50)/2.
(10) The State Budget Federal Funds are calculated as: (Total Cost for Grant Year 3 * 0.50)/2.
(11) Service Utilization/PMPM Impact is calculated directly by fiscal year in Table 10.

Table 1.4: FY 2016-17 Demonstration Costs Summary

FY 2016-17[11]	Line Item	Total Funds from All Sources	Demonstration Grant[12]	State Budget Total Funds	State Budget General Fund[13]	State Budget Federal Funds (Title XIX)[14]
Stakeholder Engagement	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$62,000	$0	$62,000	$31,000	$31,000
Out-of-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$11,024	$0	$11,024	$5,512	$5,512
In-State Travel	(1) Executive Director's Office (A) General Administration Operating Expenses	$0	$0	$0	$0	$0
Enrollment Broker (MAXIMUS)	(1) Executive Director's Office (D) Eligibility Determinations and Client Services Customer Outreach	$212,700	$0	$212,700	$106,350	$106,350
Beneficiary Rights and Protection Alliance	(1) Executive Director's Office (A) General Administration Personal Services	$84,160	$0	$84,160	$42,080	$42,080
Statewide Data and Analytics Contractor (Treo)	(2) Medical Services Premiums	$100,000	$0	$100,000	$50,000	$50,000
Actuarial Analysis and Rate Reform (Optumas)	(1) Executive Director's Office (A) General Administration General Professional Services and Special Projects	$121,800	$0	$121,800	$60,900	$60,900
Evaluation and Program Improvement	(1) Executive Director's Office (E) Utilization and Quality Review Contracts Professional Services Contracts	$100,000	$0	$100,000	$50,000	$50,000
Service Utilization/PMPM Impact[15]	(2) Medical Services Premiums	($4,358,400)	$0	($4,358,400)	($2,135,180)	($2,223,220)
FY 2016-17 Total		**($3,666,716)**	**$0**	**($3,666,716)**	**($1,789,338)**	**($1,877,378)**

(11) FY 2016-17 encompasses half of Grant Year 3 (50% federal financial participation rate) and half of Grant Year 4 (50% federal financial participation rate).
(12) There is no Demonstration Grant funding available in FY 2016-17.
(13) The State Budget General Fund is calculated as: (Total Cost for Grant Year 3 * 0.50)/2 + (Total Cost for Grant Year 4 * 0.50)/2
(14) The State Budget Federal Funds is calculated as: (Total Cost for Grant Year 3 * 0.50)/2 + (Total Cost for Grant Year 4 * 0.50)/2
(15) Service Utilization/PMPM Impact is calculated directly by fiscal year in Table 10.

Table 2: Stakeholder Engagement Costs						
Row	**Item**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Meetings**	**$12,000**	**$12,000**	**$12,000**	**$12,000**	**Estimate based on federal grant application for the Money Follows the Person**
	Statewide Conferences:					
B	Number of Conferences	1	1	0	0	Estimate hosting 2 statewide conferences in the Denver metro area through the life of the
C	Two-Day Conference Costs	$35,283	$35,283	$0	$0	Estimate based on past conference costs, including food and refreshments
D	Speaker Costs	$3,000	$3,000	$0	$0	Assumes 2 keynote speakers' travel and per diem costs
E	Travel Assistance for Participants	$40,000	$40,000	$0	$0	Estimate based on past conference costs of comparable scope/Critical for stakeholder and provider attendance
F	**Statewide Conferences Total**	**$78,283**	**$78,283**	**$0**	**$0**	**Row B * (Row C + Row D + Row E)**
	Regional Conferences:					
G	Number of Conferences	4	3	0	0	Estimate hosting 7 regional conferences throughout the State
H	One-Day Conference Costs	$20,283	$20,283	$0	$0	Estimate based on past conference costs of comparable size, including food and refreshments
I	Travel Assistance for Participants	$20,000	$20,000	$0	$0	Estimate based on past conference costs of comparable scope/Critical for stakeholder and provider attendance
J	**Regional Conferences Total**	**$161,132**	**$120,849**	**$0**	**$0**	**Row G * (Row H + Row I)**
	Education and Outreach Materials:					
K	Development of Materials	$100,000	$50,000	$0	$0	Estimate based on the Medicaid Infrastructure Grant application and experience/Assumes materials will be developed by Grant Year 3
L	Printing	$50,000	$25,000	$25,000	$25,000	Estimate based on the Medicaid Infrastructure Grant application and experience
M	Dissemination of Materials	$25,000	$25,000	$25,000	$25,000	Estimate based on the Medicaid Infrastructure Grant application and experience
N	**Education and Outreach Materials Total**	**$175,000**	**$100,000**	**$50,000**	**$50,000**	**Row K + Row L + Row M**
O	**Facilitation Contractor**	**$68,000**	**$68,000**	**$0**	**$0**	**Assumes this will no longer be necessary in Grant Year 3 and beyond**
P	**Total Stakeholder Engagement Costs**	**$494,415**	**$379,132**	**$62,000**	**$62,000**	**Row A + Row F + Row J + Row N + Row O**

Table 3: Out-of-State Conference Travel Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Number of Out-of-State Travelers**	**2**	**2**	**2**	**2**	**CMS requires that two Demonstration project management team members attend**
B	**Number of Out-of-State Conferences**	**4**	**4**	**4**	**4**	**Assumes one conference per quarter**
	Cost per Conference:					**Estimates based on current travel payments and assumes a 3-day conference**
C	Per Diem	$213	$213	$213	$213	
D	Incidental	$15	$15	$15	$15	
E	Airfare	$500	$500	$500	$500	
F	Transportation	$50	$50	$50	$50	
G	Lodging	$600	$600	$600	$600	
H	**Cost per Conference Estimated Total**	**$1,378**	**$1,378**	**$1,378**	**$1,378**	**Row C + Row D + Row E + Row F + Row G**
I	**Total Out-of-State Conference Travel Costs**	**$11,024**	**$11,024**	**$11,024**	**$11,024**	**Row A * Row B * Row H**

Table 4: In-State Conference Travel Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Number of Local Travelers**	**3**	**3**	**0**	**0**	**Medicare-Medicaid Demonstration project management team**
B	**Number of In-State Conferences**	**4**	**3**	**0**	**0**	**Assumes 7 total regional conferences**
	Cost per Conference:					**Estimates based on current travel reimbursement rates and assume 2 day duration to remain conservative for travel**
C	Mileage Reimbursement	$0.50	$0.50	$0	$0	
D	Miles Traveled	750	750	0	0	Approximate number of miles from Denver to Durango
E	Per Diem	$130	$130	$0	$0	
F	Incidental	$10	$10	$0	$0	
G	Lodging	$400	$400	$0	$0	
H	**Cost per Conference Estimated Total**	**$915**	**$915**	**$0**	**$0**	**(Row C * Row D) + Row E + Row F + Row G**
I	**Total Out-of-State Conference Travel Costs**	**$10,980**	**$8,235**	**$0**	**$0**	**Row A * Row B * Row H**

Table 5: Enrollment Broker Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
	Cost of New Client Packets:					
A	Estimated Number of Enrolled Clients per Month	8,067	3,200	3,200	3,200	Assumes 8% monthly attrition rate and 40,000 total enrollment; monthly enrollment higher in first six months for ramp-up to 40,000
B	Cost of Demonstration Program Enrollment Packets	$5.50	$5.50	$5.50	$5.50	Estimate based on current costs
C	Months in Operation	6	12	12	12	Assumes enrollment begins halfway through Grant Year 1: July 1, 2014
D	**Cost of New Client Packets Total**	**$266,211**	**$211,200**	**$211,200**	**$211,200**	**Row A * Row B * Row C**
E	**Cost of Designing/Updating Packets**	**$2,500**	**$1,500**	**$1,500**	**$1,500**	**Based on current costs for two letters and different handbook inserts per RCCO**
F	**Total Enrollment Broker Costs**	**$268,711**	**$212,700**	**$212,700**	**$212,700**	**Row D + Row E**

Table 6: Beneficiary Rights and Protections Alliance Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Current Contract Ombudsman**	**$60,000**	**$60,000**	**$0**	**$0**	**Estimate based on current contract for one ombudsman salary and benefits/Assumes a supplemental grant will fund this in Grant Year 3**
	Training/Materials for Staff:					
B	Training/Materials	$25	$10	$10	$10	Estimate based on current experiences with similar activities/Assumes refresher training materials less intensive after first year
C	Staff Trained	216	216	216	216	Estimate based on ombudsman staff/volunteers that must be trained
D	**Training/Materials for Staff Total**	**$5,400**	**$2,160**	**$2,160**	**$2,160**	**Row B * Row C**
	Materials for Beneficiaries:					
E	Beneficiary Rights Packets	$4	$4	$4	$4	Estimate based on current experiences with similar activities
F	Beneficiaries Contacted for Outreach	40,000	20,000	20,000	20,000	Estimate based on target enrollment; assumes materials ramp down over time
G	**Materials for Beneficiaries Total**	**$160,000**	**$80,000**	**$80,000**	**$80,000**	**Row E * Row F**
	Meetings with RCCOs:					
H	Number of Meetings	4	4	4	4	Assumes quarterly meetings
I	Meeting Costs	$500	$500	$500	$500	Estimate based on costs of past meetings of similar scope
J	**Meetings with RCCOs Total**	**$2,000**	**$2,000**	**$2,000**	**$2,000**	**Row H * Row I**
K	**Total Beneficiary Rights and Protections Alliance Costs**	**$227,400**	**$144,160**	**$84,160**	**$84,160**	**Row A + Row D + Row G + Row J**

Table 7: Statewide Data and Analytics Contractor (Treo) Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Statewide Data and Analytics Contractor Costs**	**$335,000**	**$100,000**	**$100,000**	**$100,000**	**Estimate includes scope of work to add data for Medicare-Medicaid enrollees to SDAC analysis and reports. Costs are front loaded to reflect the majority of the work being done within the first year**

Table 8: Actuarial Analysis and Rate Reform Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Align and Support Medicare Payment Reform**	**$50,000**	**$50,000**	**$0**	**$0**	**Estimates based on state fiscal notes for similarly scoped projects/Assumes this will no longer be necessary in Grant Year 3**
B	**Actuary Services**	**$162,400**	**$121,800**	**$121,800**	**$121,800**	**Estimates based on state fiscal notes for similarly scoped projects**
C	**Total Actuarial Analysis and Rate Reform Costs**	**$212,400**	**$171,800**	**$121,800**	**$121,800**	**Row A + Row B**

Table 9: Evaluation and Program Improvement Contractor Costs						
Row	**Component**	**Grant Year 1**	**Grant Year 2**	**Grant Year 3**	**Grant Year 4**	**Assumptions/Calculations**
A	**Evaluation and Program Improvement Contractor Costs**	**$100,000**	**$100,000**	**$100,000**	**$100,000**	**Based on current evaluation contractor costs plus funding for program monitoring and tracking**

Table 10: Estimated Impact of Service Utilization Changes and PMPM Costs of Demonstration

Row	Component	FY 2013-14[1]	FY 2014-15	FY 2015-16	FY 2016-17	Assumptions/Calculations
A	Member Months	0	385,000	480,000	480,000	Assumes 40,000 total enrollment; first six months lower due to ramp-up to 40,000
B	Cost/Savings Per Enrollee Per Month from Program Changes[2]	$0.00	$0.17	($20.92)	($30.00)	Savings/costs achieved through changes in service utilization due to the program; based on actuarial analysis.
C	State Per Member Per Month (PMPM) Costs	$0.00	$0.00	$20.92	$20.92	Assumes grant funding ($10,410,240) covers PMPM costs in FY 2014-15 and savings would be available to achieve budget neutrality in FY 2015-16.
D	Net Impact Per Enrollee Per Month	$0.00	$0.17	$0.00	($9.08)	Row B + Row C
E	Total Funds Impact	$0	$65,450	$0	($4,358,400)	Row A * Row D
F	State's Portion	50.00%	50%/48.99%	48.99%	48.99%	The State's percentage of costs/savings under current FMAP. FMAP changes from 50% to 51.01% in October 2014.
G	**Net General Fund Impact Due to Change in Utilization of Services/PMPM Costs**	**$0**	**$32,229**	**$0**	**($2,135,180)**	**Row E * Row F -- FY 2014-15 consists of 50% FMAP for the first quarter and 51.01% FMAP thereafter. Row G for this FY is calculated as (Row E * .50 * .25) + (Row E * .4899 * .75)**

No estimate for Medicare Shared Savings included, as CMS and the Department are currently negotiating the terms of the Demonstration contract.

(1) Enrollment would not begin until July 1, 2014; therefore, there would be no savings/costs associated with program utilization in FY 2013-14.

(2) Actuarial analysis calculates anticipated savings/costs per enrollee per month due to program changes based on Demonstration years. The first Demonstration year encompasses full FY 2014-15 and the first half of FY 2015-16 (through CY 2015). The second Demonstration year encompasses CY 2016, and the third Demonstration year encompasses CY 2017. Actuarial analysis estimates $0.17 cost per enrollee per month due to program changes for the first Demonstration year, $42.02 savings per enrollee per month due to program changes for the second Demonstration year, and $77.97 savings per enrollee per month due to program changes for the third Demonstration year, on average for each time period. Because FY 2015-16 is comprised half of the first Demonstration year and half of the second Demonstration year, savings is calculated as the average between $0.17 cost and $42.02 savings ($20.92 savings). FY 2016-17 is comprised half of the second Demonstration year and half of the third Demonstration year, and so savings is calculated as the average between $42.02 savings and $77.97 savings ($60.00 savings). However, to remain fiscally conservative, the Department is halving expected savings in FY 2016-17 to $30.00.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Disability Determinations Contract Reprocurement
Priority Number: BA-13

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/21/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☐ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	34,476,620	-	39,915,160	321,990	-
	FTE	358.1	-	395.1	-	-
	GF	9,380,635	-	11,215,441	160,995	-
	GFE	-	-	-	-	-
	CF	6,174,528	-	7,036,850	-	-
	RF	1,736,842	-	1,768,913	-	-
	FF	17,184,615	-	19,893,956	160,995	-
(1) Executive Director's Office, (A) General Administration, General Personal Services	**Total**	24,611,523	-	28,512,863	28,584	-
	FTE	358.1	-	395.1	-	-
	GF	8,410,879	-	10,245,685	14,292	-
	GFE	-	-	-	-	-
	CF	2,599,660	-	2,693,382	-	-
	RF	1,736,842	-	1,768,913	-	-
	FF	11,864,142	-	13,804,883	14,292	-
(1) Executive Director's Office, (D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	**Total**	9,865,097	-	11,402,297	293,406	-
	FTE	-	-	-	-	-
	GF	969,756	-	969,756	146,703	-
	GFE	-	-	-	-	-
	CF	3,574,868	-	4,343,468	-	-
	RF	-	-	-	-	-
	FF	5,320,473	-	6,089,073	146,703	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: None.
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

Cost and FTE

- The Department requests $321,990 total funds, including $160,995 General Fund, for disability determination services. This funding is only for FY 2014-15 and does not require any additional FTE.

Link to Operations

- The Department conducts disability determination services for Medicaid clients through a contracted vendor.
- The vendor receives and processes all applications from Medicaid applicants to determine if they qualify for Medicaid due to a disability.
- The disability determination process, which includes medical case file review and medical examinations, can take 70 days to complete, and longer if a client appeals the determination decision.

Problem or Opportunity

- The current contract for this service expires in 2015, and the Department is required to competitively reprocure the contract.
- As the Department transitions between vendors, determinations that overlap the vendor transition date may be unnecessarily delayed due to business process and vendor staff changes, which can impede a client's ability to receive services.
- To minimize the impact to clients and assure a smooth transition between vendors, the Department must overlap contract periods and temporarily assign a transition manager to oversee the transition. Past transitions that did not include overlapping contracts resulted in delayed service delivery, longer processing periods, clients having to resubmit information, and loss of client data.

Consequences of Problem

- If this request is not approved, clients may experience delayed services, longer processing periods, or be forced to resubmit data, which means delayed or absent services, leading to poorer health outcomes and higher costs. In some cases, it may violate federal law if clients are unable to obtain services.

Proposed Solution

- The Department requests funding for a one-time increase to the line associated with this contract to allow for a transitional overlap between vendors with a temporary transition manager who would be charged with ensuring the transition occurs in a timely and successful manner.
- The incoming vendor would be able to transition into the contractual obligations with assistance from the outgoing vendor, and affected clients should notice little to no change in service delivery.

Department Priority: BA-13
Request Detail: Disability Determinations Contract Reprocurement

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Disability Determinations Contract Reprocurement	$321,990	$160,995

Problem or Opportunity:

The Department is required to reprocure its administrative service contract for disability determination services in 2015 and is requesting funding to assure that the transition of the contract between vendors does not affect service delivery for clients. The current contract expires in FY 2014-15, and the Department is required to competitively reprocure the contract.

The Department contracts with external vendors to provide administrative services for Colorado Medicaid and Child Health Plan *Plus* (CHP+) clients. These services include disability determination services for individuals applying for Medicaid due to a disability, as the State is required to do by federal law.

The vendor for this contract makes disability determinations for individuals applying for or receiving Colorado Medicaid on the basis of disability in accordance with 42 CFR § 435.230, the implementing regulations and the Social Security Administration (SSA) Program Operations Manual System (POMS). The vendor is responsible for all aspects of work related to the disability determination process, including but not limited to: receiving applications directly from any source, including applicants, eligibility sites, and providers; entering the applicant's disability determination information into the Colorado Benefits Management System (CBMS); communicating application status with eligibility sites, providers, the Office of Administrative Courts, applicants and clients, and the Department; sending all necessary notices to applicants; and forwarding non-disability applications and related materials to the appropriate county to complete processing.

Proposed Solution:

The Department requests $321,990 total funds – comprised of $160,995 General Fund and matching federal funds – to fund a transitional overlap period for its disability determination services contract and assign a temporary transition manager during contract reprocurement. This funding is one-time and does not require any additional FTE.

To assure a smooth transition between the outgoing and incoming vendors, the Department must overlap contract periods. As a best practice, the Department believes a transition to a new vendor should begin three

to six months prior to the end-date of the incumbent vendor's contract. The new vendor will be responsible for leading, coordinating, and implementing the transition plan, with assistance from the Department. The goal is for the new vendor to demonstrate to the Department, prior to implementation, that their operations are ready to begin and services are set to be rendered. Past transitions that did not include overlapping contracts resulted in several negative consequences. For example, when the current non-emergent medical transportation (NEMT) contract was reprocured, the incoming vendor began transition activities late. The vendor's new computer system launched without being fully functional, resulting in service delays for the first few months of the contract period.

In addition to overlapping contract periods, the Department must also assign a temporary transition manager to oversee the new contract transition. When a new vendor is selected, the Department does not have the staffing resources to properly manage all the tasks of both the incoming and outgoing vendor. The transition manager is needed to perform basic project management, facilitating communication between the new and incumbent vendors, and verifying that the new contractor is operationally ready to perform. In the Department's previous transition for its eligibility determinations and enrollment services (or EEMAP) vendor, months after the current vendor took over the contract, the Department discovered that several thousand client applications and documents, which were mailed to the outgoing vendor, were left sitting in boxes. No review or determination of these cases was made. Other boxes contained applications and documentation that had been entered but not filed or categorized, which continues to create issues with locating records for internal reviews and external auditing. This type of mistake, affecting client eligibility, is categorically unacceptable and must not be allowed to happen again.

If this request is not approved, applicants with disabilities may have difficulty enrolling in Medicaid, and the Department risks client disability determinations not being completed within an appropriate time frame. As a result, applicants may experience longer processing periods or be forced to resubmit data, which results in delayed or absent services, leading to poorer outcomes and higher costs. In some cases, it may violate federal law if applicants are unable to obtain services due to processing complications.

Anticipated Outcomes:

If approved, this request would fund a one-time increase to the Department's Contracts and Special Eligibility Determinations line item to allow for a transitional overlap between the outgoing and incoming vendors of the disability determination services contract. This request would also increase the Department's Personal Services line item to fund a temporary transition manager for the contract transition, who would be charged with ensuring the transition occurs in a timely and successful manner. As a result, the incoming vendor would be able to transition into the contractual obligations with assistance from the outgoing vendor, while maintaining optimal health care access and outcomes for the clients and demonstrating sound stewardship of financial resources.

This request is in line with all five objectives of the Department's performance plan. By mitigating disruptions between outgoing and incoming disability determination services vendors, the Department is ensuring those who are eligible for Medicaid due to a disability are enrolled, ensuring those who need medical attention receive it when they need it, instead of when their condition has worsened and becomes much more expensive to treat.

Assumptions and Calculations:

The Department estimates that the total additional funding need for disability determinations services is $321,990 total funds, including $160,995 General Fund and $160,995 federal funds (see Table 1 Row B of the appendix).

Traditionally, the Department determines start-up costs to be 10% of the five-year contract amount – which is the same as 50% of a single-year amount of the contract – and spreads it out over the life of the contract. This approach can be problematic, as it requires vendors to take a loss in the short-term, which may discourage qualified vendors from bidding on the contract. Because an incoming vendor will not be incurring any operational costs during the transition period, the Department believes 25% of the FY 2013-14 contract amount, plus the cost of the temporary transition manager, will be sufficient to fund necessary start-up costs related to capital and administration. The Department applied this methodology to the contract being reprocured. However, the actual costs would be determined based on the contractor's response to the Department's request for proposals. The Department would use the standard budget process to adjust for any differences between the incurred expenditure and the estimate. Table 3 of the appendix details the FY 2013-14 contract amount for disability determination services, as well as the transition funding need for the contract.

The Department would fill the temporary transition manager position at the General Professional IV level. The current monthly salary at the General Profession IV level is $4,764 (see Table 4 of the appendix)

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

On November 1, 2013, the Department submitted R-12, "Administrative Contract Reprocurements," requesting transitional funding for a number of contracts for in FY 2014-15. This request amends R-12 by adding the contract for disability determination services. The Department inadvertently left this contract out of the original request. Therefore, this request meets budget amendment criteria as a technical error which has a substantive effect on the operation of the program.

Table 1: Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	Disability and Determinations Services	$321,990	$160,995	$0	$160,995	Table 2 Row C
B	**FY 2014-15 Additional Funding Request**	**$321,990**	**$160,995**	**$0**	**$160,995**	Row A

Table 2: Request by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	(1) Executive Director's Office, Personal Services	$28,584	$14,292	$0	$14,292	Table 3 Row C
B	(1) Executive Director's Office, Contracts for Special Eligibility Determinations	$293,406	$146,703	$0	$146,703	Table 3 Row B
C	**Total Request**	**$321,990**	**$160,995**	**$0**	**$160,995**	Row A + Row B

Table 3: Transistion Cost Estimate						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	FY 2013-14 Contract Amount	$1,173,622	$581,831	$5,000	$586,831	
B	Transition Need	$293,406	$146,703	$0	$146,703	Row A Total Funds × 25%, applied 50% match
C	Transition Manager	$28,584	$14,292	$0	$14,292	Table 4 Row C
D	**Total Request**	**$321,990**	**$160,995**	**$0**	**$160,995**	Row B + Row C

Table 4: Transition Manager (General Professional IV)			
Row	**Item**	**Monthly Rate**	**Notes**
A	Salary	$4,764	Range Minimum as of July 2013
B	Effective Months	6	Assumed
C	**Total**	**$28,584**	Row A × Row B

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Customer Service Technology True-up
Priority Number: BA-14

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☐ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	8,492,552	-	6,660,552	715,468	715,468
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	357,734	357,734
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	357,734	357,734
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	8,492,552	-	6,660,552	715,468	715,468
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	357,734	357,734
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	357,734	357,734

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☐
Schedule 13s from Affected Departments: OIT
Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: BA-14
Customer Service Technology True-up
FY 2014-15 Budget Amendment

Cost and FTE

- The Department requests $715,468 total funds comprised of $357,734 General Fund and $357,734 federal funds in FY 2014-15 and ongoing.

Link to Operations

- The Department's Customer Contact Center assists existing and potential Medicaid clients by answering questions about Medicaid eligibility, benefits, and enrollment; completing over-the phone Medicaid applications; and referring callers to outside entities when necessary.
- This service is critical to ensure individuals and families have the assistance they need when applying for and utilizing Medicaid benefits.

Problem or Opportunity

- The Customer Contact Center recently implemented interactive voice response (IVR) and customer relations management (CRM) technology per the Department's FY 2013-14 R-12 budget request, "Customer Service Technology Improvements."
- Since implementing this technology, the call volume has been triple what was projected, resulting in long wait times, high abandonment rates, and insufficient storage capacity for verbal attestations required for over-the-phone Medicaid applications.

Consequences of Problem

- Due to this high call volume, individuals and families cannot get timely assistance from the Department in navigating the eligibility requirements, benefits, and application process of Medicaid. The volume is expected to remain at high levels and potentially increase due to the implementation of the Affordable Care Act.

Proposed Solution

- The Department requests additional funding for IVR technology to account for utilization that is higher than what was originally estimated by the vendor.
- The Department also requests additional funding for data storage with the Governor's Office of Information Technology (OIT) in order to store verbal attestations for over-the-phone Medicaid applications.
- The Department also requests additional funding to support higher ongoing maintenance costs of IVR and CRM technology.
- This funding would ensure that Medicaid clients have accurate information about the Medicaid program and adequate, timely assistance when applying for and using Medicaid benefits.

Department Priority: BA-14
Request Detail: Customer Service Technology True-up

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Customer Service Technology True-up	$715,468	$357,734

Problem or Opportunity:

The Department recently implemented new Customer Contact Center technology per the Department's FY 2013-14 R-12 budget request, "Customer Service Technology Improvements." However, the original estimates for ongoing maintenance and operations appear to be insufficient due to underestimated customer call volume and the need for additional resources to provide ongoing system maintenance and fulfill requirements of HB 12-1288 related to critical Information Technology (IT) projects.

The Department's Customer Contact Center is a critical service for existing and prospective Medicaid clients. The Customer Contact Center answers questions over the phone and online about Medicaid eligibility, benefits, and enrollment; completes over-the-phone Medicaid applications, and connects callers to outside parties when appropriate.

Per the Department's FY 2013-14 R-12 budget request, the Department's Customer Contact Center implemented interactive voice response (IVR) and customer relations management (CRM) technology on October 1, 2013. Since implementing this technology, call volume has been triple the amount originally estimated. This has resulted in insufficient electronic storage for recorded verbal client attestations and, because the IVR system is paid for on a per-minute basis, insufficient funding to pay for the number of minutes that callers are spending in the IVR system. Additionally, ongoing maintenance costs are higher than originally estimated, which has resulted in insufficient funding to make regular system changes as the IVR and CRM systems evolve and has compromised compliance with HB 12-1288. HB 12-1288 created new state IT requirements applicable to the IVR and CRM technology that they currently do not fulfill; these requirements include specific minimum criteria for project plans and business requirements, required business continuity planning, and an assigned Project Manager.

The Department relied on vendor estimates in creating the cost estimates for the original budget request; however, the assumptions behind those estimates appear to be inaccurate for several reasons. First, average call length has increased more than expected due to lengthy technical questions about the Colorado Program and Eligibility Application Kit (PEAK), the implementation of the federal Affordable Care Act of 2009 (ACA), and the Colorado Health Benefits Exchange (COHBE). Second, original estimates were based on

the previous call technology, which produced limited data for estimation and had less capacity than the newly implemented IVR and CRM technology. Specifically, the Department had no data on the number of callers who received a busy signal in the previous system, which callers would get when system capacity was reached; however, under the new system, callers are put on hold instead of given a busy signal, creating a large queue of callers that the Department could not accurately predict due to the lack of data about busy-signal callers in the previous system. Finally, due to the timelines of the state budgeting process, general ongoing maintenance estimates for the IVR and CRM systems were created before detailed IT business requirements could be completed and evaluated, leading to imprecise estimates.

The insufficient call volume capacity of the IVR and CRM technology and inadequate maintenance resources for these systems threaten timely assistance to individuals and families seeking help from the Customer Contact Center. If these inadequacies are not addressed, the Department expects loss of use of IVR technology due to lack of funding for additional IVR system minutes to accommodate the higher-than-expected call volume; the inability to store verbal attestations and thus accept over-the-phone Medicaid applications due to full storage drives; and, the inability to fix any system errors or adapt to evolving business requirements due to lack of ongoing maintenance resources. These problems would likely create longer caller wait times (which are already 10 to 20 minutes on average, depending on time of day); higher caller abandonment rates; federal sanctions due to the federal requirement to store verbal attestations and accept over-the-phone Medicaid applications; noncompliance with HB 12-1288; and unreliable ongoing performance of the IVR and CRM technology.

Proposed Solution:

The Department requests $715,468 total funds comprised of $357,734 General Fund and $357,734 federal funds in FY 2014-15 and ongoing to true-up ongoing system capacity and maintenance costs of recently implemented Customer Contact Center technology.

First, to address insufficient caller minutes within the IVR system, the Department requests funding to purchase additional annual IVR minutes so that the IVR system can continue to operate under higher customer call volume. While this high customer call volume is partially a temporary surge due to ACA implementation, the Department expects call volume to remain high in the future due to increasing Medicaid enrollment under ACA; continued technical questions about PEAK and COHBE, especially during annual open enrollment periods; and the ongoing ACA requirement to process Medicaid phone applications, which can require up to an hour per caller. Alternatively, the Department could request additional staff in the Customer Contact Center; which would reduce caller time spent waiting in the IVR system and allow for additional online contact options that would divert caller volume from the IVR system to the web. While this would reduce the number of minutes callers spend in the IVR system, it would take longer to implement due to hiring and training needs.

Second, to address storage capacity for verbal Medicaid application attestations, the Department proposes to purchase additional data storage at OIT to store the verbal attestations of applicants. Since over-the-phone Medicaid applications and storing attestations are federally required and the Department could face federal sanctions if it does not store these attestations, the Department cannot identify a viable alternative.

Last, to address ongoing maintenance costs of the IVR and CRM technology, the Department proposes to fund additional system development hours with the IVR and CRM development vendor, and a business analyst and senior project manager at OIT. These additional system development hours would fund computer programmers to make changes to the IVR and CRM systems when system glitches are discovered, when new federal or state regulations are enacted that pertain to these systems, or when system efficiencies or enhancements are desired. The OIT business analyst and project manager would serve as intermediaries between Customer Contact Center staff and the developer; they would coordinate system changes with the developer, translate Department staff needs into technical specifications, perform system testing, provide training, and manage system documentation. This would ensure the technology is able to adapt to changing business requirement and would also meet the relevant requirements of HB 12-1288. Alternatively, the Department could contract with an external vendor for these resources; however, this option would likely cost more and an outside vendor would likely be less available than OIT for ongoing system troubleshooting with Department staff.

Anticipated Outcomes:

If approved, the proposed solution would address the insufficient call volume capacity and inadequate maintenance resources of the recently implemented Customer Contact Center technology. This would ensure that callers receive timely assistance from the Customer Contact Center and that the requirements of HB 12-1288 and the federal government are met.

If approved, the proposed solution would help the Department achieve its goal to "improve health outcomes, client experience, and lower per capita costs," as stated in the Department's five-year strategy plan. Specifically, this request would help meet this goal's stated performance measure to enhance customer service operations by increasing the number of calls answered and reducing calls abandoned. This enhances the experience of Colorado Medicaid clients and helps to ensure that individuals and families in Colorado receive timely assistance when reaching out to the Department's Customer Contact Center.

Assumptions and Calculations:

The requested annual ongoing funding for the components of this request are shown in Table 1 of the attached appendix. The Department assumes all components are eligible for a 50% federal financial participation (FFP) rate and that the state's share of the cost would come from the General Fund. Cost estimates and assumptions for these components are discussed in detail below.

First, the funding requested to pay for additional caller minutes in the IVR system contract is shown in Row A of Table 1. The IVR system vendor made this cost estimate based on a cost of 6 cents per minute spent in the IVR system and by projecting the annual minutes needed based on the history of minutes used since implementing the new IVR technology on October 1, 2013. The Department believes this additional annual funding will allow for enough annual minutes in the IVR system to cover the ongoing high call volume; however, since the technology is relatively new and there is little data with which to make accurate projections, the Department may request changes through the normal state budgeting process in the future to adjust this funding if further call volume data leads to revised projections.

Second, the funding requested for additional data storage for verbal attestations is shown in Row B of Table 1 and is based on cost estimates from OIT for one additional OIT server at $289 per month. This funding would be paid to OIT to implement and maintain the server.

Finally, the funding requested for additional maintenance resources is shown in Rows C through E of Table 1 and is based on cost estimates from OIT and the contracted IVR and CRM developer, Deloitte. Row C shows the OIT estimate of 1,000 additional development hours needed per year for fixing system issues, updating the system to meet new federal and state requirements, and implementing efficiencies and system enhancements. Each development hour with Deloitte is priced at $200 per hour. Additionally, Row D shows the annual cost estimate from OIT of 1 additional Business Analyst and Row E shows the annual cost estimate from OIT of 1 additional Senior IT Project Manager. These two positions would be state staff at OIT.

The above components represents the Department's updated maintenance need for the Customer Contact Center technology implemented per the Department's FY 2013-14 R-12 budget request; the total cost of these components is shown in Row F of Table 1. Per the Department's FY 2013-14 R-12 budget request, the Department received an ongoing annual appropriation of $180,000 total funds comprised of $90,000 General Fund and $90,000 federal funds for maintenance needs as shown in Row G of Table 1. This existing maintenance appropriation is subtracted from the updated maintenance need to calculate the total incremental funding that is requested in this supplemental; this requested amount is shown in Row H of Table 1.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This budget amendment is due to new, more defendable and accurate information. With the implementation of the new Customer Contact Center technology on October 1, 2013; the Department has been collecting newly available call volume data. Furthermore, as detailed business requirements were defined for the IVR and CRM systems, new estimates for ongoing maintenance were created.

Table 1 - Total Request for FY 2014-15 and Ongoing					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
	Need				
A	Additional Minutes with IVR Vendor	$550,000	$275,000	$275,000	50%
B	OIT Verbal Attestation Storage	$3,468	$1,734	$1,734	50%
C	Additional Development Hours	$200,000	$100,000	$100,000	50%
D	OIT Business Analyst	$62,000	$31,000	$31,000	50%
E	OIT Senior IT Project Manager	$80,000	$40,000	$40,000	50%
F	Subtotal: Need	$895,468	$447,734	$447,734	
	Existing Appropriation				
G	FY 2013-14 R-12 "Customer Service Technology Improvements"	$180,000	$90,000	$90,000	50%
	Budget Amendment				
H	Row F - Row G	$715,468	$357,734	$357,734	

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Community Living Caseload and Per Capita Changes
Priority Number: S-5, BA-5

Dept. Approval by: Josh Block 11/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 6 Continuation Amount FY 2015-16
Total of All Line Items	Total	5,492,237,952	(23,551,211)	6,211,221,696	(2,238,773)	(15,045)
	FTE	-	-	-	-	-
	GF	1,374,366,380	(11,775,604)	1,394,184,877	(1,102,428)	(7,370)
	GFE	469,842,084	-	469,842,084	-	-
	CF	595,915,947	-	726,986,245	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	3,049,176,650	(11,775,607)	3,618,208,490	(1,136,345)	(7,675)
(2) Medical Services Premiums	Total	4,736,824,877	(15,977)	5,323,832,795	(151,146)	13,600
	FTE	-	-	-	-	-
	GF	1,036,017,966	(7,988)	1,035,822,319	(74,428)	6,663
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	(7,989)	3,132,627,039	(76,718)	6,937
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	Total	380,837,424	29,346	456,935,528	277,618	310,696
	FTE	-	-	-	-	-
	GF	151,060,588	14,673	153,425,552	136,706	152,210
	GFE	-	-	-	-	-
	CF	2,033,883	-	12,646,177	-	-
	RF	-	-	-	-	-
	FF	227,742,954	14,673	290,863,799	140,912	158,486
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	Total	374,575,651	(23,564,580)	-	-	-
	FTE	-	-	-	-	-
	GF	187,287,826	(11,782,289)	-	-	-
	GFE	-	-	-	-	-
	CF	1	-	-	-	-
	RF	-	-	-	-	-
	FF	187,287,824	(11,782,291)	-	-	-

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	6
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	Total	-	-	338,015,700	(8,668,733)	(6,793,245)
	FTE	-	-	-	-	-
	GF	-	-	153,608,493	(4,268,701)	(3,328,011)
	GFE	-	-	-	-	-
	CF	-	-	30,798,715	-	-
	RF	-	-	-	-	-
	FF	-	-	153,608,492	(4,400,032)	(3,465,234)
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	Total	-	-	47,042,236	2,509,091	2,509,091
	FTE	-	-	-	-	-
	GF	-	-	27,481,475	1,235,539	1,229,204
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	19,560,761	1,273,552	1,279,887
NEW ITEM (7) Office of Community Living; (A) Program Costs, Children's Extensive Support Services for 692 Medicaid FPE	Total	-	-	18,785,189	5,225,437	5,302,863
	FTE	-	-	-	-	-
	GF	-	-	9,392,594	2,573,136	2,597,873
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	9,392,595	2,652,301	2,704,990
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	Total	-	-	26,610,248	(1,431,040)	(1,358,050)
	FTE	-	-	-	-	-
	GF	-	-	14,454,444	(704,680)	(665,309)
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	12,155,804	(726,360)	(692,741)

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information: Pursuant to HB 13-1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, the line items impacted by the request will be reflected in the Department of Health Care Policy and Financing.

COLORADO
Department of Health Care Policy and Financing

Priority: S-5, BA-5
Community Living Caseload and Per Capita Changes
FY 2013-14 Supplemental Request & FY 2014-15 Budget Amendment

Cost and FTE

- In FY 2013-14, the Department requests a reduction of $23,551,211 total funds, including a decrease of $11,775,604 General Fund. For FY 2014-15, the Department requests a reduction of $2,238,773 total funds, $1,102,428 General Fund.

Current Program

- Effective March 2014, the Department manages three Medicaid waiver programs for people with developmental disabilities.
- These programs ensure delivery of services such as residential care, day habilitation services and behavioral services, as well as case management, and are delivered through a variety of approved providers.

Problem or Opportunity

- The appropriation for the Medicaid waiver programs for individuals with developmental disabilities does not properly reflect current caseload or cost per capita.
- There are currently a large number of individuals who are eligible to receive services, but are not enrolled because of funding constraints.
- The Department could use existing funding to serve additional individuals on these programs.

Consequences of Problem

- If the appropriation is not adjusted, the Department would likely revert a significant amount of funding that could be repurposed.

Proposed Solution

- The Department requests that funding be redistributed across existing appropriations, and that the respective full-program equivalents (FPE) be adjusted to more accurately reflect the estimated funding needs and individuals served.
- This solution would allow for more individuals to be enrolled in the waivers with the existing funding, without requiring budget-positive adjustments to sustain those enrollments in future years.

Department Priority: S-5, BA-5
Request Detail: Community Living Caseload and Per Capita Changes

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund
Community Living Caseload and Per Capita Changes	($23,551,211)	($11,775,604)

Problem or Opportunity:

The Department requests to adjust and rebalance existing appropriations and designated full program equivalents (FPE) within three Medicaid waiver programs for people with developmental disabilities: Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD), Supported Living Services (HCBS-SLS) and Children's Extensive Services (HCBS-CES) and associated targeted case management (TCM). Adjustments to targeted appropriations will accurately reflect the current cost per capita, based upon current spending trends, and maximize the number of individuals that can be served in the programs within the appropriated funding without need for new funding.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) are provided to meet the needs of adults with developmental disabilities who require extensive supports to live safely in the community and who do not have the resources available to meet their needs. Home and Community Based Services-Supported Living Services (HCBS-SLS) are for adults who can either live independently with limited to moderate supports or who need more extensive support provided by other persons, such as their family. Home and Community Based Services-Children's Extensive Services (HCBS-CES) provides benefits to children, ages birth up to the eighteenth (18) birthday who have a developmental disability or delay, and who need near constant line of sight supervision due to behavioral or medical needs.

As of the September 30, 2013 waiting list report, there are 1,955 people currently waiting to receive HCBS-DD waiver services. The waiting list may include those requiring emergency enrollments as well as those transitioning out of institutional settings. Additionally, the list may include current Medicaid recipients being served in an alternative waiver that does not fully meet their needs, and may also include individuals being served in nursing facilities or hospitals that are not as cost-effective as the HCBS-DD waiver. Without additional Full Program Equivalents (FPE), people with developmental disabilities will transition to other less appropriate, more costly settings or become vulnerable to abuse, neglect or homelessness. The waiting lists for HCBS services will grow and demand for services will remain unmet.

Current Appropriation

In FY 2012-13, total expenditures for the HCBS-DD, HCBS-SLS, and HCBS-CES waiver programs were $12,872,193 less than the total appropriation.[1] There are several interrelated factors that contributed to the FY 2012-13 underexpenditure, with the key factors relating to how the appropriation was established. Historically, the appropriation has not been regularly revised using up-to-date utilization and enrollment trend information. In addition, the appropriation for new FPE was based on assumptions of service utilization rates determined by the date a service was provided rather than date of reimbursement, further inflating the appropriation. A final factor is that the FY 2012-13 appropriation was $4.8 million more than the Department of Human Services' FY 2012-13 budget request. While the Department cannot attribute a specific dollar amount of the underexpenditure to the budget practices, these practices, combined with the $4.8 million difference from the Department's request, are the main drivers of the FY 2012-13 underexpenditure.

Because the FY 2013-14 appropriation was set using very similar assumptions to the final FY 2012-13, a large underexpenditure is also projected for the current year. The Department calculates that, without adjustment, it would underexpend the FY 2013-14 total appropriation by $24,514,183 (see table B.1.1 in the appendix for the derivation of this figure). The increase in the projected underexpenditure primarily relates to two general factors: first, the appropriation is based on a per capita cost projection for the HCBS-DD waiver that is over $3,000 higher than the current projection; second, the appropriation assumed that claims would be paid faster than has actually occurred.

As a result of these factors, the Department's base budget request for FY 2014-15 is also projected to be higher than the true funding need. Without adjustment, the Department projects that it would underexpend the FY 2014-15 base budget request by $15,404,127 (see Table B.1.2 in the appendix).

Supported Living Services Expenditure and Enrollment

Although the Department is experiencing underexpenditure in the HCBS-DD, HCBS-CES, and targeted case management portions of the appropriation, the appropriation for HCBS-SLS is significantly below the required funding level to support the appropriated number of FPE. As a result, the targeted Medicaid appropriation for HCBS-SLS has consistently overspent. Overexpenditure of the HCBS-SLS targeted appropriation is offset by redirecting funding generally earmarked for other programs for people with developmental disabilities, primarily the HCBS-DD waiver. The average number of individuals served in HCBS-SLS has consistently been below the FPE allocated in the Long Bill. Full utilization of HCBS-SLS appropriated FPE would result in further overexpenditures. Both Medicaid funding and FPE need to be rebalanced between the HCBS-DD and HCBS-SLS waiver to accurately fund the number of FPE appropriated in the HCBS-SLS waiver. If funds are not reallocated specifically toward funding program needs for people in the HCBS-SLS waiver, the HCBS-SLS program would continue to experience overexpenditures and funds would continue to be diverted from other program areas.

[1] This total only includes Medicaid expenditures; it does not reflect any General Fund-only programs.

Children's Extensive Support Expenditure and Enrollment

Based on current enrollment trends, the Department also predicts that the current appropriation does not allocate enough funding to the HCBS-CES waiver program in order to fully eliminate the waiting list for the program. In the 2013 legislative session, the Governor requested, and the General Assembly authorized, funding for an increase in the number of enrollments to the HCBS-CES waiver sufficient to eliminate the waiting list. The number of enrollments authorized was determined in part based upon a forecast of what the waiting list would be at the end of FY 2013-14. The Department's appropriation for FY 2013-14 assumes that the Department would serve 925 children.

Normally, between 10 and 12 children are added to the waiting list monthly. However, since the enactment of the FY 2013-14 Long Bill, the Department has experienced a tripling of the numbers of individuals seeking services. The Department estimates that, as a result of this increase, the waiting list will be 279 individuals more than originally forecasted. The Department's request rebalances funding within the appropriation to move additional resources to the HCBS-CES waiver; by doing so, the Department would be able to maintain the policy of having no waiting list by the beginning of FY 2014-15.

Authorized Enrollments

After the FY 2012-13 underexpenditure, the Division for Developmental Disabilities (DDD) has aggressively worked to increase the total enrollment in the program. For example, after determining that new enrollments for FY 2013-14 were lagging behind the totals needed to support the current appropriation, DDD worked with Community Centered Boards (CCBs) beginning in November 2013 to authorize 350 new enrollments for HCBS-DD and HCBS-SLS. However, new authorized enrollments do not immediately translate into new expenditures. Ideally, the distribution of enrollment should translate directly into timely paid claims for services and supports. However, there are two key issues that can affect full utilization of distributed enrollments. These issues include the process of enrollment as well as provider capacity to provide services that meet an individual's specific needs once enrolled.

1. Process of Enrollment: There is a time lag between the date of authorization for enrollment of a person in a waiver to the date of active enrollment in services. It can take several months for a CCB to confirm Medicaid eligibility, the family to choose a provider, and the CCB to arrange for services. The capacity of county departments of Human Services to complete Medicaid eligibility determinations plays a role as well. Effective July 1, 2013, the Department of Human Services began tracking the time between the date of authorization and the date of active enrollment to monitor trends. The Department of Human Services distributed funding from the Eligibility Determination and Waiting List Management line item to provide support to the CCBs in order to build the necessary capacity to facilitate the timely processing of enrollments.

2. Provider Capacity: Provider agencies choose which services to provide, which communities in which they operate, and which populations to serve. Not all approved provider agencies choose to provide services to all populations or in all areas of the state. Due to these factors, individuals authorized for enrollment, particularly outside of the Denver-Metro area, may experience difficulty in identifying and selecting a provider that is able to meet the individual's specific needs.

To address capacity issues, the Department of Human Services solicited feedback from CCBs and providers regarding capacity to serve individuals. The Department received 33 responses from 12 CCBs and 21 providers. None of the responses indicated opposition to funding that would remove a large number of individuals off the waiting lists, but most emphasized the need for additional financial support to successfully fill all enrollments in FY 2014-15. Administrative infrastructure costs were identified as a possible constraint for fully serving all individuals. There are up-front administrative costs incurred by CCBs associated with the enrollment of these individuals and DDD is providing funding to help defray these costs. In addition, DDD must continue to develop capacity and provide resources to conduct the initial Supports Intensity Scale (SIS) assessments for these additional individuals.

Full Program Equivalents (FPE)

The Long Bill establishes the number of FPE intended to be served within the appropriated HCBS-DD funds. The total appropriation allotted for the provision of services for individuals in the HCBS-DD waiver is more than needed in relation to the number of FPE allocated in the Long Bill. This overappropriation of the HCBS-DD waiver puts the program at risk of underspending the Medicaid funding in the Adult Comprehensive Services targeted appropriation. Analysis of current spending trends indicates that the Department could serve more people within existing funding. A portion of these funds can be reallocated in the Long Bill toward HCBS-SLS program services to accurately reflect the services provided to people in that waiver. This can be achieved within the current overall appropriation. By adjusting and rebalancing existing appropriations and FPE, the Department would continue to support the goal of timely delivery of necessary supports for all people with developmental disabilities.

People enter and exit the waivers regularly. This is due to normal turnover as well as for reasons such as emergency placement or aging out of a youth waiver. Because of these factors, different numbers of people are served each month. Generally, however, the trend for individuals receiving services in any given month increases over time. Therefore, generally speaking, the number of individuals receiving services in the month of June (final month of the fiscal year) will be the highest.

In order to determine the appropriate funding level, the Department uses two core metrics. First, the number of FPE, which is defined for the purposes of this request to be the average monthly paid enrollment.[2] Second, the Department uses the per capita cost, which is the total expenditure divided by the number of FPE. These metrics, when properly calculated and multiplied together, provide an estimate of expenditure for the current and request years.

The Department notes, however, that the number of FPE is not always equal to the allowable maximum enrollment for each waiver. For example, if new enrollments were staggered throughout the year, the number

[2] During Figure Setting in March 2013, the term "full program equivalent" (FPE) was defined to be "the cost of services for one individual for one year"; in essence, this is the per capita cost. However, in the Long Bill, the appropriation makes reference to services for a certain number of FPE, which implies that FPE is a caseload metric; more specifically, it reflects the number of people served. To avoid ambiguity within this request, the Department is defining FPE to be the "average monthly paid enrollment". This is the number of distinct utilizers for whom a claim was submitted in that month. Conceptually, one FPE would be twelve months of service, regardless of how many distinct individuals were served. This metric is consistent with how the Department measures caseload for Medicaid and the Children's Basic Health Plan.

of FPE would be a fraction of the allowable maximum enrollment. The relationship of FPE to maximum enrollment can vary based on a large number of factors; however, in order to accurately set the appropriation and manage the program, it is critical to explicitly identify both the number of FPE, the maximum enrollment level, and the interaction between the two.

Proposed Solution:

In order to adjust the current appropriations for the programs administered by the Office of Community Living, the Department requests a reduction of $23,551,211 in FY 2013-14, including $11,775,604 General Fund; a reduction of $2,238,773 in FY 2014-15, including $1,102,428 General Fund; and, a reduction of $15,045 in FY 2015-16, including $7,370 General Fund. As part of this request, the Department requests an additional 279 enrollments for the HCBS-CES waiver to fully fund the projected waiting list. The Department requests that the remainder of the projected underexpenditure be used to reduce the HCBS-DD waiver waiting list. The projected underexpenditure would allow for an additional 134 enrollments for the HCBS-DD waiver. These enrollments do not require any additional funding, because they are funded using expected underexpenditure in the program. The Department is not requesting to increase the number of HCBS-SLS enrollments as part of this request. The Department submitted a November 1, 2013 Budget Request (R-7) to request new funding to eliminate the current HCBS-SLS waiting list.[3]

Based on the assumptions used in this request, the Department calculated maximum enrollment figures for each waiver program (and targeted case management services) and the number of full-program equivalents (FPE) for each fiscal year. If this request is approved, the Department calculates that it would serve (maximum enrollment): 4,695 people on the HCBS-DD waiver; 3,217 people on the HCBS-SLS waiver; and, 1,204 people on the HCBS-CES waiver. The number of associated FPE for each fiscal year is shown in exhibit B of the appendix.[4]

Anticipated Outcomes:

The Developmental Disabilities system provides long term support services in the community to children and adults with developmental disabilities who would otherwise receive services in more restrictive and expensive institutional settings. Individuals will be included in Colorado community life in fulfillment of the mission of the Office of Community Living. As part of the Triple Aim, the Department strives to provide the right services to the right people at the right time and place.

The current appropriation is structured in a way that would likely lead to an ongoing underexpenditure even taking into account reallocating underexpenditure to the HCBS-SLS waiver program. The Department believes the intent of the appropriation is, in part, to provide needed services for the highest number as well as most at-risk eligible people possible. If the Department's request is approved, an additional 134 people would receive appropriate community services and supports in the HCBS-DD waiver and an estimated 279 people in the HCBS-CES waiver, thereby improving their physical, mental, and social functioning as well as their general well-being and quality of life. Simultaneously, a portion of the current bottom-line funded

[3] This is done to prevent double counting between the two requests. If the Department attempted to further increase HCBS-SLS enrollments in this request, it would also need to reduce its R-7 request.

[4] Although not specifically identified as part of this request, these figures allow for any necessary transitions that occur from nursing facilities or regional centers as part of the Colorado Choice Transitions program.

appropriation would be reallocated toward the HCBS-SLS waiver program, as well as toward Targeted Case Management.

Assumptions and Calculations:

The Department's calculations are contained in the appendix. The appendix is organized into a series of exhibits, providing both calculation information and historical cost and caseload detail. The section below describes each exhibit individually. In many cases, the specific assumptions and calculations are contained in the exhibits directly; the narrative information below provides additional information and clarification where necessary.

The Department's calculations for this request only cover the Medicaid portions of these programs. The Department is not requesting any adjustment to General Fund-only programs at this time.

Exhibit A: Calculation of Fund Splits

This exhibit provides the final calculation of the incremental request, by line item. Values in the total request column are taken from calculations in exhibit B and exhibit C. The Department applies the effective federal medical assistance percentage to calculate the total request by fund source.

Exhibit B: Calculation of Projected Expenditures

This exhibit provides the calculation of final expenditures in two ways. First, this exhibit calculates total projected expenditure using revised assumptions about per capita cost and caseload (calculated in exhibits F and G, respectively). Second, this exhibit calculates an additional number of people that could be enrolled within existing resources, and converts the total enrollment figures into new paid enrollments for each fiscal year. Third, this exhibit calculates the new cost for additional enrollments by fiscal year.

Calculation of Expenditure Under Existing Authority

This section describes table group B.1 in exhibit B. These tables compare the existing appropriation and appropriated resources to projections of actual per capita cost and average monthly number of paid enrollments. These tables do not account for the reallocation of any projected underexpenditure to create new enrollments, and therefore do not reflect the Department's final request.

Calculation of Additional Enrollments Funded Through Redistribution of Existing Resources

This section describes table B.2 in exhibit B. Using existing program assumptions, underexpenditure can be reallocated to enroll additional people in the waiver programs without exceeding the expected out year base budget. The Department uses the expected underexpenditure calculated in table group B.1, and assigns a number of new enrollments to the HCBS-SLS and HCBS-CES waiver programs, based on the needs of the current programs. The Department uses the assigned enrollments to calculate the expected expenditure for those enrollments in the out year. The remainder of the underexpenditure is then allocated to the HCBS-DD waiver program and the Department calculates the maximum number of additional enrollments based on projected costs for that year.

The Department uses the out year underexpenditure and per capita cost projections to ensure that the requested additional enrollments do not create a General Fund obligation in subsequent years. If, instead, the Department tried to maximize enrollments based on the current year underexpenditure, the Department would be required to request additional General Fund in the request and out years to continue to fund those enrollments, or be forced to decrease the maximum enrollment number in those years.

Calculation of New Paid Enrollments by Fiscal Year

This section describes table B.3 in exhibit B. Based on the additional new enrollments that are able to be funded in the out year (calculated in the prior section), the Department must perform two calculations. First, the Department determines the number of people of the total who would be enrolled during the fiscal year. Second, the Department must convert enrollments into average monthly paid enrollment totals to determine the appropriate increase to the number of full-program equivalents (FPEs). These FPE must then be distributed properly to each fiscal year. In order to make this conversion, the Department uses a series of multipliers to account for the needed conversions.

- Enrollment multiplier: This multiplier represents an adjustment for when new enrollments would start. Because new enrollments require additional authorization from the General Assembly, the Department assumes that new enrollments would begin after a supplemental bill is enacted. Specific assumptions about the multiplier are contained in the table.

- FPE multiplier: Although it is straight forward to calculate the number of individuals enrolled at any point in time, the calculation to determine how many paid enrollments is complicated by the fact that each enrollment cohort has a different number of paid months in each fiscal year. Because there is a billing lag between the time enrollments occur, and the time claims are paid, the Department assumes a two month lag between actual enrollment and paid enrollment. For example, individuals enrolled in July would have 10 months of paid enrollment in a fiscal year, while individuals enrolled in August would have 9 months of paid enrollment, and so forth. As a result, even though the full complement of additional enrollments will be complete by the end of the request year, the Department will not pay the full per capita for each individual for each year.

  Further, the Department adjusts for the rate at which new enrollments occur. In many cases, providers can only enroll clients at a fixed rate. Therefore, the Department assumes that new enrollments will be staggered over a set number of months.

  Controlling for the billing lag and the staggered enrollment, the FPE multiplier converts the number of additional enrollments into a number of full program equivalents, which can be multiplied by the estimated per capita to estimate the amount the Department would pay in

each fiscal year.[5] The Department's calculation of the multipliers is not shown, due to the complexity of the calculation. However, details are available upon request.

Calculation of Final Requests Expenditure

This section describes table group B.4. Using the calculations of per capita, FPE, and additional enrollments from the other sections of this exhibit, the Department calculates the incremental change to expenditure and the final projected incremental request, along with an adjusted FPE total for each fiscal year.

Table B.4.3, Row I, reflects the requested FPE for FY 2015-16 and also the requested maximum enrollment levels for each of the waiver programs, regardless of the fiscal year.

Exhibit C: Change in State Plan Service Costs for New DIDD Waiver Enrollees

This exhibit provides the calculation of the change in state plan costs, by line item. Although the total change in cost is calculated in exhibit B, this exhibit separates those costs into physical health (Medical Services Premiums) and behavioral health components.

Exhibit D: Calculation of Change in State Plan Service Costs for New DIDD Waiver Enrollees

This exhibit provides the calculation of the change in state plan service costs for each individual new enrollee. New enrollees to DIDD waivers could potentially be enrolled in an existing Medicaid waiver, be enrolled Medicaid without being enrolled in waiver, or not be enrolled in Medicaid. Based on historical information about individuals on the waiting list for services, the Department assumes a certain percentage split for the distribution of new enrollees. This information is used to create a weighted average per capita cost for individuals who become newly eligible for a DIDD waiver program.

Exhibit E: Summary of Program Costs

This exhibit provides a summary of historical expenditure, as paid for through the Department's Medicaid Management Information System (MMIS), and projected totals as calculated in exhibit B.

Exhibit F: Calculation of Per Capita Costs

This exhibit provides a summary of historical per capita expenditure, and calculates estimated per capita costs for the years covered in this request.

The Department's methodology begins with the per capita cost calculated using final FY 2012-13 expenditure. The calculation of per capita cost for the current year includes the expected effect of approved policy in the Long Bill and a trend adjustment which accounts for factors including shifts in the service-level mix, changes in billing patterns or utilization, and other factors.

[5] The FPE multiplier directly takes into account the enrollment pattern. Therefore, it does not need to be explicitly adjusted by the enrollment multiplier.

For FY 2013-14, the General Assembly appropriated funding to implement a 4.0% rate increase to DIDD waiver programs. Although the rate increase was effective July 1, 2013, because the programs operate on a cash-accounting basis, the rate increase affects the per capita across multiple fiscal years, as some claims incurred in FY 2013-14 will not be paid until FY 2014-15.

Exhibit G: Calculation of Paid Enrollment

This exhibit provides a summary of historical paid enrollment, and calculates estimated paid enrollment for the years covered in this request.

In order to properly calculate expenditure, the Department must use a consistent caseload metric for the program. In this table, and throughout the request, the Department uses average monthly paid enrollment to determine the number of clients for which is anticipates it will pay claims for in each fiscal year. The Department calculates this metric by determining the number of clients for whom it paid claims for in each month, and calculating the average across each fiscal year. This caseload metric is referred to as "full-program equivalents," or FPE.

The Department's methodology begins with the FPE calculated using final FY 2012-13 claims information. The calculation of FPE for the current year includes a base trend estimate, which reflects the change from the prior year's total to the expected current total.[6] Then, where applicable, the Department includes an adjustment for enrollments which have been authorized and sent to Community Centered Boards (CCBs), but which have not year been observed in paid claims data. This adjustment reflects the additional number of FPE, and therefore accounts for adjustments for the expected enrollment dates and an adjustment to reflect the timing of when claims are expected to be paid. The sum of the additional authorized enrollments reflects the total additional enrollments which were distributed to CCBs.

For FY 2013-14, the base trend reflects existing enrollments and adjusts for the estimated increase in FPE that are projected to occur as claims are submitted by providers. The Department then adjusts the FPE to account for expected enrollments which have not yet occurred or been billed, but have already been authorized under current spending authority. For the HCBS-DD waiver, this reflects 200 new enrollments beginning January 1, 2014. For the HCBS-SLS waiver, this reflects 150 new enrollments beginning January 1, 2014. For the HCBS-CES waiver, this reflects the 532 new enrollments authorized in the Long Bill. Finally, the Department adjusts the forecast for the requested new enrollments as described in exhibit B.

For FY 2014-15, for HCBS-DD and HCBS-CES, the Department selected base trends under the assumption that it would have hit maximum enrollment levels by the end of FY 2013-14. In doing so, the trend factor becomes the value needed to ensure that the final estimated FPE totals match the currently authorized maximum enrollments (table G.3, row L). This incorporates the effect of the new enrollments occurring in FY 2013-14. For HCBS-SLS, the Department selected a trend factor to account for a ramp-up related to enrollments that have already currently been authorized, and to prevent double-requesting enrollments with

[6] The trend estimate is only a partial projection. For FY 2013-14, the Department uses current enrollment through October 2013 to create a monthly trend factor; that trend is then used to project enrollment through January 2014. Monthly enrollment is then held constant to generate the Initial Estimated FPE. In this way, the calculation does not double count FPE with the "Additional Authorized FPE Under Current Policy" row.

the Department's November 1, 2013 R-7 budget request. The Department is current working with Community Centered Boards to enroll clients in the program, and this work will continue until the Department reaches the maximum enrollment level.

For FY 2015-16, the Department assumes that it would maintain the maximum enrollment levels for the full year; therefore, there is neither a trend factor nor additional authorized enrollments.

Exhibit H – Summary of Monthly Expenditure

This exhibit provides a summary of monthly expenditure for each of the DIDD waiver programs and targeted case management. It does not include projections for months which have not yet occurred; the Department's forecasting methodology does not provide monthly projections.

Exhibit I – Summary of Monthly Paid Enrollment

This exhibit provides a summary of monthly paid enrollment for each of the DIDD waiver programs and targeted case management. It does not include projections for months which have not yet occurred; the Department's forecasting methodology does not provide monthly projections. The totals for targeted case management are the sum of the totals for individual waivers, rather than a separate calculation.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This request meets supplemental and budget amendment criteria because it contains new data resulting in substantive changes in funding needs. This request incorporates data through October 2013.

TABLE OF CONTENTS

Exhibits for the Division for Intellectual and Developmental Disabilities
Full Program Equivalent True-up Budget Request

Exhibit A

Table A.1
Calculation of Fund Splits - FY 2013-14

Item	Total Request	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate	Source
Medical Services Premiums	($15,977)	($7,988)	$0	$0	($7,989)	50.00%	Table C.1
Behavioral Health Capitation Payments	$29,346	$14,673	$0	$0	$14,673	50.00%	Table C.1
HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	($21,136,488)	($10,568,244)	$0	$0	($10,568,244)	50.00%	Table B.4.1, Row H
HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	$1,152,296	$576,148	$0	$0	$576,148	50.00%	Table B.4.1, Row H
HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	($776,643)	($388,321)	$0	$0	($388,322)	50.00%	Table B.4.1, Row H
HCBS - Targeted Case Management (TCM)	($2,803,745)	($1,401,872)	$0	$0	($1,401,873)	50.00%	Table B.4.1, Row H
Total Projected FY 2013-14 Over/(Under)Expenditure	**($23,551,211)**	**($11,775,604)**	**$0**	**$0**	**($11,775,607)**		
Total Projected FY 2013-14 Over/(Under)Expenditure for HCPF Long Bill Group (6)	*($23,564,580)*	*($11,782,289)*	*$0*	*$0*	*($11,782,291)*		*Total without physical and mental health*

Footnote: The four HCBS lines above are, for FY 2013-14, concentrated into one appropriation in the Department. The accompanying Schedule 13 reflects this. All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals nor Cash-funded appropriations.

Exhibit A

Table A.2 Calculation of Fund Splits - FY 2014-15							
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP Rate**	**Source**
Medical Services Premiums	($151,146)	($74,428)	$0	$0	($76,718)	50.76%	Table C.2
Behavioral Health Capitation Payments	$277,618	$136,706	$0	$0	$140,912	50.76%	Table C.2
HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	($8,668,733)	($4,268,701)	$0	$0	($4,400,032)	50.76%	Table B.4.2, Row H
HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	$2,509,091	$1,235,539	$0	$0	$1,273,552	50.76%	Table B.4.2, Row H
HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	$5,225,437	$2,573,136	$0	$0	$2,652,301	50.76%	Table B.4.2, Row H
HCBS - Targeted Case Management (TCM)	($1,431,040)	($704,680)	$0	$0	($726,360)	50.76%	Table B.4.2, Row H
Total Projected FY 2014-15 Over/(Under)Expenditure	**($2,238,773)**	**($1,102,428)**	**$0**	**$0**	**($1,136,345)**		

Footnote: All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals nor Cash-funded appropriations.

The federal medical assistance percentage (FMAP) is set to increase for Colorado in October 2014 to 51.01%. This will create a blended rate for the year of 50.76%. The Department has used a calculation of 50% * 3 months and 51.01% * 9 months to arrive at the blended rate.

Exhibit A

Table A.3 Calculation of Fund Splits - FY 2015-16							
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP Rate**	**Source**
Medical Services Premiums	$13,600	$6,663	$0	$0	$6,937	51.01%	Table C.3
Behavioral Health Capitation Payments	$310,696	$152,210	$0	$0	$158,486	51.01%	Table C.3
HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	($6,793,245)	($3,328,011)	$0	$0	($3,465,234)	51.01%	Table B.4.3, Row H
HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	$2,509,091	$1,229,204	$0	$0	$1,279,887	51.01%	Table B.4.3, Row H
HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	$5,302,863	$2,597,873	$0	$0	$2,704,990	51.01%	Table B.4.3, Row H
HCBS - Targeted Case Management (TCM)	($1,358,050)	($665,309)	$0	$0	($692,741)	51.01%	Table B.4.3, Row H
Total Projected FY 2015-16 Over/(Under)Expenditure	**($15,045)**	**($7,370)**	**$0**	**$0**	**($7,675)**		

Footnote: All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals nor Cash-funded appropriations.
The federal medical assistance percentage (FMAP) is set to increase for Colorado in October 2014 to 51.01%. The Department assumes that this FMAP rate will remain constaint in FY 2015-16.

Exhibit B

Table B.1.1
FY 2013-14 Projected Expenditures

Row	Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)[1]	New State Plan Costs	Total	Notes
A	FY 2013-14 Appropriation	$299,108,740	$38,808,009	$13,201,051	$20,519,121		$371,636,921	See Footnote (2)
B	Appropriated FPE	4,471.20	3,417.50	659.00	8,547.70			SB 13-230
C	Appropriated Per Capita Expenditure	$66,896.75	$11,355.67	$20,031.94	$2,400.54			Row A / Row B
D	Projected Actual FPE	4,356.75	3,098.00	584.66	8,039.41			Table G.3 Row E
E	Projected Actual Per Capita	$63,782.17	$12,898.74	$19,929.64	$2,192.62			Table F.3 Row D
F	Total Projected Expenditure	$277,882,957	$39,960,305	$11,652,134	$17,627,342		$347,122,738	Row D * Row E
G	**Estimated Over/(Underexpenditure)**	**($21,225,783)**	**$1,152,296**	**($1,548,917)**	**($2,891,779)**		**($24,514,183)**	**Row F - Row A**

(1) The Targeted Case Management Medicaid appropriation includes $2,900,000 for Utilization Review, Quality Assurance, and Supports Intensity Scale. These are distinct from Targeted Case Management services provided to individual clients. The $2,900,000 has therefore been taken out of the Row A Appropriation in this table.

(2) All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals, cash-funded appropriations, or services provided to individuals in the Early Intervention program.

Table B.1.2
FY 2014-15 Projected Expenditures

	Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)[1]	New State Plan Costs	Total	Notes
A	FY 2014-15 Base Funding Request	$307,216,985	$39,121,522	$18,785,189	$21,411,608		$386,535,304	See Footnote (2)
B	Appropriated FPE	4,561.00	3,440.00	925.00	8,926.00			Annualization of SB 13-230
C	Appropriated Per Capita Expenditure	$67,357.37	$11,372.54	$20,308.31	$2,398.79			Row A / Row B
D	Projected Actual FPE	4,561.00	3,217.00	925.00	8,703.00			Table G.3 Row L
E	Projected Actual Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82			Table F.3 Row H
F	Total Projected Expenditure	$291,849,346	$41,630,613	$18,506,186	$19,145,032		$371,131,177	Row D * Row E
G	**Estimated Over/(Underexpenditure)**	**($15,367,639)**	**$2,509,091**	**($279,003)**	**($2,266,576)**		**($15,404,127)**	**Row F - Row A**

(1) The Targeted Case Management Medicaid appropriation includes $2,900,000 for Utilization Review, Quality Assurance, and Supports Intensity Scale. These are distinct from Targeted Case Management services provided to individual clients. The $2,900,000 has therefore been taken out of the Row A Appropriation in this table.

(2) All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals, cash-funded appropriations, or services provided to individuals in the Early Intervention program.

Table B.1.3
FY 2015-16 Projected Expenditures

Row	Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)[1]	New State Plan Costs	Total	Notes
A	FY 2015-16 Base Funding Request	$307,216,985	$39,121,522	$18,785,189	$21,411,608		$386,535,304	See Footnote (2)
B	Appropriated FPE	4,561.00	3,440.00	925.00	8,926.00			Annualization of SB 13-230
C	Appropriated Per Capita Expenditure	$67,357.37	$11,372.54	$20,308.31	$2,398.79			Row A / Row B
D	Projected Actual FPE	4,561.00	3,217.00	925.00	8,703.00			Table G.3 Row S
E	Projected Actual Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82			Table F.3 Row L
F	Total Projected Expenditure	$291,849,346	$41,630,613	$18,506,186	$19,145,032		$371,131,177	Row D * Row E
G	**Estimated Over/(Underexpenditure)**	**($15,367,639)**	**$2,509,091**	**($279,003)**	**($2,266,576)**		**($15,404,127)**	**Row F - Row A**

(1) The Targeted Case Management Medicaid appropriation includes $2,900,000 for Utilization Review, Quality Assurance, and Supports Intensity Scale. These are distinct from Targeted Case Management services provided to individual clients. The $2,900,000 has therefore been taken out of the Row A Appropriation in this table.

(2) All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals, cash-funded appropriations, or services provided to individuals in the Early Intervention program.

Exhibit B

Table B.2
Additional Enrollments Funded Through Redistribution of Existing Resources

Row	Item	Total	Source/Forumla
A	Estimated Out Year Underexpenditure	$15,404,127	Table B.1.3, Row G * -1
B	Assigned New Enrollments to HCBS-SLS	0.00	Requested; see narrative
C	HCBS-SLS Per Capita	$12,940.82	Table B.1.3, Row E
D	HCBS TCM Per Capita	$2,199.82	Table B.1.3, Row E
E	State Plan Costs	$785.22	Table D.2, Row M
F	Net Cost of Additional HCBS-SLS FPE	$0	Row B * (Row C + D + E)
G	Assigned New Enrollments to HCBS-CES	279.00	Requested; see narrative
H	HCBS-CES Per Capita	$20,006.69	Table B.1.3, Row E
I	HCBS TCM Per Capita	$2,199.82	Table B.1.3, Row E
J	State Plan Costs	$785.22	Table D.2, Row M
K	Net Cost of Additional HCBS-CES FPE	$6,414,692	Row G * (Row H + I + J)
L	Remaining Underexpenditure for Distributio	$8,989,435	Row A - Row F - Row K
M	HCBS-DD Per Capita	$63,988.02	Table B.1.3, Row E
N	HCBS TCM Per Capita	$2,199.82	Table B.1.3, Row E
O	State Plan Costs	$785.22	Table D.2, Row M
P	**Calculated New Enrollments for HCBS-DD**	**134.00**	**Row L / (Row M + N + O)** Rounded down to nearest whole FPE

Exhibit B

Table B.3 Calculation of New Paid Enrollments by Fiscal Year						
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Total**	**Source/Formula**
A	Additional Enrollment Funded Through Redistribution of Existing Resources	134.00	0.00	279.00	413.00	Table B.2
	FY 2013-14					
B	Enrollment Multiplier	0.38	0.00	1.00		See footnote
C	Actual Enrollments	50.00	0.00	279.00	329.00	Row A * Row B
D	FPE Multiplier	0.0104	0.0000	0.1389		See footnote
E	**New Paid Enrollments**	**1.40**	**0.00**	**38.75**	**40.15**	**Row A * Row D**
	FY 2014-15					
F	Enrollment Multiplier	1.00	0.00	1.00		See footnote
G	Actual Enrollments	134.00	0.00	279.00	413.00	Row A * Row F
H	FPE Multiplier	0.7813	0.0000	0.9861		See footnote
I	**New Paid Enrollments**	**104.69**	**0.00**	**275.13**	**379.82**	**Row A * Row H**
	FY 2015-16					
J	Enrollment Multiplier	1.00	0.00	1.00		See footnote
K	Actual Enrollments	134.00	0.00	279.00	413.00	Row A * Row J
L	FPE Multiplier	1.0000	0.0000	1.0000		See footnote
M	**New Paid Enrollments**	**134.00**	**0.00**	**279.00**	**413.00**	**Row A * Row L**

Enrollment multiplier:
For HCBS-DD, the Department assumes new enrollments would begin April 1, 2014, and take eight months to complete. The enrollment multiplier is therefore 3/8ths.
For HCBS-CES, the Department assumes new enrollments would begin January 1, 2014, and take six months to complete. The multiplier for FY 2013-14, therefore, is

FPE multiplier:
See the narrative for a description of this calculation.

Exhibit B

Table B.4.1 FY 2013-14 New Resources and Expenditure Rebalancing								
Row	**Office of Community Living**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**New State Plan Costs**	**Total**	**Notes**
A	Total Projected Expenditure	$277,882,957	$39,960,305	$11,652,134	$17,627,342		$347,122,738	Table B.1.1, Row F
B	Additional Enrollments Funded Through Redistribution of Existing Resources	134.00	0.00	279.00	413.00	413.00		Table B.2
C	New FPE (above appropriated level)	1.40	0.00	38.75	40.15	40.15		Table B.3, Row E
D	Projected Per Capita	$63,782.17	$12,898.74	$19,929.64	$2,192.62	$332.98		Table F.1 Row G State Plan: Table D.1 Row M
E	Projected Additional Expenditure	$89,295	$0	$772,274	$88,034	$13,369	$962,972	Row C * Row D
F	Projected Final Expenditure with Adjusted FPE	$277,972,252	$39,960,305	$12,424,408	$17,715,376	$13,369	$348,085,710	Row A + Row E
G	FY 2013-14 Appropriation	$299,108,740	$38,808,009	$13,201,051	$20,519,121		$371,636,921	Table B.1.1, Row A
H	**Projected Final Over/(Underexpenditure)**	**($21,136,488)**	**$1,152,296**	**($776,643)**	**($2,803,745)**	**$13,369**	**($23,551,211)**	**Row F - Row G**
I	Adjusted FPE	4,358.15	3,098.00	623.41	8,079.56			Row C + Table B.1.1 Row D

Exhibit B

Table B.4.2 FY 2014-15 New Resources and Expenditure Rebalancing								
Row	**Office of Community Living**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**New State Plan Costs**	**Total**	**Notes**
A	Total Projected Expenditure	$291,849,346	$41,630,613	$18,506,186	$19,145,032		$371,131,177	Table E.1, Row H
B	Additional Enrollments Funded Through Redistribution of Existing Resources	134.00	0.00	279.00	413.00	413.00		Table B.2
C	New FPE (above appropriated level)	104.69	0.00	275.13	379.82	379.82		Table B.3, Row I
D	Projected Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82	$332.98		Table F.1 Row H State Plan: Table D.1, Row M
E	Projected Additional Expenditure	$6,698,906	$0	$5,504,440	$835,536	$126,472	$13,165,354	Row C * Row D
F	Projected Final Expenditure with Adjusted FPE	$298,548,252	$41,630,613	$24,010,626	$19,980,568	$126,472	$384,296,531	Row A + Row E
G	FY 2014-15 Base Funding Request	$307,216,985	$39,121,522	$18,785,189	$21,411,608		$386,535,304	Table B.1.2, Row A
H	**Projected Final Over/(Underexpenditure)**	**($8,668,733)**	**$2,509,091**	**$5,225,437**	**($1,431,040)**	**$126,472**	**($2,238,773)**	**Row F - Row G**
I	Adjusted FPE	4,665.69	3,217.00	1,200.13	9,082.82			Row C + Table B.1.2 Row D

Exhibit B

Table B.4.3 FY 2015-16 New Resources and Expenditure Rebalancing								
Row	**Office of Community Living**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**New State Plan Costs**	**Total**	**Notes**
A	Total Projected Expenditure	$291,849,346	$41,630,613	$18,506,186	$19,145,032		$371,131,177	Table E.1, Row I
B	Additional Enrollments Funded Through Redistribution of Existing Resources	134.00	0.00	279.00	413.00	413.00		Table B.2
C	New FPE (above appropriated level)	134.00	0.00	279.00	413.00	413.00		Table B.3, Row M
D	Projected Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82	$785.22		Table F.1 Row I State Plan: Table D.2, Row M
E	Projected Additional Expenditure	$8,574,394	$0	$5,581,866	$908,526	$324,296	$15,389,082	Row C * Row D
F	Projected Final Expenditure with Adjusted FPE	$300,423,740	$41,630,613	$24,088,052	$20,053,558	$324,296	$386,520,259	Row A + Row E
G	FY 2015-16 Base Funding Request	$307,216,985	$39,121,522	$18,785,189	$21,411,608		$386,535,304	Table B.1.3, Row A
H	**Projected Final Over/(Underexpenditure)**	**($6,793,245)**	**$2,509,091**	**$5,302,863**	**($1,358,050)**	**$324,296**	**($15,045)**	**Row F - Row G**
I	Adjusted FPE	4,695.00	3,217.00	1,204.00	9,116.00			Row C + Table B.1.3, Row D

Exhibit C

Table C.1 FY 2013-14 Change in State Plan Service Costs for New DIDD Waiver Enrollees			
FY 2013-14	Medical Services Premiums	Behavioral Health Capitation Payments	Notes
Change to State Plan Cost	($397.94)	$730.92	Table D.1, Rows H and L
New FPE	40.15	40.15	Table B.4, Row E (Total Column)
Total	($15,977)	$29,346	

Table C.2 FY 2014-15 Cost-Shift of State Plan Services for New DIDD Waiver Enrollees			
FY 2014-15	Medical Services Premiums	Behavioral Health Capitation Payments	Notes
Change to State Plan Cost	($397.94)	$730.92	Table D.1, Rows H and L
New FPE	379.82	379.82	Table B.4, Row I (Total Column)
Total	($151,146)	$277,618	

Table C.3 FY 2015-16 Cost-Shift of State Plan Services for New DIDD Waiver Enrollees			
FY 2015-16	Medical Services Premiums	Behavioral Health Capitation Payments	Notes
Change to State Plan Cost	$32.93	$752.29	Table D.2, Rows H and L
New FPE	413.00	413.00	Table B.4, Row M (Total Column)
Total	$13,600	$310,696	

Exhibit D

Table D.1
FY 2014-15
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to New DIDD Waiver Enrollees

		Current Medicaid Recipients		Non-Medicaid Recipients	Total	Formula/Assumptions
		Waiver	No Waiver			
A	Percentage of Clients	4.00%	58.00%	38.00%	100.00%	
	Impact to Medical Services Premiums					
B	Current State Plan Costs Per Person	$14,128.33	$13,447.46	$0.00	$8,364.66	Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13
C	Estimated State Plan Cost Per Person After Enrollment in DIDD Waiver Program	$8,446.72	$8,446.72	$8,446.72	$8,446.72	Based on CMS 372 report less Targeted Case Management and Mental Health
D	**Difference**	**($5,681.61)**	**($5,000.74)**	**$8,446.72**	**$82.06**	**Row C - Row B**
E	Current Medical Services Premiums Waiver Costs Per Person	$11,999.88	$0.00	$0.00	$480.00	Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13
F	Estimated Medical Services Premiums Waiver Cost Per Person After Enrollment in DIDD Waiver Program	$0.00	$0.00	$0.00	$0.00	Clients can only be enrolled in a single waiver program.
G	**Difference**	**($11,999.88)**	**$0.00**	**$0.00**	**($480.00)**	**Row F - Row E**
H	**Total Difference to Medical Services Premiums Per Person**	**($17,681.49)**	**($5,000.74)**	**$8,446.72**	**($397.94)**	**Row D + Row G**
I	**Impact to Behavioral Health Community Programs**					
J	Current Behavioral Health Costs Per Person	$1,923.48	$1,923.48	$0.00	$1,192.56	Based on the Department's FY 2013-14 S-2 Request
K	Estimated Behavioral Health Costs Per Person After Enrollment in DIDD Waiver Program	$1,923.48	$1,923.48	$1,923.48	$1,923.48	Based on the Department's FY 2013-14 S-2 Request
L	**Total Difference to Behavioral Health Community Programs Per Person**	**$0.00**	**$0.00**	**$1,923.48**	**$730.92**	**Row K - Row J**
M	**Grand Total Difference Per Person to Existing Programs**	**($17,681.49)**	**($5,000.74)**	**$10,370.20**	**$332.98**	**Row H + Row L**

Note: Unless otherwise specified, values shown in the "Total" column are the sumproduct of the values in the row and the percentages in Row A.

Exhibit D

Table D.2
FY 2015-16
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to New DIDD Waiver Resources

		Current Medicaid Recipients		Non-Medicaid Recipients	Total	Formula/Assumptions
		Waiver	No Waiver			
A	Percentage of Clients	4.00%	58.00%	38.00%	100.00%	
	Impact to Medical Services Premiums					
B	Current State Plan Costs Per Person	$14,128.33	$13,447.46	$0.00	$8,364.66	Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13
C	Estimated State Plan Cost Per Person After Enrollment in DIDD Waiver Program	$8,877.59	$8,877.59	$8,877.59	$8,877.59	Based on CMS 372 report less Targeted Case Management and Mental Health
D	**Difference**	**($5,250.74)**	**($4,569.87)**	**$8,877.59**	**$512.93**	**Row C - Row B**
E	Current Medical Services Premiums Waiver Costs Per Person	$11,999.88	$0.00	$0.00	$480.00	Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13
F	Estimated Medical Services Premiums Waiver Cost Per Person After Enrollment in DIDD Waiver Program	$0.00	$0.00	$0.00	$0.00	Clients can only be enrolled in a single waiver program.
G	**Difference**	**($11,999.88)**	**$0.00**	**$0.00**	**($480.00)**	**Row F - Row E**
H	**Total Difference to Medical Services Premiums Per Person**	**($17,250.62)**	**($4,569.87)**	**$8,877.59**	**$32.93**	**Row D + Row G**
I	**Impact to Behavioral Health Community Programs**					
J	Current Behavioral Health Costs Per Person	$1,979.70	$1,979.70	$0.00	$1,227.41	Based on the Department's FY 2013-14 S-2 Request
K	Estimated Behavioral Health Costs Per Person After Enrollment in DIDD Waiver Program	$1,979.70	$1,979.70	$1,979.70	$1,979.70	Based on the Department's FY 2013-14 S-2 Request
L	**Total Difference to Behavioral Health Community Programs Per Person**	**$0.00**	**$0.00**	**$1,979.70**	**$752.29**	**Row K - Row J**
M	**Grand Total Difference Per Person to Existing Programs**	**($17,250.62)**	**($4,569.87)**	**$10,857.29**	**$785.22**	**Row H + Row L**

Note: Unless otherwise specified, values shown in the "Total" column are the sumproduct of the values in the row and the percentages in Row A.

Exhibit E

Table E.1 - Total Developmental Disabilities Medicaid Waivers Expenditures and Forecast

Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	TOTAL
FY 2007-08	$208,102,462	$39,029,490	$5,756,235	$14,338,722	$267,226,909
FY 2008-09	$224,745,841	$45,210,324	$6,750,695	$16,833,173	$293,540,033
FY 2009-10	$252,576,457	$36,132,497	$6,956,802	$18,522,404	$314,188,159
FY 2010-11	$271,701,338	$36,416,459	$7,811,219	$21,675,435	$337,604,451
FY 2011-12	$264,137,545	$35,839,658	$7,219,044	$19,649,535	$326,845,782
FY 2012-13	$261,824,376	$37,269,826	$7,016,020	$18,967,392	$325,077,613
Estimated FY 2013-14	$277,972,252	$39,960,305	$12,424,408	$17,715,376	$348,072,341
Estimated FY 2014-15	$298,548,252	$41,630,613	$24,010,626	$19,980,568	$384,170,059
Estimated FY 2015-16	$300,423,740	$41,630,613	$24,088,052	$20,053,558	$386,195,963

Table E.2 - Percent Change in Year-over-year Expenditures

Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)	TOTAL
FY 2007-08					
FY 2008-09	8.00%	15.84%	17.28%	17.40%	9.85%
FY 2009-10	12.38%	-20.08%	3.05%	10.04%	7.03%
FY 2010-11	7.57%	0.79%	12.28%	17.02%	7.45%
FY 2011-12	-2.78%	-1.58%	-7.58%	-9.35%	-3.19%
FY 2012-13	-0.88%	3.99%	-2.81%	-3.47%	-0.54%
Estimated FY 2013-14	6.17%	7.22%	77.09%	-6.60%	6.49%
Estimated FY 2014-15	7.40%	4.18%	93.25%	12.79%	10.37%
Estimated FY 2015-16	0.63%	0.00%	0.32%	0.37%	0.53%

Exhibit F

Table F.1 - Developmental Disabilities Medicaid Waivers Expenditures and Forecast					
Per Capita Expenditures					
Row	**Office of Community Living**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	$56,198.34	$16,830.31	$19,780.88	$2,297.87
B	FY 2008-09	$59,050.40	$18,712.88	$20,581.39	$2,436.41
C	FY 2009-10	$63,065.28	$13,696.93	$21,339.88	$2,541.14
D	FY 2010-11	$65,644.20	$12,764.27	$21,758.27	$2,516.60
E	FY 2011-12	$63,940.34	$12,526.97	$21,232.48	$2,321.54
F	FY 2012-13	$62,727.45	$12,332.83	$20,045.77	$2,115.72
G	Estimated FY 2013-14	$63,782.17	$12,898.74	$19,929.64	$2,192.62
H	Estimated FY 2014-15	$63,988.02	$12,940.82	$20,006.69	$2,199.82
I	Estimated FY 2015-16	$63,988.02	$12,940.82	$20,006.69	$2,199.82

Table F.2 - Percent Change in Year-over-year Per Capita Cost					
Row	**Office of Community Living**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08				
B	FY 2008-09	5.07%	11.19%	4.05%	6.03%
C	FY 2009-10	6.80%	-26.80%	3.69%	4.30%
D	FY 2010-11	4.09%	-6.81%	1.96%	-0.97%
E	FY 2011-12	-2.60%	-1.86%	-2.42%	-7.75%
F	FY 2012-13	-1.90%	-1.55%	-5.59%	-8.87%
G	Estimated FY 2013-14	1.68%	4.59%	-0.58%	3.63%
H	Estimated FY 2014-15	0.32%	0.33%	0.39%	0.33%
I	Estimated FY 2015-16	0.00%	0.00%	0.00%	0.00%

Exhibit F

Table F.3 - Calculation of Per Capita Forecasts					
Row	**Office of Community Living**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2012-13 Per Capita	$62,727.45	$12,332.83	$20,045.77	$2,115.72
B	FY 2013-14 4.0% Rate Increase	3.67%	3.67%	3.67%	3.67%
C	Base Trend	-1.91%	0.90%	-4.10%	-0.03%
D	Estimated FY 2013-14 Per Capita	$63,782.62	$12,899.46	$19,929.41	$2,192.65
E	FY 2013-14 Per Capita	$63,782.17	$12,898.74	$19,929.64	$2,192.62
F	Annualization of FY 2013-14 4.0% Rate Increase	0.33%	0.33%	0.33%	0.33%
G	Base Trend	-0.01%	0.00%	0.06%	0.00%
H	Estimated FY 2014-15 Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82
I	FY 2014-15 Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82
J	Annualization of FY 2013-14 4.0% Rate Increase	0.00%	0.00%	0.00%	0.00%
K	Base Trend	0.00%	0.00%	0.00%	0.00%
L	Estimated FY 2015-16 Per Capita	$63,988.02	$12,940.82	$20,006.69	$2,199.82

A 4.00% Provider Rate increase was added beginning in July 2013. Because of lag between the dates certain services are provided and the dates claims are paid, the 4% increase was recognized gradually (i.e. some claims paid early in FY 2013-14 were for services provided in FY 2012-13). This, likewise, will have a slight carryover effect into FY 2014-15.

Exhibit G

Table G.1 - Developmental Disabilities Medicaid Waivers Claims Caseload and Forecast

Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)
FY 2007-08	3,702.50	2,319.17	290.92	6,312.58
FY 2008-09	3,806.08	2,415.92	328.08	6,550.08
FY 2009-10	4,004.67	2,637.75	325.50	6,967.92
FY 2010-11	4,138.75	2,853.42	359.33	7,351.50
FY 2011-12	4,130.58	2,861.42	340.25	7,332.25
FY 2012-13	4,173.92	3,022.42	349.58	7,545.92
Estimated FY 2013-14	4,358.15	3,098.00	623.41	8,079.56
Estimated FY 2014-15	4,665.69	3,217.00	1,200.13	9,082.82
Estimated FY 2015-16	4,695.00	3,217.00	1,204.00	9,116.00

Table G.2 - Percent Change in Claims Caseload

Office of Community Living	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)
FY 2007-08				
FY 2008-09	2.80%	4.17%	12.78%	3.76%
FY 2009-10	5.22%	9.18%	-0.79%	6.38%
FY 2010-11	3.35%	8.18%	10.39%	5.50%
FY 2011-12	-0.20%	0.28%	-5.31%	-0.26%
FY 2012-13	1.05%	5.63%	2.74%	2.91%
Estimated FY 2013-14	4.41%	2.50%	78.33%	7.07%
Estimated FY 2014-15	7.06%	3.84%	92.51%	12.42%
Estimated FY 2015-16	0.63%	0.00%	0.32%	0.37%

Exhibit G

Table G.3 - Calculation of FPE						
Row	**FY 2013-14**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Notes and Formulas**
A	FY 2012-13 FPE	4,173.92	3,022.42	349.58	7,545.92	Table G.1, Row F
B	Base Trend Increase	2.98%	1.47%	21.61%	3.24%	See narrative
C	Initial Estimated FY 2013-14 FPE	4,298.42	3,066.75	425.14	7,790.31	Row A * Row B
D	Additional Authorized FPE Under Current Policy	58.33	31.25	159.52	249.10	See narrative
E	**Final Estimated FY 2013-14 FPE Under Current Policy**	**4,356.75**	**3,098.00**	**584.66**	**8,039.41**	**Row C + Row D**
F	Requested FPE from Reallocation of Existing Resources	1.40	0.00	38.75	40.15	Table B.3, Row E
G	**Final Estimated FY 2013-14 FPE with Request**	**4,358.15**	**3,098.00**	**623.41**	**8,079.56**	Row E + Row F
Row	**FY 2014-15**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Notes and Formulas**
H	Initial Estimated FY 2013-14 FPE	4,356.75	3,098.00	584.66	8,039.41	Row E
I	Base Trend Increase	1.44%	0.01%	3.64%	1.05%	See narrative
J	Initial Estimated FY 2014-15 FPE	4,419.33	3,098.25	605.96	8,123.54	Row H * Row I
K	Additional Authorized Enrollments	141.67	118.75	319.04	579.46	See narrative
L	**Final Estimated FY 2014-15 FPE Under Current Policy**	**4,561.00**	**3,217.00**	**925.00**	**8,703.00**	**Row J + Row K**
M	Requested FPE from Reallocation of Existing Resources	104.69	0.00	275.13	379.82	Table B.3, Row I
N	**Final Estimated FY 2014-15 FPE with Request**	**4,665.69**	**3,217.00**	**1,200.13**	**9,082.82**	Row L + Row M
Row	**FY 2015-16**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Notes and Formulas**
O	Initial Estimated FY 2014-15 FPE	4,561.00	3,217.00	925.00	8,703.00	Row L
P	Base Trend Increase	0.00%	0.00%	0.00%	0.00%	See narrative
Q	Initial Estimated FY 2015-16 FPE	4,561.00	3,217.00	925.00	8,703.00	Row O * Row P
R	Additional Authorized Enrollments	0.00	0.00	0.00	0.00	See narrative
S	**Final Estimated FY 2015-16 FPE Under Current Policy**	**4,561.00**	**3,217.00**	**925.00**	**8,703.00**	**Row Q + Row R**
T	Requested FPE from Reallocation of Existing Resources	134.00	0.00	279.00	413.00	Table B.3, Row M
U	**Final Estimated FY 2015-16 FPE with Request**	**4,695.00**	**3,217.00**	**1,204.00**	**9,116.00**	Row S + Row T

Exhibit H

Table H.1 - Medicaid Expenditures FY 2007-08					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Total**
July 2007	$16,763,521	$3,566,218	$725,302	$1,193,686	$22,248,726
August 2007	$10,830,228	$296,684	$47,212	$722,406	$11,896,530
September 2007	$18,249,424	$4,057,746	$635,533	$965,489	$23,908,192
October 2007	$18,927,684	$3,413,412	$481,516	$1,547,932	$24,370,544
November 2007	$17,390,423	$3,279,628	$404,130	$1,230,129	$22,304,309
December 2007	$16,379,719	$3,825,527	$428,944	$1,214,847	$21,849,037
January 2008	$16,286,897	$2,680,546	$330,986	$1,107,568	$20,405,996
February 2008	$17,692,956	$2,981,840	$467,354	$1,267,709	$22,409,859
March 2008	$18,900,946	$3,801,578	$522,827	$1,215,066	$24,440,418
April 2008	$20,428,981	$3,938,805	$495,186	$1,308,229	$26,171,200
May 2008	$17,618,430	$2,617,184	$654,219	$1,243,775	$22,133,608
June 2008	$18,633,254	$4,570,322	$563,026	$1,321,888	$25,088,489
Year-to-Date Average	$208,102,462	$39,029,490	$5,756,235	$14,338,722	$267,226,909

Table H.2 - Medicaid Expenditures FY 2008-09					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**TOTAL**
July 2008	$16,409,032	$2,508,401	$657,743	$1,301,008	$20,876,183
August 2008	$16,024,290	$3,918,685	$519,703	$943,404	$21,406,081
September 2008	$19,688,435	$3,990,359	$558,343	$1,468,594	$25,705,730
October 2008	$18,695,931	$4,389,070	$508,289	$1,324,024	$24,917,314
November 2008	$18,004,361	$2,352,667	$399,487	$1,434,100	$22,190,616
December 2008	$19,268,796	$5,162,735	$746,098	$1,512,545	$26,690,175
January 2009	$15,003,821	$749,896	$138,882	$1,165,714	$17,058,313
February 2009	$18,663,217	$4,530,797	$642,312	$1,206,029	$25,042,354
March 2009	$19,985,272	$4,408,070	$637,427	$1,641,378	$26,672,148
April 2009	$17,501,555	$3,721,866	$590,048	$1,628,258	$23,441,727
May 2009	$20,749,067	$4,005,851	$640,655	$1,536,768	$26,932,341
June 2009	$24,752,064	$5,471,928	$711,706	$1,671,352	$32,607,051
Year-to-Date Average	$224,745,841	$45,210,324	$6,750,695	$16,833,173	$293,540,033

Exhibit H

Table H.3 - Medicaid Expenditures FY 2009-10					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**TOTAL**
July 2009	$19,588,721	$4,307,257	$859,286	$1,614,183	$26,369,446
August 2009	$20,543,903	$2,317,790	$405,318	$248,893	$23,515,903
September 2009	$21,846,732	$3,251,965	$443,706	$2,114,039	$27,656,442
October 2009	$20,912,301	$2,956,981	$455,885	$1,363,358	$25,688,526
November 2009	$21,213,347	$3,244,955	$579,976	$807,019	$25,845,297
December 2009	$21,584,619	$3,300,653	$759,658	$2,135,278	$27,780,209
January 2010	$18,557,760	$2,127,267	$462,754	$1,580,877	$22,728,659
February 2010	$21,214,768	$3,533,712	$747,091	$1,761,262	$27,256,834
March 2010	$24,366,239	$3,116,201	$683,780	$1,992,142	$30,158,362
April 2010	$21,087,043	$2,675,553	$421,389	$2,054,866	$26,238,851
May 2010	$21,087,022	$3,034,541	$753,849	$1,847,049	$26,722,461
June 2010	$20,574,001	$2,265,623	$384,110	$1,003,437	$24,227,170
Year-to-Date Average	$252,576,457	$36,132,497	$6,956,802	$18,522,404	$314,188,159

Table H.4 - Medicaid Expenditures FY 2010-11					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**TOTAL**
July 2010	$27,064,210	$3,910,011	$896,654	$2,398,798	$34,269,672
August 2010	$22,573,577	$2,788,059	$634,094	$1,739,840	$27,735,570
September 2010	$21,382,225	$3,192,276	$815,298	$1,763,992	$27,153,791
October 2010	$23,958,207	$3,178,731	$635,169	$1,477,822	$29,249,928
November 2010	$23,384,435	$3,076,003	$635,451	$2,008,851	$29,104,740
December 2010	$22,968,488	$2,780,951	$592,771	$1,728,785	$28,070,994
January 2011	$20,317,116	$2,564,023	$507,710	$1,260,357	$24,649,206
February 2011	$21,295,733	$2,265,517	$517,176	$1,756,572	$25,834,999
March 2011	$21,384,774	$3,626,454	$708,427	$1,988,375	$27,708,031
April 2011	$22,157,168	$3,104,326	$545,680	$1,630,210	$27,437,383
May 2011	$22,723,089	$2,954,261	$728,889	$2,173,578	$28,579,817
June 2011	$22,492,317	$2,975,848	$593,899	$1,748,256	$27,810,321
Year-to-Date Average	$271,701,338	$36,416,459	$7,811,219	$21,675,435	$337,604,451

Exhibit H

Table H.5 - Medicaid Expenditures FY 2011-12					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**TOTAL**
July 2011	$21,226,068	$2,658,556	$666,960	$1,880,694	$26,432,278
August 2011	$22,793,565	$3,467,581	$786,694	$1,674,639	$28,722,479
September 2011	$21,551,315	$2,585,981	$593,444	$1,186,568	$25,917,307
October 2011	$22,504,554	$3,215,514	$442,063	$1,965,745	$28,127,875
November 2011	$23,335,607	$3,357,606	$671,249	$2,161,561	$29,526,022
December 2011	$21,729,190	$2,925,740	$592,502	$1,246,538	$26,493,971
January 2012	$18,236,160	$2,351,113	$736,535	$1,821,186	$23,144,994
February 2012	$23,974,234	$2,959,172	$565,541	$1,456,241	$28,955,188
March 2012	$22,495,459	$3,169,169	$536,168	$1,585,907	$27,786,703
April 2012	$22,700,433	$3,196,769	$460,018	$1,383,866	$27,741,086
May 2012	$22,501,621	$2,785,589	$675,309	$1,683,493	$27,646,012
June 2012	$21,089,339	$3,166,869	$492,560	$1,603,097	$26,351,865
Year-to-Date Average	$264,137,545	$35,839,658	$7,219,044	$19,649,535	$326,845,782

Table H.6 - Medicaid Expenditures FY 2012-13					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**TOTAL**
July 2012	$23,178,705	$3,482,879	$899,136	$1,917,789	$29,478,509
August 2012	$21,403,422	$2,748,266	$608,449	$1,388,109	$26,148,247
September 2012	$21,542,072	$2,964,709	$474,857	$1,320,211	$26,301,849
October 2012	$22,143,091	$3,316,026	$622,094	$1,818,288	$27,899,497
November 2012	$21,815,639	$2,962,318	$530,523	$1,275,224	$26,583,704
December 2012	$21,350,618	$3,339,158	$646,462	$1,637,068	$26,973,306
January 2013	$21,533,144	$2,837,498	$532,311	$1,681,016	$26,583,969
February 2013	$21,902,790	$3,045,643	$527,711	$1,516,882	$26,993,026
March 2013	$20,552,988	$2,924,645	$470,881	$1,439,673	$25,388,186
April 2013	$22,365,724	$3,502,184	$624,842	$1,938,093	$28,430,843
May 2013	$21,606,715	$2,896,247	$528,959	$1,307,075	$26,338,995
June 2013	$22,429,469	$3,250,253	$549,795	$1,727,964	$27,957,481
Year-to-Date Average	$261,824,376	$37,269,826	$7,016,020	$18,967,392	$325,077,613

Exhibit H

Table H.7 - Medicaid Expenditures FY 2013-14					
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**TOTAL**
July 2013	$22,259,036	$3,384,083	$766,046	$1,826,994	$28,236,159
August 2013	$21,697,578	$3,020,563	$685,472	$1,579,597	$26,983,210
September 2013	$25,827,546	$3,590,924	$637,836	$1,652,626	$31,708,932
October 2013	$21,872,754	$3,555,814	$666,169	$1,830,497	$27,925,235
November 2013					
December 2013					
January 2014					
February 2014					
March 2014					
April 2014					
May 2014					
June 2014					
Year-to-Date Average					

Exhibit I

Table I.1 - Medicaid Clients for Whom Claims were Paid FY 2007-08				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2007	4,002.00	2,688.00	334.00	7,024.00
August 2007	2,801.00	208.00	37.00	3,046.00
September 2007	3,898.00	2,257.00	335.00	6,490.00
October 2007	3,885.00	2,512.00	333.00	6,730.00
November 2007	3,690.00	2,578.00	304.00	6,572.00
December 2007	3,711.00	2,665.00	323.00	6,699.00
January 2008	3,631.00	2,316.00	269.00	6,216.00
February 2008	3,705.00	2,369.00	329.00	6,403.00
March 2008	3,701.00	2,671.00	310.00	6,682.00
April 2008	3,814.00	2,592.00	316.00	6,722.00
May 2008	3,747.00	2,108.00	312.00	6,167.00
June 2008	3,845.00	2,866.00	289.00	7,000.00
Year-to-Date Average	**3,702.50**	**2,319.17**	**290.92**	**6,312.58**

Table I.2 - Medicaid Clients for Whom Claims were Paid FY 2008-09				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2008	3,608.00	1,969.00	317.00	5,894.00
August 2008	3,621.00	2,542.00	327.00	6,490.00
September 2008	3,728.00	2,734.00	348.00	6,810.00
October 2008	3,729.00	2,894.00	354.00	6,977.00
November 2008	3,761.00	1,755.00	288.00	5,804.00
December 2008	3,872.00	2,864.00	389.00	7,125.00
January 2009	3,697.00	764.00	113.00	4,574.00
February 2009	3,816.00	2,731.00	337.00	6,884.00
March 2009	3,928.00	2,501.00	344.00	6,773.00
April 2009	3,916.00	2,532.00	370.00	6,818.00
May 2009	3,958.00	2,746.00	377.00	7,081.00
June 2009	4,039.00	2,959.00	373.00	7,371.00
Year-to-Date Average	**3,806.08**	**2,415.92**	**328.08**	**6,550.08**

Exhibit I

Table I.3 - Medicaid Clients for Whom Claims were Paid FY 2009-10				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2009	3,905.00	2,760.00	349.00	7,014.00
August 2009	3,934.00	2,083.00	233.00	6,250.00
September 2009	3,954.00	2,582.00	257.00	6,793.00
October 2009	3,959.00	2,663.00	275.00	6,897.00
November 2009	3,961.00	2,850.00	371.00	7,182.00
December 2009	4,018.00	2,900.00	378.00	7,296.00
January 2010	3,949.00	2,347.00	345.00	6,641.00
February 2010	4,074.00	2,638.00	370.00	7,082.00
March 2010	4,114.00	2,876.00	390.00	7,380.00
April 2010	4,060.00	2,605.00	283.00	6,948.00
May 2010	4,076.00	2,952.00	379.00	7,407.00
June 2010	4,052.00	2,397.00	276.00	6,725.00
Year-to-Date Average	**4,004.67**	**2,637.75**	**325.50**	**6,967.92**

Table I.4 - Medicaid Clients for Whom Claims were Paid FY 2010-11				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2010	4,170.00	2,960.00	384.00	7,514.00
August 2010	4,129.00	2,752.00	326.00	7,207.00
September 2010	4,065.00	2,880.00	341.00	7,286.00
October 2010	4,134.00	2,881.00	366.00	7,381.00
November 2010	4,149.00	2,921.00	373.00	7,443.00
December 2010	4,175.00	2,855.00	368.00	7,398.00
January 2011	4,135.00	2,610.00	342.00	7,087.00
February 2011	4,106.00	2,541.00	342.00	6,989.00
March 2011	4,164.00	2,982.00	378.00	7,524.00
April 2011	4,122.00	2,968.00	370.00	7,460.00
May 2011	4,145.00	2,901.00	369.00	7,415.00
June 2011	4,171.00	2,990.00	353.00	7,514.00
Year-to-Date Average	**4,138.75**	**2,853.42**	**359.33**	**7,351.50**

Exhibit I

Table I.5 - Medicaid Clients for Whom Claims were Paid FY 2011-12				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2011	4,135.00	2,646.00	312.00	7,093.00
August 2011	4,152.00	2,938.00	358.00	7,448.00
September 2011	4,130.00	2,578.00	357.00	7,065.00
October 2011	4,187.00	2,990.00	326.00	7,503.00
November 2011	4,169.00	3,002.00	366.00	7,537.00
December 2011	4,142.00	3,002.00	375.00	7,519.00
January 2012	3,893.00	2,637.00	337.00	6,867.00
February 2012	4,175.00	2,980.00	362.00	7,517.00
March 2012	4,158.00	2,834.00	346.00	7,338.00
April 2012	4,155.00	2,976.00	299.00	7,430.00
May 2012	4,150.00	2,745.00	337.00	7,232.00
June 2012	4,121.00	3,009.00	308.00	7,438.00
Year-to-Date Average	**4,130.58**	**2,861.42**	**340.25**	**7,332.25**

Table I.6 - Medicaid Clients for Whom Claims were Paid FY 2012-13				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2012	4,148.00	3,071.00	359.00	7,578.00
August 2012	4,147.00	2,891.00	314.00	7,352.00
September 2012	4,162.00	2,932.00	314.00	7,408.00
October 2012	4,166.00	3,055.00	347.00	7,568.00
November 2012	4,156.00	3,043.00	325.00	7,524.00
December 2012	4,167.00	3,075.00	358.00	7,600.00
January 2013	4,179.00	3,068.00	355.00	7,602.00
February 2013	4,181.00	3,064.00	363.00	7,608.00
March 2013	4,177.00	2,923.00	342.00	7,442.00
April 2013	4,207.00	3,102.00	370.00	7,679.00
May 2013	4,210.00	2,978.00	371.00	7,559.00
June 2013	4,187.00	3,067.00	377.00	7,631.00
Year-to-Date Average	**4,173.92**	**3,022.42**	**349.58**	**7,545.92**

Exhibit I

Table I.7 - Medicaid Clients for Whom Claims were Paid FY 2013-14				
Office of Community Living	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
July 2013	4,242.00	3,101.00	386.00	7,729.00
August 2013	4,214.00	3,033.00	368.00	7,615.00
September 2013	4,252.00	3,019.00	385.00	7,656.00
October 2013	4,265.00	3,072.00	419.00	7,756.00
November 2013				
December 2013				
January 2014				
February 2014				
March 2014				
April 2014				
May 2014				
June 2014				
Year-to-Date Average				

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Leased Space
Priority Number: S-6, BA-6

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
		Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	2,630,846	(459,849)	2,633,042	1,646,927	491,979
	FTE	-	-	-	-	-
	GF	1,023,046	(226,872)	1,091,192	826,021	229,402
	GFE	-	-	-	-	-
	CF	275,281	(3,053)	208,371	(2,560)	16,585
	RF	23,910	-	23,910	-	-
	FF	1,308,609	(229,924)	1,309,569	823,466	245,992
(1) Executive Director's Office; (A) General Administration, Leased Space	**Total**	866,780	(459,849)	894,859	226,525	466,159
	FTE	-	-	-	-	-
	GF	289,521	(226,872)	302,118	115,820	216,492
	GFE	-	-	-	-	-
	CF	143,871	(3,053)	145,314	(2,560)	16,585
	RF	-	-	-	-	-
	FF	433,388	(229,924)	447,427	113,265	233,082
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	1,764,066	-	1,738,183	1,420,402	25,820
	FTE	-	-	-	-	-
	GF	733,525	-	789,074	710,201	12,910
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	710,201	12,910

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

For FY 2013-14
Of this amount, ~~$143,871~~ $140,818 shall be from the Hospital Provider Fee Cash Fund...

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A); FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A

Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: S-6, BA-6
Leased Space True-up
FY 2013-14 Supplemental Request &
FY 2014-15 Budget Amendment

Cost and FTE

- For FY 2013-14, the Department requests a reduction of $459,849 total funds, consisting of $226,872 General Fund, $3,053 cash funds from the Hospital Provider Fee cash fund, and $229,924 federal funds.
- For FY 2014-15, the Department requests $1,646,927 total funds, consisting of $826,021 General Fund, a reduction of $2,560 cash funds from the Hospital Provider Fee cash fund, and $823,446 federal funds.

Current Program

- On June 20, 2013, the Department's interim supplemental request for Leased Space was approved, giving the Department additional FY 2013-14 spending authority in its Leased Space line item of $350,720 total funds, composed of $175,360 General Fund and $175,360 federal funds.
- In March 2015, several of the Department's leases at 225 E. 16th St. will expire.

Problem or Opportunity

- Subsequent to the approval of the interim supplemental request, the Department was able to negotiate lease terms for 303 E. 17th Avenue which resulted in a substantially reduced funding need in FY 2013-14. This resulted in excess funding included in its budget in FY 2013-14.
- In March 2015, several of the Department's leases at 225 E. 16th St. will expire. Based on recent information, the Department believes that it is likely to experience an increase in rental costs when it enters into new leased space agreements.

Consequences of Problem

- If this request is not approved, the Department would have excess funding included in its budget; in FY 2013-14 this funding would be unspent and revert at the end of the fiscal year.
- In addition, the Department would lack the needed funding to secure leased space when several of the Department's leases at 225 E. 16th St. expire in March 2015.

Proposed Solution

- In order to true up previously appropriated funding for the Department's Leased Space line item, and to ensure funding is available to secure leased space in March 2015, the Department requests a reduction of funding FY 2013-14.
- For FY 2014-15, the Department requests an increase in funding to account for the likelihood of higher rents, and the possibility of having to move to a new location.

Department Priority: S-6, BA-6
Request Detail: Leased Space True-up

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund
Leased Space True-Up	($459,849)	($226,872)

Problem or Opportunity:

On June 20, 2013, the Department's interim supplemental request for Leased Space was approved, giving the Department additional FY 2013-14 spending authority in its (1) Executive Director's Office; (A) General Administration, Leased Space line item of $350,720 total funds, composed of $175,360 General Fund and $175,360 federal funds. Subsequent to the approval of the interim supplemental request, the Department was able to negotiate lease terms for 303 E. 17th Avenue which resulted in a need of only $45,797 in FY 2013-14. As the interim supplemental request was only for the estimated incremental need, the Department is able to true up the estimates provided in the interim supplemental request with actual costs; this results in $463,294 in excess funding included in its budget in FY 2013-14.

In addition, several of the Department's leases at 225 E. 16th Street will expire in March 2015. Based on recent information, the Department believes that it is likely to experience an increase in rental costs when it enters into new leased space agreements.

Proposed Solution:

In order to true up previously appropriated funding for the Department's (1) Executive Director's Office; (A) General Administration, Leased Space line item, and to ensure funding is available to secure leased space in March 2015, the Department requests a reduction of $459,849 total funds, including $226,872 General Fund, in FY 2013-14.

For FY 2014-15, the Department requests an increase in funding of $1,646,927, including $826,021 General Fund, to account for the likelihood of higher rents and the possibility of having to move to a new location. This includes an increase of $226,525 total funds for higher leased space costs in FY 2014-15, and $1,420,402 total funds for the cost of moving locations, including the net cost of furnishing new office space and costs to physically move the Department's existing furniture and office equipment.

For FY 2015-16 and ongoing, the Department requests an increase of $491,979 total funds, including $229,402 General Fund, for higher leased space costs, maintenance, support, and usage charges for networking capability and the Department's physical security system.

Anticipated Outcomes:

The approval of this request would prevent a significant reversion from the Department's Leased Space line item in FY 2013-14, and would allow the Department to remain in a consolidated location and have flexibility when the current leases expire at 225 E. 16th Street in March 2015. This request would ensure the Department has the adequate space necessary to continue to administer the Medicaid and Child Health Plan *Plus* programs, as well as a variety of other programs for Colorado's low-income families, the elderly, and persons with disabilities.

Assumptions and Calculations:

A detailed description of the Department's calculations for this request can be found in Appendix A.

To estimate the funding need for this request, estimated rental rates are derived from the Department's existing leases with 5% yearly inflation increases. Leased space operating expenses are estimated based on historical operating expenses actually incurred by the Department in space occupied at 225 E. 16th Street.

The Department also assumes in this request that the staff currently located at 225 E. 16th Street will move to two additional floors at 303 E. 17th Avenue in March 2015 when leases expire. While this is not certain, the Department is making the request based on this assumption so flexibility will be available at that time. As this request assumes the movement of staff to a new location upon expiration of current leases, this request can be separated into three components: leased space costs, build out costs, and equipment and furnishings costs.

Leased space costs are those costs related only to the actual rental of the space needed. Table 4 through Table 9 of the Appendix give a detailed description of leased space appropriation needs, while Table 14 and Table 15 show the calculations for the amount of the leased space request. For FY 2014-15, the Department assumes that it would be required to lease space at the net rate of $22.25 per square foot (Table 6); this figure was calculated based on the Department's rental rate in its most recently acquired commercial leased space, inflated by 5%. The Department applies this same methodology for FY 2015-16 costs (Table 8); this also accounts for the contracted increase in the rental rates. Further, the Department has assumed an increase in total square feet rented; this estimate accounts for the possibility of the Department being required to rent larger continuous spaces as opposed to multiple smaller units.

Build out costs are those costs related only to the actual building out of the space itself to make it usable by State employees. This includes the design, purchase and installation of cubicles in the space, along with any other furniture required for use by staff. Table 10 of the request details the request for build out costs. The Department included an offset in the build out costs to account for the resale or reuse of existing cubicles and furniture.

Equipment and furnishings are those costs related to other types of equipment and furnishing needed for common use by all of the employees of the space, such as conference room furniture and equipment needed for computer networking capability. Table 11 of Appendix A includes a detailed description of the individual components of the Department's equipment and furnishings portion of this request.

This request assumes that the Department would purchase all new furniture and equipment. However, the Department would consider and is exploring other options, such as moving existing cubicles, selling existing cubicles, buying used furniture, and other strategies to reduce the cost of making the new space usable.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This request meets the supplemental criteria of new data resulting in substantive changes in funding needs. Subsequent to the approval of the interim Leased Space supplemental request, the Department was able to negotiate lease terms for 303 E. 17th Avenue which resulted in substantially less need in FY 2013-14. For FY 2014-15, this request meets budget amendment criteria of new data, as the Department received new information from the Department's existing landlord about the likelihood of increases in rental costs that could not be incorporated into the November 1, 2013 Budget Request.

Table 1: Leased Space Appropriations FY 2013-14								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	**SB 13-230 FY 2013-14 Long Bill**	**$788,679**	**$289,521**	**$104,820**	**$0**	**$394,338**	**$0**	
B	SB 13-200 "Expand Medicaid Eligibility"	$78,101	$0	$39,051	$0	$39,050	$0	
C	R-5 MMIS Reprocurement Leased Space	$127,429	$11,382	$2,318	$0	$113,729	$0	
D	1331 Leased Space	$350,720	$175,360	$0	$0	$175,360	$0	
E	HRSA Grant	$16,536	$0	$0	$0	$0	$16,536	
F	**Year-to-date FY 2013-14 Available for Leased Space**	**$1,361,465**	**$476,263**	**$146,189**	**$0**	**$722,477**	**$16,536**	**Sum Rows A:E**

Table 2: Leased Space Appropriations FY 2014-15								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	**Year-to-date FY 2013-14 Available for Leased Space**	**$1,344,929**	**$476,263**	**$146,189**	**$0**	**$722,477**	**$0**	**Table 1, Row F minus Table 1 Row E**
B	Annualization of FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	$28,079	$12,597	$1,443	$0	$14,039	$0	
C	**FY 2014-15 Base Request**	**$1,373,008**	**$488,860**	**$147,632**	**$0**	**$736,516**	**$0**	**Row A + Row B**

Table 3: Leased Space Appropriations FY 2015-16								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	**Year-to-date FY 2015-16 Available for Leased Space**	**$1,373,008**	**$488,860**	**$147,632**	**$0**	**$736,516**	**$0**	Continuation from FY 2014-15

Table 4: FY 2013-14 Summary of Leased Space by Unit									
Unit	**Square Feet**	**Yearly Price/ Sq Ft**	**Prop. Tax Adjustment**	**Net Yearly Price/Sq. ft.**	**Months Rented**	**Gross Annual Rent**	**Annual Tax Adjustment**	**Operating Expenses**	**Net Total Rent**
225 E. 16th St. Unit 120	7,239	$21.00	($2.41)	$18.59	12	$152,019	($17,446)	$3,620	$138,193
225 E. 16th St. Unit 220	5,817	$21.00	($2.41)	$18.59	12	$122,157	($14,019)	$2,909	$111,047
225 E. 16th St. Unit 350	1,770	$21.57	($2.59)	$18.98	12	$38,179	($4,585)	$1,814	$35,408
225 E. 16th St. Unit 650	8,347	$21.00	($2.41)	$18.59	12	$175,287	($20,117)	$4,174	$159,344
225 E. 16th St. Unit 690	2,440	$21.00	($2.59)	$18.41	12	$51,240	($6,320)	$195	$45,115
225 E. 16th St. Unit 900	10,846	$22.25	($2.66)	$19.59	12	$241,324	($28,851)	$13,341	$225,814
225 E. 16th St. Unit 1050	2,676	$21.57	($2.59)	$18.98	12	$57,722	($6,931)	$2,743	$53,534
226 E. 16th St. Unit B52	2,791	$18.00	($2.38)	$15.62	7	$29,306	($3,875)	$0	$25,431
225 E. 16th St. Unit B200	765	$15.00	($2.59)	$12.41	12	$11,475	($1,982)	$784	$10,277
225 E. 16th St. Storage	80	$12.00	$0.00	$12.00	12	$960	$0	$0	$960
1120 Lincoln St. Suite 125	4,978	$21.00	($1.88)	$19.12	6	$52,269	($4,680)	$0	$47,589
303 E. 17th Ave. Unit 335	847	$25.55	($2.93)	$22.62	2	$3,607	($414)	$252	$3,445
303 E. 17th Ave. Unit 700	25,935	$24.35	($3.16)	$21.19	1	$52,627	($6,830)	$0	$45,797
Total	**74,531**					**$988,172**	**($116,050)**	**$29,831**	**$901,953**

Table 5: FY 2013-14 Summary of Leased Space by Funding Source						
Units	**TF**	**GF**	**CF**	**RF**	**FF**	**Grant Funded**
225 E. 16th St. Unit 120	$138,193	$69,096	$0	$0	$69,097	$0
225 E. 16th St. Unit 220	$111,047	$55,523	$0	$0	$55,524	$0
225 E. 16th St. Unit 350	$35,408	$14,696	$0	$0	$14,696	$6,016
225 E. 16th St. Unit 650	$159,344	$79,672	$0	$0	$79,672	$0
225 E. 16th St. Unit 690	$45,115	$22,558	$0	$0	$22,557	$0
225 E. 16th St. Unit 900	$225,814	$112,907	$0	$0	$112,907	$0
225 E. 16th St. Unit 1050	$53,534	$22,219	$0	$0	$22,220	$9,095
226 E. 16th St. Unit B52	$25,431	$12,716	$0	$0	$12,715	$0
225 E. 16th St. Unit B200	$10,277	$4,258	$0	$0	$4,257	$1,762
225 E. 16th St. Storage	$960	$480	$0	$0	$480	$0
1120 Lincoln St. Suite 125	$47,589	$23,795	$0	$0	$23,794	$0
303 E. 17th Ave. Unit 335	$3,445	$1,723	$0	$0	$1,722	$0
303 E. 17th Ave. Unit 700	$45,797	$22,899	$0	$0	$22,898	$0
Total	**$901,953**	**$442,542**	**$0**	**$0**	**$442,538**	**$16,873**
R-5 MMIS Reprocurement Adjustment	$0	($52,333)	$2,318	$0	$50,015	$0
Hospital Provider Fee Adjustment	$0	($140,818)	$140,818	$0	$0	$0
Net Total	**$901,953**	**$249,391**	**$143,136**	**$0**	**$492,553**	**$16,873**

Table 6: FY 2014-15 Summary of Leased Space by Unit									
Unit	**Square Feet**	**Yearly Price/ Sq Ft**	**Prop. Tax Adjustment**	**Net Yearly Price/Sq. ft.**	**Months Rented**	**Gross Annual Rent**	**Annual Tax Adjustment**	**Operating Expenses**	**Net Total Rent**
Current Leased Space									
225 E. 16th St. Unit 120	7,239	$21.00	($2.41)	$18.59	9	$114,015	($13,085)	$5,429	$106,359
225 E. 16th St. Unit 220	5,817	$21.00	($2.41)	$18.59	9	$91,618	($10,515)	$4,363	$85,466
225 E. 16th St. Unit 350	1,770	$21.57	($2.59)	$18.98	9	$28,635	($3,439)	$1,633	$26,829
225 E. 16th St. Unit 650	8,347	$21.00	($2.41)	$18.59	9	$131,466	($15,088)	$6,260	$122,638
225 E. 16th St. Unit 690	2,440	$21.00	($2.59)	$18.41	9	$38,430	($4,740)	$146	$33,836
225 E. 16th St. Unit 900	10,846	$22.25	($2.66)	$19.59	9	$180,993	($21,638)	$10,005	$169,360
225 E. 16th St. Unit 1050	2,676	$21.57	($2.59)	$18.98	9	$43,291	($5,199)	$2,469	$40,561
226 E. 16th St. Unit B52	2,791	$18.00	($2.38)	$15.62	12	$50,238	($6,643)	$723	$44,318
225 E. 16th St. Unit B200	765	$15.00	($2.59)	$12.41	9	$8,607	($1,487)	$706	$7,826
225 E. 16th St. Storage	80	$12.00	$0.00	$12.00	12	$960	$0	$0	$960
1120 Lincoln St. Suite 125	4,978	$21.00	($1.88)	$19.12	12	$104,538	($9,359)	$0	$95,179
303 E. 17th Ave. Unit 335	847	$25.55	($2.93)	$22.62	12	$21,641	($2,482)	$1,515	$20,674
303 E. 17th Ave. Unit 700	25,935	$24.35	($3.16)	$21.19	12	$631,518	($81,955)	$6,719	$556,282
Subtotal Current Leased Space	**74,531**					**$1,445,950**	**($175,630)**	**$39,969**	**$1,310,289**
New Leased Space									
Space required due to lease expiration	52,000	$25.57	($3.32)	$22.25	3	$332,378	($43,134)	$0	$289,244
Grand Total	**126,531**	**$14.05**	**($1.73)**	**$12.33**		**$1,778,328**	**($218,764)**	**$39,969**	**$1,599,533**

Table 7: FY 2014-15 Summary of Leased Space by Funding Source						
Units	**TF**	**GF**	**CF**	**RF**	**FF**	**Grant Funded**
Current Leased Space						
225 E. 16th St. Unit 120	$106,359	$53,180	$0	$0	$53,179	$0
225 E. 16th St. Unit 220	$85,466	$42,733	$0	$0	$42,733	$0
225 E. 16th St. Unit 350	$26,829	$13,415	$0	$0	$13,414	$0
225 E. 16th St. Unit 650	$122,638	$61,319	$0	$0	$61,319	$0
225 E. 16th St. Unit 690	$33,836	$16,918	$0	$0	$16,918	$0
225 E. 16th St. Unit 900	$169,360	$84,680	$0	$0	$84,680	$0
225 E. 16th St. Unit 1050	$40,561	$20,280	$0	$0	$20,281	$0
226 E. 16th St. Unit B52	$44,318	$22,159	$0	$0	$22,159	$0
225 E. 16th St. Unit B200	$7,826	$3,913	$0	$0	$3,913	$0
225 E. 16th St. Storage	$960	$480	$0	$0	$480	$0
1120 Lincoln St. Suite 125	$95,179	$47,590	$0	$0	$47,589	$0
303 E. 17th Ave. Unit 335	$20,674	$10,337	$0	$0	$10,337	$0
303 E. 17th Ave. Unit 700	$556,282	$278,141	$0	$0	$278,141	$0
Subtotal Current Leased Space	**$1,310,289**	**$655,145**	**$0**	**$0**	**$655,144**	**$0**
New Leased Space						
Space required due to lease expiration	$289,244	$144,622	$0	$0	$144,622	$0
Grand Total	**$1,599,533**	**$799,767**	**$0**	**$0**	**$799,766**	**$0**
R-5 MMIS Reprocurement Adjustment	$0	($52,333)	$2,318	$0	$50,015	$0
Hospital Provider Fee Adjustment	$0	($142,754)	$142,754	$0	$0	$0
Net Total	**$1,599,533**	**$604,680**	**$145,072**	**$0**	**$849,781**	**$0**

Table 8: FY 2015-16 Summary of Leased Space by Unit									
Unit	**Square Feet**	**Yearly Price/ Sq Ft**	**Prop. Tax Adjustment**	**Net Yearly Price/Sq. ft.**	**Months Rented**	**Gross Annual Rent**	**Annual Tax Adjustment**	**Operating Expenses**	**Net Total Rent**
Current Leased Space									
225 E. 16th St. Unit 120	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Unit 220	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Unit 350	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Unit 650	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Unit 690	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Unit 900	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Unit 1050	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
226 E. 16th St. Unit B52	2,791	$18.00	($2.38)	$15.62	12	$50,238	($6,643)	$2,892	$46,487
225 E. 16th St. Unit B200	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
225 E. 16th St. Storage	80	$12.00	$0.00	$12.00	12	$960	$0	$0	$960
1120 Lincoln St. Suite 125	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
303 E. 17th Ave. Unit 335	847	$25.55	($2.93)	$22.62	12	$21,641	($2,482)	$1,515	$20,674
303 E. 17th Ave. Unit 700	25,935	$24.65	($3.16)	$21.49	12	$639,298	($81,955)	$26,877	$584,220
Subtotal Current Leased Space	**29,653**					**$712,137**	**($91,080)**	**$31,284**	**$652,341**
New Leased Space									
Space required due to lease expiration	52,000	$25.88	($3.32)	$22.56	12	$1,345,890	($172,536)	$13,472	$1,186,826
Grand Total	**81,653**	**$25.20**	**($3.23)**	**$21.98**		**$2,058,027**	**($263,616)**	**$44,756**	**$1,839,167**

Table 9: FY 2015-16 Summary of Leased Space by Funding Source						
Units	**TF**	**GF**	**CF**	**RF**	**FF**	**Grant Funded**
Current Leased Space						
225 E. 16th St. Unit 120	$0	$0	$0	$0	$0	$0
225 E. 16th St. Unit 220	$0	$0	$0	$0	$0	$0
225 E. 16th St. Unit 350	$0	$0	$0	$0	$0	$0
225 E. 16th St. Unit 650	$0	$0	$0	$0	$0	$0
225 E. 16th St. Unit 690	$0	$0	$0	$0	$0	$0
225 E. 16th St. Unit 900	$0	$0	$0	$0	$0	$0
225 E. 16th St. Unit 1050	$0	$0	$0	$0	$0	$0
226 E. 16th St. Unit B52	$46,487	$23,244	$0	$0	$23,243	$0
225 E. 16th St. Unit B200	$0	$0	$0	$0	$0	$0
225 E. 16th St. Storage	$960	$480	$0	$0	$480	$0
1120 Lincoln St. Suite 125	$0	$0	$0	$0	$0	$0
303 E. 17th Ave. Unit 335	$20,674	$10,337	$0	$0	$10,337	$0
303 E. 17th Ave. Unit 700	$584,220	$292,110	$0	$0	$292,110	$0
Subtotal Current Leased Space	**$652,341**	**$326,171**	**$0**	**$0**	**$326,170**	**$0**
New Leased Space						
Space required due to lease expiration	$1,186,826	$593,413	$0	$0	$593,413	$0
Grand Total	**$1,839,167**	**$919,584**	**$0**	**$0**	**$919,583**	**$0**
R-5 MMIS Reprocurement Adjustment[1]	$0	($52,333)	$2,318	$0	$50,015	$0
Hospital Provider Fee Adjustment	$0	($161,899)	$161,899	$0	$0	$0
Net Total	**$1,839,167**	**$705,352**	**$164,217**	**$0**	**$969,598**	**$0**

Table 10: FY 2014-15 Leased Space Buildout Costs			
Row	Component	Unit(s)	Calculation
A	Total Square Feet Available	52,000	
B	Sq. ft. per FTE	204	
C	Estimated Number of Cubicles in Space	254	Row A / Row B
D	Cost per Cubicle	$3,473	Office Furniture Common Policy
E	Cubicles in Space	254	Row C
F	**Total Cost to build out space**	**$882,142**	**Row D * Row E**
G	Adjustment for Existing Cubes	($17,900)	179 cubes at $100 per cube
H	**Net Total Cost to build out space**	**$864,242**	**Row F + Row G**

Table 11: FY 2014-15 Equipment and Furnishings					
Row	Item	Cost Per Unit	Quantity	Total Initial Cost	Ongoing Yearly Cost
A	High Speed Scanners	$5,000	2	$10,000	$0
B	Shredders	$1,500	0	$0	$0
C	Conference Room Tables	$350	24	$8,400	$0
D	Conference Room Chairs	$250	48	$12,000	$0
E	Tables	$250	0	$0	$0
F	Office Furniture	$3,000	24	$72,000	$0
G	File Cabinets	$900	0	$0	$0
H	Bookshelves	$300	0	$0	$0
I	Break Room Furniture	$1,300	0	$0	$0
J	Signage	$10,620	1	$10,620	$0
K	Conference Room Projectors	$815	4	$3,260	$0
L	Conference Room Sound	$11,000	4	$44,000	$0
M	Conference Room Phones	$560	4	$2,240	$0
N	Sound masking system	$16,500	2	$33,000	$0
O	Physical Security System	$10,000	2	$20,000	$720
P	Networking Capability	$140,400	2	$280,800	$25,100
Q	**Total**			**$496,320**	**$25,820**

Table 12: Moving Costs						
Number of Employees	**Cost per Employee**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
220.0	$272.00	$59,840	$29,920	$0	$0	$29,920

Table 13: Leased Space Calculations FY 2013-14								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	Leased Space Appropriations	$1,361,465	$476,263	$146,189	$0	$722,477	$16,536	Table 1, Row F
B	Leased Space Need	$901,953	$249,391	$143,136	$0	$492,553	$16,873	Table 5, Net Total
C	**Net Request**	**($459,512)**	**($226,872)**	**($3,053)**	**$0**	**($229,924)**	**$337**	**Row B - Row A**

Table 14: Leased Space Calculations FY 2014-15								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	Leased Space Appropriations	$1,373,008	$488,860	$147,632	$0	$736,516	$0	Table 2, Row C
B	Leased Space Need	$1,599,533	$604,680	$145,072	$0	$849,781	$0	Table 7, Net Total
C	**Net Request**	**$226,525**	**$115,820**	**($2,560)**	**$0**	**$113,265**	**$0**	**Row B - Row A**

Table 15: Leased Space Calculations FY 2015-16								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	Leased Space Appropriations	$1,373,008	$488,860	$147,632	$0	$736,516	$0	Table 3, Row A
B	Leased Space Need	$1,839,167	$705,352	$164,217	$0	$969,598	$0	Table 9, Net Total
C	**Net Request**	**$466,159**	**$216,492**	**$16,585**	**$0**	**$233,082**	**$0**	**Row B - Row A**

Table 16: Leased Space Buildout, Equipment and Furnishings, and Moving FY 2014-15								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	Available appropriations	$0	$0	$0	$0	$0	$0	
B	Build out and equipment Need	$1,360,562	$680,281	$0	$0	$680,281	$0	Table 10, Row H + Table 11, Total Initial Cost Row Q
C	Moving Need	$59,840	$29,920	$0	$0	$29,920	$0	Table 12
D	**Net Request**	**$1,420,402**	**$710,201**	**$0**	**$0**	**$710,201**	**$0**	**Row B + Row C - Row A**

Table 17: Leased Space Buildout, Equipment and Furnishings, and Moving FY 2015-16								
Row	Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Grant Funds	Calculation
A	Available appropriations	$0	$0	$0	$0	$0	$0	
B	Build out and equipment Need	$25,820	$12,910	$0	$0	$12,910	$0	Table 11, Ongoing Yearly Cost Row Q
C	Moving Need	$0	$0	$0	$0	$0	$0	
D	**Net Request**	**$25,820**	**$12,910**	**$0**	**$0**	**$12,910**	**$0**	**Row B + Row C - Row A**

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Benefits Utilization Services Application
Priority Number: S-7, BA-7

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☑ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	-	201,447	1,319,571	60,122	60,122
	FTE	-	-	-	-	-
	GF	-	100,723	648,834	30,061	30,061
	GFE	-	-	-	-	-
	CF	-	-	6,061	-	-
	RF	-	-	-	-	-
	FF	-	100,724	664,676	30,061	30,061
(1) Executive Director's Office; (A) General Administration, Payments to OIT (NEW LINE)	**Total**	-	201,447	1,319,571	60,122	60,122
	FTE	-	-	-	-	-
	GF	-	100,723	648,834	30,061	30,061
	GFE	-	-	-	-	-
	CF	-	-	6,061	-	-
	RF	-	-	-	-	-
	FF	-	100,724	664,676	30,061	30,061

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

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: ☐ **Not Required:** ☐
Schedule 13s from Affected Departments: OIT
Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: S-7, BA-7
Benefits Utilization Services Application
FY 2013-14 Supplemental Request &
FY 2014-15 Budget Amendment

Cost and FTE

- FY 2013-14: $201,447 total funds, $100,723 General Fund, and $100,724 federal funds;
- FY 2014-15 and ongoing: $60,122 total funds, $30,061 General Fund, and $30,061 federal funds.

Current Program

- The Benefits Utilization Services application (BUS), which is maintained by the Governor's Office of Information Technology (OIT), is used to assess eligibility for long-term services and supports (LTSS) by documenting a Medicaid client's activity level and ongoing medical needs.
- Case management workers use the BUS to create and update LTSS client service plans; these plans are needed to approve medical services for LTSS clients and timely management of these plans ensures clients continue to receive the appropriate level of service.

Problem or Opportunity

- The BUS uses substandard computing practices by sharing a single computing environment for all system needs including operating the BUS, developing system changes, training new end users, and recovering the system in disaster events.
- Substandard computing practices cause: potential system instability for case managers and Department users when system changes are required; difficulty training new users of the BUS; and, increased risk for lengthy unscheduled downtime and permanent data loss in disaster events such as hardware malfunctions.
- OIT recently evaluated the BUS due to system failures and determined that if not addressed, BUS system deficiencies could jeopardize timely medical services for LTSS clients.

Consequences of Problem

- Not addressing the current limitations of the BUS compromises service delivery to LTSS clients by jeopardizing system availability, case manager training, and timely client health data exchange between the Department and the BUS.
- Limiting access to BUS data risks timely completion of mandatory federal reports, which could jeopardize federal financial participation for this population.

Proposed Solution

- Based on estimates provided by OIT, the Department requests funding to create and maintain additional BUS environments for development, training, and disaster recovery, ensuring timely receipt of health services and federal financial support.

Department Priority: S-7, BA-7
Request Detail: Business Utilization Services Application

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund
Business Utilization Services Application	$201,447	$100,723

Problem or Opportunity:

The substandard information technology (IT) infrastructure of the Business Utilization Services application (BUS) is inadequate for administering long-term services and supports (LTSS) for Medicaid clients, jeopardizing the Department's goal to provide effective and efficient health care for Colorado's Medicaid population.

The BUS is a database application maintained by the Governor's Office of Information Technology (OIT) used to input and store client assessments that determine eligibility for LTSS programs. The BUS is also used to create and update LTSS client service plans that document client needs and are subsequently used to determine authorization of Medicaid payments. Service plans must be updated timely to ensure a client's authorized services match his or her changing needs. Finally, BUS data is used to fulfill federal reporting requirements of the Centers for Medicare and Medicaid Services (CMS) to maintain ongoing federal funding for the Department's home and community based services (HCBS) waivers.

The BUS currently relies on substandard IT infrastructure, diminishing system usability and stability. The infrastructure is substandard because the BUS only uses one IT environment for multiple functions such as recording and viewing data, developing and testing system changes, and training new users. If the Department were to follow IT industry-standard System Development Lifecycle (SDLC) practices, it would need to separate these various functions into multiple environments, which are essentially separate copies of the application tailored to a specific function. The lack of multiple environments diminishes the usability of the system and causes instability. For example, system changes take an unacceptably long time and can potentially cause system instability while changes are implemented; user training is inefficient due to users having to utilize the full system without a training-friendly environment; and, permanent data loss is possible due to the lack of a backup environment.

These system usability and stability issues make the BUS inadequate for effectively and efficiently delivering care to LTSS clients. System instability jeopardizes access to the BUS for inputting functional assessments and determining LTSS eligibility and updating service plans, compromising timely service delivery when a client's needs are established or changed. Additionally, system instability could lead to data loss and

unplanned downtime, which jeopardizes federal reporting requirements, subsequently compromising federal financial participation.

Proposed Solution:

The Department requests funding in FY 2013-14 to correct the inadequacy of the BUS's IT infrastructure by creating a multi-environment infrastructure. The solution would be designed, implemented, and maintained by OIT. OIT would build separate environments for development, training, production, and disaster recovery. Further, the Department requests funding in FY 2014-15 and ongoing years for ongoing annual maintenance costs.

Implementing a multi-environment solution for the BUS would ensure efficient and effective delivery of services that are critical to maintaining the health of the Department's LTSS clients. Multiple environments support system stability during system changes, ease the training of new users, and help avoid data loss and unscheduled downtime in events such as hardware malfunctions.

If this request is not approved, the Department and OIT believe that the BUS is likely to fail in the near future. A BUS failure would jeopardize the Department's ability to enroll individuals in LTSS, maintain services plans, and compromise the Department's ability to submit required federal reports. These failures would not only put the Department's ability to draw federal funds for these services at risk, but could also potentially prevent clients from being served properly in the community.

Alternatively, the Department considered allowing the existing system to continue to function until it is replaced by the Department's new Medicaid Management Information System (MMIS). Per the Department's FY 2013-14 R-5 budget request, "Medicaid Management Information System Reprocurement," the Department is in the process of implementing a new MMIS that will replace the current BUS. While the Department expects the new MMIS will provide a more robust and stable solution for the BUS, the Department and OIT believe that the current state of the BUS is too prone to failure to wait until the expected implementation date of the new MMIS in FY 2016-17.

Anticipated Outcomes:

If approved, the proposed solution would move the BUS to a SDLC-compliant environment. As a result, the system would have improved performance due to proper testing, training, and disaster recovery environments added to the system's main production environment for running the application. These changes would ensure the stability of the system, preventing sluggish system performance, unscheduled downtime, and catastrophic failure or permanent data loss. As a result, the proposed solution would help ensure LTSS clients receive timely care by creating an efficient and effective multiple environment system, allowing concurrent development, training, production and disaster recovery.

The proposed solution would help the Department achieve three goals of the Department's five-year strategy plan. First, the proposed solution would help achieve the goal to "improve health outcomes, client experience, and lower per capita costs" by ensuring that approved services for LTSS clients are kept up-to-date and are available when the client needs them. Second, the proposed solution would help achieve the goal to "enhance efficiency and effectiveness through process improvement" by improving system stability

of the BUS application, ensuring that case managers and the Department are able to access the system timely and are able to effectively train to use the system. Lastly, the proposed solution would help achieve the goal to "ensure sound stewardship of financial resources" by ensuring that BUS data is timely reported to CMS to maintain federal financial support for HCBS waivers.

Assumptions and Calculations:

This request is based on estimates from OIT to implement and maintain a multi-environment solution for the BUS. In the attached appendix, see Table 1 for the implementation cost components of this request and Table 2 for the ongoing maintenance cost components. If this supplemental amendment is approved, the Department assumes implementation would occur in FY 2013-14 and ongoing annual maintenance costs would begin in FY 2014-15. Beginning in FY 2015-16, the Department assumes ongoing annual maintenance costs would be incorporated into the Department's common policy billing to OIT.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This request is due to new information. The BUS has recently shown symptoms of serious system inadequacies, prompting OIT to assess the application and make recommendations on how to mitigate the problems. These assessments occurred in fall 2013, leading to the solution proposed in this request.

Table 1 - Total Request for FY 2013-14					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	New Hardware	$126,447	$63,223	$63,224	50%
B	OIT Resource Hours for Implementation (500 hours at $150 per hour)	$75,000	$37,500	$37,500	50%
C	**Total**	**$201,447**	**$100,723**	**$100,724**	

Table 2 - Total Request for FY 2014-15 and Ongoing					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
A	Hardware Maintenance[1]	$60,122	$30,061	$30,061	50%
B	**Total**	**$60,122**	**$30,061**	**$30,061**	

[1] The Department anticipates that the first year of hardware maintenance (FY 2014-15) will be paid to OIT separately from the Department's common policy bill. However, the Department expects that subsequent years of hardware maintenance will be incorporated into the Department's common policy bill. This arrangment is due to the timing of when common policy billing adjustments can be made.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Technical Adjustment for Hospice Rate Increase
Priority Number: S-8

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	-	317,665	-	-	-
	FTE	-	-	-	-	-
	GF	-	317,665	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	-	-	-
NEW ITEM (4) Hospice Supplemental Payment	**Total**	-	317,665	-	-	-
	FTE	-	-	-	-	-
	GF	-	317,665	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	-	-	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: N/A
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: S-8
Technical Adjustment for Hospice Rate Increase
FY 2013-14 Supplemental Request

Cost and FTE

- The Department requests an increase of $317,665 General Fund in FY 2013-14 to account for General Fund only payments to hospice providers from an existing appropriation.

Current Program

- The General Assembly increased the Department's FY 2013-14 appropriation to account for a rate increase for hospice providers.

Problem or Opportunity

- It is unclear whether the Centers for Medicare and Medicaid Services (CMS) will approve the rate increase for hospice providers.
- Should CMS not approve the rate increase, State funds associated with the rate increase would not receive a federal match.
- Statutory authority does not exist to allow the Department to use General Fund on a program that is not authorized in statute.
- Further stipulations in the Long-Bill prevent the use of General Fund moneys without matching federal funds.

Consequences of Problem

- If CMS does not approve the rate increase to hospice providers, the Department would have no avenue through which to enact the General Assembly's previously approved rate increase for hospice providers.

Proposed Solution

- The Department requests a one-time $317,665 increase to General Fund appropriated for the rate increase for hospice providers to make a one-time General Fund only payment to hospice providers under the assumption that CMS would not approve the rate increase.
- Making one-time General Fund only payments to hospice providers in lieu of a rate increase would require an exception to the federal funding requirement of the Long-Bill (also known as the (M) headnote).
- The Department would require statutory authority to apply General Fund moneys to this rate increase without a federal match.

Department Priority: S-8
Request Detail: Technical Adjustment for Hospice Rate Increase

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund
Technical Adjustment for Hospice Rate Increase	$317,665	$317,665

Problem or Opportunity:

The General Assembly approved a rate increase for hospice providers in the FY 2013-14 Long Bill; however, it is currently unclear whether the Centers for Medicare and Medicaid Services (CMS) will also approve the rate increase. In the event that CMS does not approve the rate increase, the State would not receive a federal match on its spending for an increase to hospice rates. Because the Department's appropriation for Medical Services Premiums is subject to the (M) headnote in the Long Bill, the Department does not have the authority to use General Fund moneys without matching federal funds. Further, the Department has no explicit statutory authorization to give hospice providers a General Fund-only payment.

Proposed Solution:

The Department requests one-time funding of $317,665 General Fund in FY 2013-14 to make supplemental payments to hospice providers in the event that CMS does not approve the rate increase. This request is General Fund neutral in FY 2013-14 as compared to the Department's base budget; however, there is an offsetting reduction in the Department's November 1, 2013 R-1 request for Medical Services Premiums. Therefore, this supplemental request reflects a General Fund increase.

The General Assembly's originally approved rate increase for hospice providers included the assumption of a federal match to General Fund spending. Under the new assumption that CMS does not approve the rate increase, fulfilling the General Assembly's approval of the rate increase would require General Fund appropriation for this request be removed from a line item under the (M) headnote and transferred to a new line item that would allow General Fund spending without matching federal funds.

Anticipated Outcomes:

Approval of this request would allow the State to provide hospice providers with General Fund funding already appropriated for a rate increase by the General Assembly, regardless of whether CMS approves the rate increase. The Department would provide eligible hospices with a one-time supplemental payment using the available funding. The Department would establish a methodology based on Medicaid utilization, and if necessary, establish a framework for the payments in rule.

Assumptions and Calculations:

The Department has used documentation presented to the Joint Budget Committee (JBC) on March 18, 2013 to determine the available amount of General Fund.[1] The documentation shows that the JBC included an appropriation of $635,331 total funds in FY 2013-14 for rate increases for hospice providers; the General Fund share of that amount would be $317,665, assuming 50% federal financial participation.

The Department assumes that CMS would not approve the rate increase to hospice providers. If this is the case, then there would be no federal funding available for the rate increase. If CMS subsequently approves the rate increase, the Department would use the standard budget process to account for the available federal financial participation.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

The Department has received new information that CMS might not approve the rate increase to hospice providers.

[1] See page 105 of the linked PDF file: http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/staffcomebacks-03-18-13.pdf

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Behavioral Health Services Contracts Reprocurement
Priority Number: S-9

Dept. Approval by: Josh Block 1/2/14 Date

OSPB Approval by: 12/31/13 Date

- ☐ Decision Item FY 2014-15
- ☐ Base Reduction Item FY 2014-15
- ☑ Supplemental FY 2013-14
- ☐ Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	380,837,424	1,000,000	-	-	-
	FTE	-	-	-	-	-
	GF	151,060,588	500,000	-	-	-
	GFE	-	-	-	-	-
	CF	2,033,883	-	-	-	-
	RF	-	-	-	-	-
	FF	227,742,953	500,000	-	-	-
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	**Total**	380,837,424	1,000,000	-	-	-
	FTE	-	-	-	-	-
	GF	151,060,588	500,000	-	-	-
	GFE	-	-	-	-	-
	CF	2,033,883	-	-	-	-
	RF	-	-	-	-	-
	FF	227,742,953	500,000	-	-	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: N/A
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- The Department requests $1,000,000 total funds, including $500,000 General Fund and $500,000 federal funds for the behavioral health services contracts within Behavioral Health Community Programs. This funding is only for FY 2013-14 and does not require any additional FTE.

Current Program

- The Department conducts a contractor-delivered service that manages the behavioral health services for Medicaid members through five Behavioral Health Organizations (BHOs).
- The BHOs are regional, managed care providers that provide comprehensive behavioral health services to Medicaid members in Colorado.

Problem or Opportunity

- The current contracts for behavioral health services expire June 30, 2014, and the Department is required to competitively reprocure the contracts.
- To assure a smooth transition between vendors, the Department plans for a two to four month transition period, which would allow any incoming vendors enough time to be equipped to begin providing services in July 2014.

Consequences of Problem

- If this request is not approved, clients may experience delayed services, longer processing periods, or be forced to resubmit data, which means delayed or absent services, leading to poorer outcomes and higher costs. In some cases, it may violate federal law if clients are unable to obtain services.

Proposed Solution

- The Department requests one-time funding of $1,000,000 total funds for the reprocurement of the BHO managed care contracts to fund transition activities in the event of a change of vendors. In the event that all existing vendors are recontracted, no transition funds would be utilized.
- Vendors would be required to submit transition plans as part of the competitive bidding process; funding needs for the transition period would not be allowed to exceed $200,000 per contract.
- The incoming vendors would be able to transition into the contractual obligations with assistance from the outgoing vendors, and affected clients should notice little to no change in service delivery.

Department Priority: S-9
Request Detail: Behavioral Health Services Contracts Reprocurement

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund
Behavioral Health Services Contracts Reprocurement	$1,000,000	$500,000

Problem or Opportunity:

The Department is in the process of procuring five new behavioral health service contracts in 2014 and is requesting funding to assure that the transition of these contracts between potential new vendors does not affect service delivery for Medicaid clients.

The Department contracts with vendors to provide behavioral health services in five geographic service areas for the administration, management, and operation of the Behavioral Health Services Program. Medicaid members are assigned to one of the five Behavioral Health Organizations (BHOs) based on where they reside. For any client assigned to a BHO and with a qualifying behavioral health diagnosis, a BHO is responsible for providing access to services that include, but are not limited to the following: inpatient/outpatient hospital, emergency, vocational, residential, psychiatric, and medication management services. These contracts are competitively rebid every five years.

It has been the Department's recent experience that failing to provide a transition period can result in disruption of services and additional expenses incurred by the State. This was the case when the Department transitioned to a new non-emergent medical transportation broker in January 2013. Clients were unable to arrange for transportation, creating a barrier to access of health care services.

Proposed Solution:

The Department requests $1,000,000 total funds, comprised of $500,000 General Fund and $500,000 federal funds, for transition costs associated with a new vendor winning their respective bid of the behavioral health services contracts. This funding is for FY 2013-14 only, and does not require any additional FTE.

To assure a smooth transition between vendors, the Department has incorporated a two to four month transition period. There will not be an overlap in services and contract dates, but as a best practice, the Department believes that the transition to a new vendor should begin two to four months prior to the end-date of the incumbent vendor's contract. This ensures that as of the new contract start date, the incoming vendor will be able to provide services, and clients will experience no disruptions in care. All prospective

vendors will be required to submit a transition plan in their proposal addressing their specific needs; the vendors will address what they expect their administrative costs to be and submit what assistance they request from the Department. The new vendor will be responsible for leading, coordinating, and implementing the transition plan, with assistance from the Department. The goal is for the new vendor to demonstrate to the Department, prior to their contract start date, that operations are ready to begin and services can be rendered. Transition funding would be limited to the amount of funding approved by the General Assembly.

If this request is not approved, a delay in services could lead to poorer outcomes and higher costs. Specifically, the vendor may not have the financial capacity to complete key tasks associated with the startup process of a BHO. The new vendor will need to set up new provider agreements and networks and may not have all of the financial resources necessary to do this adequately. Also, it would be necessary for the new vendor to establish an infrastructure capable of billing/reimbursing their providers. It would be unreasonable to expect the vendor to absorb all of the costs, especially since they would need to meet State requirements relating to information security and processing guidelines. Another cost prior to the contract start date would be the designing and distribution of materials to members. These materials would include outreach to clients explaining the vendor transition that would allow for a smooth transition between providers with no disruption in services. Assuming no Department assisted transitional period for new vendors, it would be unrealistic to expect the new vendor to seamlessly begin providing services starting July 1, 2014.

Anticipated Outcomes:

If approved, this request would fund a one-time increase to the line items associated with these contracts to allow for a transitional overlap period between the outgoing and incoming vendors. As a result, the incoming vendor would be able to transition into their contractual obligations with assistance from the outgoing vendor and the Department, while maintaining optimal health care access and outcomes for the clients.

This request is in line with all five objectives of the Department's performance plan. By mitigating disruptions between outgoing and incoming behavioral health services vendors, the Department is ensuring those who are eligible for Medicaid mental health services have needed services available leading to greater health outcomes.

Assumptions and Calculations:

The Department assumes that a new BHO contractor would need some degree of funding to help with the process of setting up the infrastructure necessary to become a fully functioning BHO by the contract start date. Some examples of the administrative tasks that the new vendor would need to do include setting up provider agreements and networks and establishing infrastructure capable of billing/reimbursing and collecting/disseminating data. Bidders would be required to detail a transition plan as part of their responses to the Department's Request for Proposals.

The Department assumes that the funding assistance that any new vendors would be allowed would be capped at a maximum of $200,000 per contract. In the event that all of the current BHO vendors are re-contracted by the Department, no transition funds will be utilized.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This request is a result of new data resulting in substantive changes in funding needs. Based on the Department's 2013 experience with other contracts which were transitioning between vendors, the Department reevaluated its policies and procedures related to contract transitions. The January 2, 2014 supplemental deadline is the first opportunity since that point to request additional funding for FY 2013-14.