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

Decision Item FY 2010-11	☑	**Base Reduction Item FY 2010-11** ☐	**Supplemental FY 2009-10** ☐	**Budget Amendment FY 2010-11** ☐
Request Title:	Medicaid Management Information System Cost Adjustment			
Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 2, 2009 10/15/09
Priority Number:	DI-5	**OSPB Approval:**		**Date:** 10-29-09

	Fund	1 Prior-Year Actual FY 2008-09	2 Appropriation FY 2009-10	3 Supplemental Request FY 2009-10	4 Total Revised Request FY 2009-10	5 Base Request FY 2010-11	6 Decision/ Base Reduction FY 2010-11	7 November 1 Request FY 2010-11	8 Budget Amendment FY 2010-11	9 Total Revised Request FY 2010-11	10 Change from Base (Column 5) FY 2011-12
Total of All Line Items	**Total**	22,200,548	27,451,189	0	27,451,189	36,883,007	269,528	37,152,535	0	37,152,535	269,528
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,299,911	6,006,676	0	6,006,676	6,205,903	65,361	6,271,264	0	6,271,264	65,361
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	540,118	1,176,844	0	1,176,844	2,488,901	2,830	2,491,731	0	2,491,731	2,830
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,167,341	0	20,167,341	28,087,875	201,337	28,289,212	0	28,289,212	201,337
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	**Total**	22,200,548	27,451,189	0	27,451,189	36,883,007	269,528	37,152,535	0	37,152,535	269,528
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,299,911	6,006,676	0	6,006,676	6,205,903	65,361	6,271,264	0	6,271,264	65,361
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	540,118	1,176,844	0	1,176,844	2,488,901	2,830	2,491,731	0	2,491,731	2,830
	CFE/RF	100,328	100,328	0	100,328	100,328	0	100,328	0	100,328	0
	FF	16,260,191	20,167,341	0	20,167,341	28,087,875	201,337	28,289,212	0	28,289,212	201,337

Non-Line Item Request: None.

Letternote Revised Text: The cash funds amount of $2,491,731 for FY 2010-11 includes $1,897,689 from the Hospital Provider Fees, $284,899 from the Health Care Expansion Fund, $288,358 from the Children's Basic Health Plan Fund, $1,885 from the Colorado Autism Treatment Fund, and $18,900 from the Department of Health Care Policy and Financing Cash Fund (Fund 23G).

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX, CF: Children's Basis Health Plan Trust Fund, Fund 11G

Reappropriated Funds Source, by Department and Line Item Name: None.

Approval by OIT? Yes: ☐ No: ☐ N/A: ☑

Schedule 13s from Affected Departments: None.

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-5
Change Request Title:	Medicaid Management Information System Cost Adjustments

SELECT ONE (click on box):

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

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

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

Short Summary of Request: This request is for $269,528 total funds for an annual cost adjustment and increase for the fixed price portion of the Medicaid Management Information System (MMIS) contract.

Background and Appropriation History: Section 1903(r)(1) of the Social Security Act states that, to receive federal funding for use of automated data systems in administration of the Medicaid program, the State must have a mechanized claims processing and information retrieval system. The Centers for Medicare and Medicaid Services' State Medicaid Manual, Chapter 11, states that for Medicaid purposes, the mechanized system is the Medicaid Management Information System. The MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The system may be operated by either a state agency or a fiscal agent, which is a private contractor hired by the state.

Section 1903(a) of the Social Security Act authorizes a 90% federal reimbursement rate for design, development, or installation of an MMIS and a 75% reimbursement for operation of an MMIS. The Centers for Medicare and Medicaid Services' State Medicaid

Manual identifies the specific types of MMIS costs that are allowable for federal reimbursement. For such costs to be allowable at the enhanced rate of 75%, they must be related to the operations of the MMIS for ongoing automated processing of claims, payments, and reports.

In Colorado, the MMIS processes or adjudicates claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants for payment are produced by the State based on the information electronically transmitted from the MMIS.

Beginning in March 1, 2004, a portion of the MMIS contract was converted to a fixed price contract. This move toward a fixed price contract was the result of three managed care organizations leaving the Medicaid market in FY 2002-03 and the subsequent increase in claims processing for moving these clients into a fee-for-service environment. By moving to a fixed price contract, the Department was able to contain costs related to claims processing, prior authorization reviews, and some administrative or operational functions. Any remaining functions provided by the fiscal agent, such as development costs and postage that were more difficult to predict, were excluded from fixed price and paid based on actual expenditures.

During the FY 2006-07 reprocurement process, the request for proposals submitted to the public specified that the Department wanted to continue the fixed price arrangement but include more administrative or operational functions under the fixed price portion. As a result of this procurement, on July 1, 2007, the MMIS fixed price contract now covers:

- base operations, including administrative costs;
- regular Medicaid claims processing;
- Children's Basic Health Plan capitation payments processing;
- Breast and Cervical Cancer Prevention and Treatment claims processing;
- Nurse Home Visitor claims processing;
- SB 04-177 Autism claims processing and prior authorization reviews;

- orthodontia prior authorization reviews;
- Old Age Pension State Medical Program claims processing;
- school based health claims processing;
- health care expansion population claims processing and disk maintenance;
- health care expansion population pharmacy prior authorization reviews;
- drug rebate analysis and management system; and
- regular Medicaid pharmacy prior authorization reviews.

The only two items that remain outside the fixed price portion are: 1) development costs for systems or programming changes to implement new legislation and 2) postage costs. Postage costs were excluded from the fixed price portion due to the Department not being able to determine when the United States Post Office would increase postage rates.

After the incumbent fiscal agent was reselected, the Department entered into negotiations to finalize the contract. Part of these negotiations included an annual cost adjustment for administrative and operational costs incurred by the contractor and a Memorandum of Renegotiation.

Prior Fixed Price Contract Adjustments

Through negotiations, the Department and fiscal agent agreed to fixed price amounts for the first three base years of the contract or FY 2007-08, FY 2008-09, and FY 2009-10. For FY 2007-08 the Department was able to negotiate a lower fixed price amount relative to FY 2006-07 while including more functions under the fixed price portion of the contract. As a result, the Department submitted Stand Alone Budget Amendment, BA-3, *"Adjustments to Fixed Price for Medicaid Management Information System Contract in FY 07-08"*on January 24, 2007 requesting a reduction in the amount of $1,450,102 total funds. However, during FY 2007-08 Figure Setting on February 14, 2007, the Joint Budget Committee (JBC) approved two additional reductions to the contract, which included $290,000 for pharmacy prior authorizations and $35,000 for postage costs. The total reduction amounted to $1,775,102 total funds and was appropriated in the

Department's Long Bill, SB 07-239. To fund the contract increase for FY 2008-09, the Department submitted DI-5, *"MMIS Fixed Price Increase"*, on November 1, 2007 requesting $313,010 total funds. During FY 2008-09 Figure Setting on March 11, 2008, the JBC approved the Department's request and appropriated the additional funding in the Department's Long Bill, HB 08-1375. Finally, for FY 2009-10, the Department submitted DI-10, *"Annual Medicaid Management Information System Cost Adjustment"*, on November 3, 2008 requesting $290,117 total funds for the third base year contract increase. The Department's request was approved by the JBC and appropriated in the Department's Long Bill, SB 09-259. While each increase would allow the fiscal agent to cover increases for their internal operating expenditures, the additional funding is not directly associated with any increase in operational responsibility or claims volume. The following table shows the annual contract adjustments previously agreed to by the Department and fiscal agent, as well as the estimated figure for FY 2010-11.

Table 1: MMIS Fixed Price Contract Cost For Base Years, 1 – 3

Base Year	Fiscal Year	Fixed Price Amount	Percent Increase
1	FY 2007-08	$21,136,463	N/A
2	FY 2008-09	$21,446,002	1.46%
3	FY 2009-10	$21,736,119	1.35%
	FY 2010-11	*$22,005,647*	*1.24%*

Italicized font in table denotes estimated figures for FY 2010-11. See Table 4.

Memorandum of Renegotiation

Prior to July 1, 2007, the Department and fiscal agent did not include any contract stipulations to request renegotiation of the contract should annual claims volume exceed a specified threshold. Rather both parties had a standing verbal agreement to renegotiate in the event of higher than expected annual claims volume. However, under the existing MMIS contract, which was executed on July 1, 2007, the Department and fiscal agent drafted a Memorandum of Renegotiation to describe the conditions upon which the fiscal agent could request renegotiation of the fixed price contract: should claims volume exceed

34 million, it would prompt renegotiation for a higher claims volume threshold and consequently a higher fixed price amount.

The portion of the Memorandum of Renegotiation that refers to renegotiation for increased claims volume reads as follows:

> "*Reference Appendix H, Schedule C, pages H-4 through H-6, concerning the anticipated annual claims volume increasing to 35-40 million claims after the third (3rd) year of the base contract. The Department and the Contractor agree that the current claim volume is approximately 20,000,000 fee-based claims, approximately 7,000,000 capitated claims, and an anticipated 7,000,000 claims for encounters claims. The Parties agree that should claim volume rise above 20% from levels stated on fee-based claims, capitated claims, or encounters claims then the Contractor is allowed to request renegotiation of the price for the optional contract years, after the three (3)- year base period expires.*"

Upon finalizing claims volume for FY 2008-09, the Department learned that fee-based claims volume exceeded a 20% increase over the stated base level of 20 million. Based on this information and the fact the third base year expires on June 30, 2010, the fiscal agent is permitted by contract to request renegotiation of the fixed price contract beginning FY 2010-11. The following table depicts claims volume for fee-based claims for the first two base years, FY 2007-08 and FY 2008-09.

Table 2: Growth in Fee-based Claims Over Base Levels

Fiscal Year	Contract Base Level for Fee-based Claims	Actual Fee-based Claims	Percent Difference from Base Level
FY 2007-08	20,000,000	21,073,218	5.37%
FY 2008-09	20,000,000	25,917,676	29.59%

During an informal meeting in July 2009, the fiscal agent informed the Department it would request renegotiation of the fixed price contract and begin formal meetings in

October or November 2009. After the Department finalizes this negotiation, it will submit a budget request through the normal budget process to fund the increase in the fixed price contract for processing a higher volume of claims.

General Description of Request: This request is for $269,528 in additional funds to fund a contract adjustment for the fixed price portion of the MMIS contract.

Based on Chapter 2 of the State Medicaid Manual, Section 2080.4, the Department may extend the MMIS contract up to eight years including all optional contract renewal periods. After FY 2009-10, the Department may extend the contract for an additional five years before submitting the MMIS contract for reprocurement.

While the existing MMIS contract does not indicate any final fixed price amounts beyond the third base year or FY 2009-10, the Department anticipates the renegotiation talks with the fiscal agent to produce final figures for the remaining five years under contract. Since renegotiation talks are scheduled to begin in October or November 2009, the Department needs to estimate the contract increase for FY 2010-11. Therefore, it estimates the fixed price amount would be $22,005,647 for continuation of MMIS services by the fiscal agent. This amount represents an increase of 1.24% or $269,528 over the FY 2009-10 fixed price amount (see Table 4).

While the increase would allow the fiscal agent to cover increases for their internal operating expenditures during FY 2010-11, the additional funding is not directly associated with any increase in operational responsibility or claims volume.

Consequences if Not Funded: If the request for additional funding is not approved, the Department may need to stop claims processing with approval required from the Joint Budget Committee five days before the end of the fiscal year based on current claim volume in order to manage expenditures under the existing appropriations. Consider the total requested fixed price amount of $22,005,647 for FY 2010-11 divided by 365 days. This yields an average daily rate of claims processing costs of $60,289. Dividing the requested increase amount of $269,528 by the average daily rate of $60,289 equates to approximately five days. The

five days would be in addition to the one week delay in paying provider payments legislated under SB 09-265.

Additionally, if the Department experiences any delay in paying provider payments, it may result in noncompliance of the prompt pay requirements under the American Recovery and Reinvestment Act. The prompt pay provisions require that the state pay 90% of clean claims within 30 days of the date of receipt of the claims and that 99% of claims are paid within 90 days of the date of receipt.

Calculations for Request:

Summary of Request FY 2010-11	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**
Total Request	$269,528	$65,361	$2,830	$201,337
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$269,528	$65,361	$2,830	$201,337

Summary of Request FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**
Total Request	$269,528	$65,361	$2,830	$201,337
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$269,528	$65,361	$2,830	$201,337

Table 3: Funding Splits Between Medicaid and Children's Basic Health Plan for Annual MMIS Contract Increase					
Program Splits	**Total Percentage**	**Total Costs**	**General Fund**	**Cash Funds**	**Federal Funds**
Total Costs	100%	$269,528	$65,361	$2,830	$201,337
Medicaid Percentage	97%		25%	0%	75%
Medicaid Costs		$261,442	$65,361	$0	$196,081
Children's Basic Health Plan Percentage	3%		0%	35%	65%
Children's Basic Health Plan Costs		$8,086	$0	$2,830	$5,256

Cash Funds Projections:

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

Assumptions for Calculations:

The Department assumes that the requested increase for Medicaid would be funded with 75% federal financial participation for regular operations of the MMIS. The 75% federal financial participation is applied to the 97% Medicaid portion of the total funding for the request.

For this request, the Children's Basic Health Plan contribution to the total cost is assumed to be 3%. Historically, this percentage has been determined by the ratio of capitations paid for the Children's Basic Health Plan in the MMIS compared to the total forecasts of claims and capitations paid. Federal financial participation for the Title XXI, the Children's Basic Health Plan, is 65%.

Fixed Price Contract Adjustment

The estimated fixed price percent increase for FY 2010-11 was calculated by averaging the percent increases from the prior five fiscal years. See the following table.

Table 4: Historical Percent Increases for MMIS Fixed Price Contract	
Fiscal Year	**Fixed Price Percent Increase**
FY 2004-05	N/A
FY 2005-06	3.7%
FY 2006-07	3.1%
FY 2007-08	-3.4%
FY 2008-09	1.46%
FY 2009-10	1.35%
FY 2010-11	*1.24%*

Data source: Percentage increases were calculated from negotiated contract amounts with fiscal agent, ACS. Italicized font in table denotes estimated figure for FY 2010-11.

Cost Benefit Analysis:

FY 2010-11 Cost Benefit Analysis	**Benefit**	**Cost**
Request	The fixed price agreement continues to place much of the risk onto the fiscal agent for any changes in caseload and utilization.	$269,528 total funds in FY 2010-11 of which $65,361 is General Fund.
Consequences if not funded	No additional General Fund expenditure for annual contract adjustment.	The Department risks non-payment of Medicaid claims during the last five days of the fiscal year in order to manage expenditures within the existing appropriation. Moreover, any delay in paying provider payments, the Department risks loss of enhanced funding from the American Recovery and Reinvestment Act if it does not pay clean claims within 30 days of receipt.

Statutory and Federal Authority:

25.5-4-204 (3), C.R.S. (2009) *The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that: (b) Adequate financing is available to facilitate the implementation and maintenance of the system. Financing may include, but is not limited to, federal funds, appropriations from the general fund, provider transactions fees, or any other financing mechanisms which the state department may impose, and grants or contributions from public or private entities.*

§1903 (a) of the Social Security Act [42 U.S.C. 1396b] (a) …*the Secretary…shall pay to each State which has a plan approved under this title…(3) an amount equal to – …(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State)…which are approved by the Secretary…*

The American Recovery and Reinvestment Act (ARRA) provides funding to increase the Federal Medical Assistance Percentage (FMAP) for Medicaid services. To receive the enhanced FMAP, this Act requires states to report monthly to the U.S. Department of Health and Human Services on the states' compliance with the Medicaid prompt pay requirements (42 U.S.C. 1396a(a)(37)(A)), which specifies that the state must pay 90% of clean claims within 30 days of the date of receipt of the claims and that 99% of claims are paid within 90 days of the date of receipt. States must also provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program. Existing prompt payment provisions apply to practitioners, in individual or group practice, and the ARRA amendment extends its application to nursing facilities and hospitals. States are prevented from receiving the increased

FMAP for claims received by the state for days during any period when the state is out of compliance with the Medicaid prompt pay requirements.

Performance Measures:

Increasing funds for the fixed price portion of the Medicaid Management Information System contract will help the Department achieve its objective to monitor expenditures for programs managed by the Department to ensure accurate financial reporting at all times.