

**Schedule 13**  
**Funding Request for the 2012-13 Budget Cycle**

Department: Health Care Policy and Financing

Request Title: Hospital Provider Fee Administrative True-up

Priority Number: S-7

Dept. Approval by: John Bartholomew *JTB* 12/20/11 Date

OSPB Approval by: *Eric J. R. Sch...* 12/27/11 Date

<input type="checkbox"/>	Decision Item FY 2012-13
<input type="checkbox"/>	Base Reduction Item FY 2012-13
<input checked="" type="checkbox"/>	Supplemental FY 2011-12
<input type="checkbox"/>	Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
<b>Total of All Line Items</b>	<b>Total</b>	\$96,766,237	\$3,920,338	\$98,483,655	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$27,485,261	\$0	\$27,272,835	\$0	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$9,809,945	\$2,023,541	\$11,183,319	\$0	\$0
	RF	\$121,320	\$0	\$121,810	\$0	\$0
	FF	\$59,349,711	\$1,896,797	\$59,905,691	\$0	\$0
<b>(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects<sup>a</sup></b>	<b>Total</b>	\$6,596,052	(\$120,000)	\$6,410,052	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,430,918	\$0	\$1,487,168	\$0	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$721,750	(\$60,000)	\$497,500	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$4,443,384	(\$60,000)	\$4,425,384	\$0	\$0
<b>(1) Executive Director's Office; (C) Information Technology Contracts, Centralized Eligibility Vendor Contract Project<sup>b</sup></b>	<b>Total</b>	\$2,221,482	\$2,230,940	\$4,584,648	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$0	\$0	\$0	\$0	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$964,169	\$1,246,853	\$2,129,467	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$1,257,313	\$984,087	\$2,455,181	\$0	\$0
<b>(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards<sup>c</sup></b>	<b>Total</b>	\$120,000	\$9,240	\$120,000	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$59,203	\$0	\$59,203	\$0	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$0	\$4,620	\$0	\$0	\$0
	RF	\$1,593	\$0	\$1,593	\$0	\$0
	FF	\$59,204	\$4,620	\$59,204	\$0	\$0
<b>(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration<sup>d</sup></b>	<b>Total</b>	\$33,547,878	(\$2,361,502)	\$34,008,773	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$10,300,790	\$0	\$10,373,188	\$0	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$6,513,282	(\$1,180,751)	\$6,671,332	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$16,733,806	(\$1,180,751)	\$16,964,253	\$0	\$0

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14	
		1	2	3	4	5	
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14	
	Fund						
<b>(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration (new line item) <sup>e</sup></b>		<b>Total</b>	\$0	\$2,361,502	\$0	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0	
	GF	\$0	\$0	\$0	\$0	\$0	
	GFE	\$0	\$0	\$0	\$0	\$0	
	CF	\$0	\$1,180,751	\$0	\$0	\$0	
	RF	\$0	\$0	\$0	\$0	\$0	
	FF	\$0	\$1,180,751	\$0	\$0	\$0	
<b>(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach <sup>f</sup></b>		<b>Total</b>	\$5,213,157	\$90,506	\$4,895,961	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0	
	GF	\$2,550,470	\$0	\$2,376,649	\$0	\$0	
	GFE	\$0	\$0	\$0	\$0	\$0	
	CF	\$56,109	\$45,253	\$71,333	\$0	\$0	
	RF	\$0	\$0	\$0	\$0	\$0	
	FF	\$2,606,578	\$45,253	\$2,447,979	\$0	\$0	
<b>(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts <sup>g</sup></b>		<b>Total</b>	\$7,670,839	\$243,612	\$7,801,722	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0	
	GF	\$2,100,370	\$0	\$2,100,370	\$0	\$0	
	GFE	\$0	\$0	\$0	\$0	\$0	
	CF	\$60,537	\$53,795	\$100,654	\$0	\$0	
	RF	\$0	\$0	\$0	\$0	\$0	
	FF	\$5,509,932	\$189,817	\$5,600,698	\$0	\$0	
<b>(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System <sup>h</sup></b>		<b>Total</b>	\$8,983,839	\$1,466,040	\$8,895,282	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0	
	GF	\$4,461,609	\$0	\$4,416,786	\$0	\$0	
	GFE	\$0	\$0	\$0	\$0	\$0	
	CF	\$14,428	\$733,020	\$14,520	\$0	\$0	
	RF	\$19,399	\$0	\$19,889	\$0	\$0	
	FF	\$4,488,403	\$733,020	\$4,444,087	\$0	\$0	
<b>Letternote Text Revision Required?</b>		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>		If yes, describe the Letternote Text Revision:			
a Of this amount, <del>\$2,545,858</del> \$2,485,858 shall be from the Hospital Provider Fee Cash Fund...							
b Of this amount, <del>\$964,169</del> \$2,211,022 shall be from the Hospital Provider Fee Cash Fund...							
c Of this amount \$4,620 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.							
d Of this amount, <del>\$1,180,751</del> \$0 shall be from the Hospital Provider Fee Cash Fund...							
e Of this amount, \$1,180,751 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.							
f Of this amount, <del>\$56,109</del> \$101,362 shall be from the Hospital Provider Fee Cash Fund...							
g Of this amount <del>\$60,537</del> \$114,332 shall be from the Hospital Provider Fee Cash Fund...							
h Of this amount. \$733,020 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.							
Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A); FF: Title XIX, Title XXI							
Reappropriated Funds Source, by Department and Line Item Name:							
Approval by OIT? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Not Required: <input checked="" type="checkbox"/>							
Schedule 13s from Affected Departments: Department of Human Services, Governor's Office of Information Technology							
Other Information: N/A.							

**Schedule 13**  
**Funding Request for the 2012-13 Budget Cycle**

Department: Governor's Office of Information Technology  
 Request Title: Hospital Provider Fee Administrative True-up  
 Priority Number: HCPF S-12

Dept. Approval by: [Signature] Date \_\_\_\_\_  
 OSPB Approval by: [Signature] 12/29/11 Date

- Decision Item FY 2012-13
- Base Reduction Item FY 2012-13
- Supplemental FY 2011-12
- Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	6
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
<b>Total of All Line Items</b>	<b>Total</b>	19,007,729	1,466,040	19,127,288		
	FTE	-	-	-		
	GF	-	-	-		
	GFE	-	-	-		
	CF	-	-	-		
	RF	19,007,729	1,466,040	19,127,288		
	FF	-	-	-		
<b>(5) Office of Information Technology, (E) Colorado Benefits Management System, Operating Expenses</b>	<b>Total</b>	19,007,729	1,466,040	19,127,288	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	1,466,040	19,127,288	-	-
	FF	-	-	-	-	-

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

Cash or Federal Fund Name and COFRS Fund Number: COFRS Fund 613 (IT Revolving Fund)  
 Reappropriated Funds Source, by Department and Line Item Name: User charges  
 Approval by OIT? Yes:  No:  Not Required:   
 Schedule 13s from Affected Departments: Departments of Health Care Policy & Financing  
 Other Information:



# DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper  
Governor

*FY 2011-12 Supplemental Request  
January 3, 2012*

Susan E. Birch  
Executive Director

*Department Priority: S-7*

*Request Title: Hospital Provider Fee Administrative True-up*

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Request	\$3,920,338	\$0	0.0

### **Request Summary:**

The Department requests an increase of \$3,920,338 total funds, comprised of \$2,023,541 hospital provider fee cash funds and \$1,896,797 federal funds in FY 2011-12, in order to true-up appropriations with actual need for hospital provider fee administration.

To date, appropriations for hospital provider fee administration have for the most part been directly from the original fiscal note developed for HB 09-1293. Since then however, implementation dates of programs have changed and caseload forecasts have begun to deviate from those originally estimated, requiring a true-up to bring the appropriations in line with actual need based on the current caseload and program implementation dates. This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals and that the fees collected for administration are being allocated accurately.

HB 09-1293 authorized the Department to collect a hospital provider fee for the purpose of obtaining federal financial participation, and to use the combined funds to increase reimbursement to hospitals that provide medical care under the State Medical Assistance Program and the Colorado Indigent Care Program (CICP), increase the number of persons covered by public medical assistance, and to pay the administrative costs of the Department in implementing and

administering the program. This request is to true-up the hospital provider fee appropriations to administrative lines that are required in the implementation and administration of the program. All adjustments to medical, mental health, and dental costs due to updated caseload forecasts for Medicaid and Children's Basic Health Plan (CHP+) expansions under the hospital provider fee are incorporated in the Department's November 1, 2011 R-1, R-2, and R-3.

### **Anticipated Outcomes:**

This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals and that the fees collected for administration are being allocated accurately.

### **Assumptions for Calculations:**

To estimate the adjustments required to individual line items, the most recent caseload forecasts for FY 2011-12 and FY 2012-13 are used with the goal of equalizing the hospital provider fee spending authority with the proportion of the expansion populations funded under the hospital provider fee relative to the appropriate total caseload. Each line item is adjusted to reflect the proportion of the relevant expansion caseload to the total caseload. Appendix A outlines which proportions are used to adjust each line item in this request, along with

justifications for each adjustment. Please refer to Table B.1 in Appendix B for the calculations of the different percentages used to adjust the various line items in the request.

**Consequences if not Funded:**

If this request is not approved, funding would be appropriated to the administrative functions of the hospital provider fee program in a disproportionate and inadequate manner. These appropriations would be for the most part directly from the original fiscal note, which was developed more than two years ago. Since then, the need for administrative appropriations has deviated due to adjusted expansion population implementation dates and updated caseload forecasts. This results in inefficiencies in the hospital provider fee model, and may result in over-collection of provider fee or the need to request spending authority at a later date.

**Impact to Other State Government Agency:**

There would be impacts to the Department of Human Services and to the Governor’s Office of Information Technology.

See Attachment A for financial impacts.

**Cash Fund Projections:**

Cash Funds used in this request are exclusively from the Hospital Provider Fee Cash Fund, which is created at 25.5-4-402.3 C.R.S. (2011). Revenue into the fund is from provider fees collected from hospitals, which is modeled to match projected expenditures. For more detail, please refer to the Colorado Health Care Affordability Act Update included in the Department’s November 1, 2011 Budget Request.

<b>Cash Fund Name</b>	<b>Hospital Provider Fee Cash Fund</b>
<b>Cash Fund Number</b>	24A
<b>FY 2010-11 Expenditures</b>	\$426,069,052
<b>FY 2010-11 End of Year Cash Balance</b>	\$22,198,436
<b>FY 2011-12 End of Year Cash Balance Estimate</b>	\$22,198,436
<b>FY 2012-13 End of Year Cash Balance Estimate</b>	\$22,198,436
<b>FY 2013-14 End of Year Cash Balance Estimate</b>	\$22,198,436

**Supplemental, 1331 Supplemental, or Budget Amendment Criteria:**

New data has resulted in a substantive change in funding need.

**Current Statutory Authority or Needed Statutory Change:**

25.5-4-402.3 C.R.S. (2011) establishes the Hospital Provider Fee and authorizes the Department to charge and collect hospital provider fees.

25.5-4-402.3 (3) (a) (I) (III) C.R.S. (2011) and 25.5-4-402.3 (4) (b) (VI) C.R.S. (2011) allow the provider fee and federal matching funds collected to be used to pay the administrative costs of the Department in implementing and administering the Hospital Provider Fee.

## Appendix A: Line Item Detailed Narrative

### **General Administration, Legal Services and Third Party Recovery Legal Services and Administrative Law Judge Services**

These lines are for legal services provided by the Department of Law and administrative law judges and paralegals from the Office of Administrative Courts. The services cover the Department as a whole, and will be adjusted to be proportionate with all of the expansions funded under the Hospital Provider fee relative to Medicaid and the Children's Basic Health Plan (CHP+) in total. This adjustment, however, is not being done through this request; rather, it will be done through the Common Policy adjustments toward the end of FY 2011-12. At that time, the Department will collaborate with the affected Departments to ensure that the FY 2011-12 and FY 2012-13 appropriations from the hospital provider fee are brought in line with the proportion of all expansion populations relative to total caseload in Medicaid and CHP+.

### **General Administration, General Professional Services and Special Projects**

The appropriation to this line item is used to fund some of the contracts required to implement and administer the hospital provider fee. These contracted activities include assisting the Department in responding to questions from the Centers for Medicare and Medicaid Services (CMS) after submission of the provider fee model each year, reviewing the Department's upper payment limit calculations and recommending any necessary changes, assisting in development of benefit packages and cost-effective rates for the Disabled Buy-In and the Adults without Dependent Children (AwDC) programs, and assistance in the development of hospital quality incentive payments. The original fiscal note for HB 09-1293 also included funding of \$120,000 for a project manager for the significant and complex information technology work required to implement the bill. Since the implementation of HB 09-1293 however, the Department has been able to perform this function internally, and therefore the Department requests to reduce this appropriation by \$120,000 in FY 2011-12.

### **Information Technology Contracts and Projects, Information Technology Contracts**

This line contains funding for the Medicaid Management Information System (MMIS), which is a system of hardware and software used to process Medicaid claims and manage information about Medicaid and CHP+ beneficiaries and services. In addition to the FY 2011-12 Long Bill appropriation of \$4,402,843, the Department also received rollforward authority in the amount of \$1,087,619 for hospital provider fee projects that were not completed in FY 2010-11, resulting in total FY 2011-12 spending authority of \$5,490,462. The Department is adjusting the MMIS appropriation for hospital provider fee projects in its FY 2012-13 BA-6 "MMIS Technical Adjustments."

### **Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project**

This line has a FY 2011-12 appropriation of \$2,221,482. The Department did not expend any of the appropriation to this line item in FY 2009-10 or FY 2010-11 because the volume triggers included in the Department's contract with Maximus, the CHP+ eligibility and enrollment vendor, were not reached. As such, the funding was not needed. However, effective FY 2011-12, the Department has executed a contract amendment with Maximus in the amount of \$843,877 due to increased call volume per the terms of the eligibility and enrollment contract. The Department is requesting to adjust the FY 2011-12 appropriation to the amounts shown in Table A.1 below. The updated estimates are based on the actual contract amendment for the CHP+ expansion, updated caseload estimates for the Disabled Buy-In and AwDC expansions, and the Department's implementation of a waitlist for the AwDC population, which the Centralized Eligibility Vendor will manage.

<b>Table A.1: Revised Centralized Eligibility Vendor Costs</b>			
	<b>FY 2011-12</b>	<b>FY 2012-13</b>	<b>FY 2013-14</b>
<b>Estimated Eligibility and Enrollment Vendor Cost for CHP+- Eligibility</b>	<b>\$843,877</b>	<b>\$843,877</b>	<b>\$843,877</b>
State Costs (Provider Fee)	\$406,749	\$406,749	\$406,749
Federal Funds	\$437,128	\$437,128	\$437,128
<b>Estimated Eligibility and Enrollment Vendor Cost for Disabled Buy-In and AwDC</b>	<b>\$3,608,545</b>	<b>\$4,254,910</b>	<b>\$5,306,068</b>
State Costs (Provider Fee)	\$1,804,273	\$2,127,455	\$2,653,034
Federal Funds	\$1,804,272	\$2,127,455	\$2,653,034
<b>Total</b>	<b>\$4,452,422</b>	<b>\$5,098,787</b>	<b>\$6,149,945</b>
State Costs (Provider Fee)	\$2,211,022	\$2,534,204	\$3,059,783
Federal Funds	\$2,241,400	\$2,564,583	\$3,090,162

### **Medical Identification Cards**

Currently, this line does not have a hospital provider fee appropriation as total funding to this line has historically exceeded overall need. Going forward however, with the growing and upcoming expansions funded under the hospital provider fee, the Department is requesting to include a hospital provider fee appropriation in proportion with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. Based on the most recent caseload estimates, the Department is requesting total funds appropriations to this line item of \$9,240 in FY 2011-12.

### **Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations**

This line has a FY 2011-12 appropriation of \$5,602,536. This funding was for two separate items: \$3,074,400 for Hospital Outstationing and \$2,528,136 for disability determinations for the Disabled Buy-In population. In FY 2010-11, the Department was working to develop a model to distribute the Hospital Outstationing funding and the expansions to the Disabled Buy-In populations were delayed, both of which contributed to the Department not expending any of this appropriation. For FY 2011-12, the Department will implement the model to pay the \$3,074,400 appropriated for Hospital Outstationing. Further, the Disabled Buy-In populations for which money was appropriated for disability determinations will be implemented in FY 2011-12, creating the need for the disability determination portion of the appropriation. In addition to the Disabled Buy-In populations for which the Department originally anticipated the need for disability determination funding, the Department has subsequently learned that there will be funding needs for two other types of disability determinations. First, a portion of the AwDC population will require a disability determinations due to federal requirements prohibiting individuals that are deemed "medically frail" from being enrolled in a benchmark benefit package. Second, some Disabled Buy-in clients may require extra services through Consumer Directed Attendant Support Services (CDASS), which will require a separate disability determination. These costs were not included in the fiscal note for HB 09-1293, and thus are not built into the appropriation. Policy decisions still need to be made in these areas, and estimates of costs are still unknown. Due to these unknown factors, the Department is not requesting to change the appropriation for disability determinations at this time. If the anticipated costs for disability determinations differ from the appropriation once these policy decisions are made, the Department will request an adjustment to this appropriation through the normal budget process.

### **Eligibility Determinations and Client Services, County Administration and Eligibility Determinations and Client Services, Hospital Provider Fee County Administration (*new line item*)**

The County Administration line item has a FY 2011-12 hospital provider fee related appropriation of \$2,361,502 total funds. Currently, the funding for the County Administration line item as a whole is composed of General Fund, cash funds, and federal funds, with the cash funds portion consisting of both

the hospital provider fee and a local match from the counties. The Department reimburses local county departments of social/human services for processing Medicaid applications and on-going case management according to the methodology agreed upon by the Department and the Department of Human Services, which is based on actual costs incurred by the county and a random moment time study. The Hospital Provider Fee appropriation however, contains no local match, and the Department is currently developing an alternate methodology to the random moment time study mentioned above to distribute these funds to the counties to ensure that expenditures are appropriately aligned with actual workloads related to the hospital provider fee expansions. Because of these factors, the Department requests to move the hospital provider fee funding for county administration to a new line item, Eligibility Determinations and Client Services, Hospital Provider Fee County Administration. The movement of the hospital provider fee funding to this new line item will make the budget more transparent, allow for easier tracking of hospital provider fee funds, and separate funding sources that are allocated based on differing methodologies. The Department will work with the counties to develop an allocation methodology for these funds that more accurately reflects hospital provider fee related expenditures.

While the Centralized Eligibility Vendor discussed above is intended to complete eligibility determinations and provide on-going case management services for the CHP+ expansion to 250% FPL, Disabled Buy-In, and AwDC, clients would still have the option of applying for assistance at a county office. The Department does anticipate that some of these expansion clients will apply at local county departments of social/human services, but the number of applications for these expansion populations, time allocated to them, and the cost associated with the initial processing are all unknown at this time. The Department will reimburse counties for the costs associated with the initial intake of any such application through a methodology to be developed and agreed upon by the Department and counties based on actual costs incurred by the county. Because these factors are currently unknown, the Department is not requesting to adjust this appropriation amount at this time.

#### **Eligibility Determinations and Client Services, Customer Outreach**

This line contains the funding for both the S.B. 97-05 Enrollment Broker, which is contracted to provide information on health plan choices and Medicaid benefits offered through the plans, and the administrative cost to provide outreach and case management for the federally required Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) program. The Enrollment Broker appropriation includes 3.7% hospital provider fee and federal matching funds for FY 2011-12. Since the services provided are to Medicaid populations only, the Department requests to bring this budget line's hospital provider fee funding in proportion with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. This results in the hospital provider fee appropriation being increased to 7.15% of the total appropriation for FY 2011-12. This increase is due to the inclusion of the Disabled Buy-In and AwDC populations. In the original fiscal note for HB 09-1293, the Department had assumed that enrollment broker functions for these populations would be performed by the Centralized Eligibility Vendor, similar to the current process in CHP+. However, because these clients will be enrolled in traditional Medicaid, the Department has determined that the Medicaid enrollment broker must be used for these functions. For the EPSDT program, the appropriation includes 0.44% hospital provider fee and federal matching funds for FY 2011-12. However, because Continuous Eligibility for Medicaid Children is not currently scheduled to be implemented in FY 2011-12, the Department is eliminating the hospital provider fee appropriation to this line item at this time.

#### **Utilization and Quality Review Contracts, Professional Services Contracts**

This line contains funding for external quality review, acute care utilization review, and drug utilization review. External quality review funds performance improvement projects and calculation of required

quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); acute care utilization review funds prospective and retrospective reviews of specified services to ensure proper coverage and medical necessity, and; drug utilization review is federally required to ensure appropriate use of drug therapy through prospective and retrospective reviews. The appropriation to this line item includes 3.33% hospital provider fee and federal matching funds for FY 2011-12. As these services are for the Medicaid program only, the Department requests that this line's hospital provider fee funding be brought in line with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. This results in the hospital provider fee appropriation being increased to 7.15% of the total appropriation for FY 2011-12.

**Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System**

This line contains funding for the Colorado Benefits Management System (CBMS), which tracks clients, data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. The Department's hospital provider fee appropriation to this line item in FY 2011-12 is \$228,864 total funds. In addition, the Department of Human Services has a Hospital Provider Fee appropriation of \$368,616 total funds, for a total appropriation between the two departments of \$597,480. However, due to the delayed implementation of the Disabled Buy-In and AwDC expansion populations, this funding is inadequate to complete systems development. The Department requests an increase of \$1,466,040 to the appropriation to have sufficient funds to complete the system development work within CBMS to implement the Working Adults Buy-in and AwDC on March 1, 2012 and the Children's Buy-in 4 to 6 months later. The purpose of this request is only to true-up the amount of funding needed for system development. If the Department's FY 2012-13 S-12, BA-5 "CBMS Technical Adjustment for HB 09-1293 and HCPF Only Projects" is approved, the Department requests that the incremental appropriations from both this request and the Department's FY 2012-13 R-12 "Hospital Provider Fee Administrative True-up" be made to the new line item, "Colorado Benefits Management System Projects HCPF Only."

Please note that the FY 2011-12 request includes \$187,800 for correspondence costs. Of this amount, \$87,800 is for those clients that the Department anticipates to enroll in FY 2011-12, and assumes three mailings per year at a cost of \$0.63 each for an annual average of 46,455 clients. An additional \$100,000 is also being requested for correspondence costs for those individuals that will be placed on the waitlist for AwDC and those that may apply and be denied for the expansion populations. This \$100,000 would allow for approximately 52,910 individuals on the waitlist to receive three mailing a year at \$0.63 each. This funding would also cover the cost of the mailings for those who apply for the program and are denied. Many individuals applying may not know their income level, so there may be many denials resulting solely from applicants being over the income limit for AwDC. The Department expects the largest influx of applicants to occur in FY 2011-12, with FY 2012-13 only having the costs associated with churn in the waitlist and a reduced number of applicants applying and being denied compared to FY 2011-12. Please see Table A.2 below for the CBMS costs for FY 2011-12.

	Hours	Cost per Hour	Total Cost
AwDC Development	5,159	\$108	\$557,172
Working Adults Buy-in Development	7,239	\$108	\$781,812
Children's Buy-in Development	4,068	\$108	\$439,344
Waitlist Development	624	\$108	\$67,392
CBMS Correspondence	-	-	\$187,800
Pipeline Expansion	-	-	\$30,000
<b>Total</b>	<b>17,090</b>		<b>\$2,063,520</b>

**Appendix B: Tables and Calculations**

**Table B.1: Calculations of Medicaid/CHP+ Percentages**

Row		FY 2012-13
1	FY 2012-13 Total Medicaid Caseload Projection	673,956
2	FY 2012-13 Total CHP+ Caseload Projection	79,257
3	FY 2012-13 Total Medicaid and CHP + Caseload Projection (Row 1 + Row 2)	753,213
4	FY 2012-13 Expansion Adults to 100% Caseload Projection	36,083
5	FY 2012-13 Adults Without Dependent Children (AwDC) Caseload Projection	10,000
6	FY 2012-13 Disabled Buy-In Caseload Projection	2,126
7	FY 2012-13 Medicaid Expansion Projections (Row 4 + Row 5 + Row 6)	48,209
8	FY 2012-13 CHP+ Expansion to 250% Caseload Projection (Children + Prenatal)	11,436
9	FY 2012-13 Medicaid and CHP + Expansion Projections (Row 7 + Row 8)	59,645
10	<b>Expansion Adults to 100% as % of Medicaid Caseload (Row 4 / Row 1)</b>	<b>5.35%</b>
11	<b>All Medicaid Expansions as % of Medicaid (Row 7 / Row 1)</b>	<b>7.15%</b>
12	<b>All Expansions as % of Medicaid and CHP+ (Row 9 / Row 3)</b>	<b>7.92%</b>

**Table B.2: Summary of Incremental Request FY 2011-12**

	Total Funds	General Fund	Cash Funds (Provider Fee)	Federal Funds
<b>Total Request</b>	<b>\$3,920,338</b>	<b>\$0</b>	<b>\$2,023,541</b>	<b>\$1,896,797</b>
(A) General Administration, General Professional Services and Special Projects	(\$120,000)	\$0	(\$60,000)	(\$60,000)
(C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	\$2,230,940	\$0	\$1,246,853	\$984,087
(D) Medical Identification Cards	\$9,240	\$0	\$4,620	\$4,620
(D) Eligibility Determinations and Client Services, County Administration	(\$2,361,502)	\$0	(\$1,180,751)	(\$1,180,751)
(D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration ( <i>new line item</i> )	\$2,361,502	\$0	\$1,180,751	\$1,180,751
(D) Eligibility Determinations and Client Services, Customer Outreach	\$90,506	\$0	\$45,253	\$45,253
(E) Utilization and Quality Review Contracts, Professional Services Contracts	\$243,612	\$0	\$53,795	\$189,817
(6) (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	\$1,466,040	\$0	\$733,020	\$733,020