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

	Decision Item FY 08-09 ☐	Base Reduction Item FY 08-09 ☐	Supplemental FY 07-08 ☑	Budget Request Amendment FY 08-09 ☐
Request Title:	General Fund Request for CMS Disallowances			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** January 2, 2008
Priority Number:	S-15	**OSPB Approval:**		**Date:** 12/31/07

	Fund	1 Prior-Year Actual FY 06-07	2 Appropriation FY 07-08	3 Supplemental Request FY 07-08	4 Total Revised Request FY 07-08	5 Base Request FY 08-09	6 Decision/ Base Reduction FY 08-09	7 November 1 Request FY 08-09	8 Budget Amendment FY 08-09	9 Total Revised Request FY 08-09	10 Change from Base (Column 5) FY 09-10
Total of All Line Items	Total	205,690,153	227,631,464	10,926,331	238,557,795	239,425,103	0	239,425,103	0	239,425,103	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	89,832,730	91,315,646	10,926,331	102,241,977	95,539,317	0	95,539,317	0	95,539,317	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	12,953,226	22,836,532	0	22,836,532	24,510,250	0	24,510,250	0	24,510,250	0
	FF	102,904,197	113,479,286	0	113,479,286	119,375,536	0	119,375,536	0	119,375,536	0
(5) Other Medical Services, SB 97-101 Public School Health Services	Total	21,049,585	31,327,813	10,438,941	41,766,754	31,322,948	0	31,322,948	0	31,322,948	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	10,438,941	10,438,941	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	10,472,200	16,007,021	0	16,007,021	16,007,021	0	16,007,021	0	16,007,021	0
	FF	10,577,385	15,320,792	0	15,320,792	15,315,927	0	15,315,927	0	15,315,927	0
(3) Medicaid Mental Health Community Programs, (A) Mental Health Capitation Payments	Total	184,640,568	196,303,651	487,390	196,791,041	208,102,155	0	208,102,155	0	208,102,155	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	89,832,730	91,315,646	487,390	91,803,036	95,539,317	0	95,539,317	0	95,539,317	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	2,481,026	6,829,511	0	6,829,511	8,503,229	0	8,503,229	0	8,503,229	0
	FF	92,326,812	98,158,494	0	98,158,494	104,059,609	0	104,059,609	0	104,059,609	0

Letternote revised text:

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

IT Request: ☐ Yes ☑ No

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

CHANGE REQUEST for FY 07-08 BUDGET REQUEST CYCLE

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

SELECT ONE (click on box):

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

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

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

Short Summary of Request:

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

Background and Appropriation History:

Child Placement Agencies

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

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

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

Public School Health Services Program

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

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

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

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

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

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

Child Placement Agencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Public School Health Services Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Consequences if Not Funded:

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

Calculations for Request:

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

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

Impact on Other Government Agencies: None.

Cost Benefit Analysis:

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

Statutory and Federal Authority:

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

(i) The actuarial certification of the capitation rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance Measures: This Change Request affects the following Performance Measures:

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