

STATE OF COLORADO FY 2011-12 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Schedule 13 Change Request for FY 2011-12 Budget Request Cycle											
Decision Item FY 2011-12		Base Reduction Item FY 2011-12			Supplemental FY 2010-11			Budget Amendment FY 2011-12			
<b>Request Title:</b>		CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements									
<b>Department:</b>		Health Care Policy and Financing			<b>Dept. Approval by:</b> John Bartholomew <i>JB</i>			<b>Date:</b> November 1 2010 <i>10/20</i>			
<b>Priority Number:</b>		DI-5			<b>OSP Approval:</b> <i>Jeli</i>			<b>Date:</b> <i>10.22.10</i>			
	Fund	1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual FY 2009-10	Appropriation FY 2010-11	Supplemental Request FY 2010-11	Total Revised Request FY 2010-11	Base Request FY 2011-12	Decision/ Base Reduction FY 2011-12	November 1 Request FY 2011-12	Budget Amendment FY 2011-12	Total Revised Request FY 2011-12	Change from Base (Column 5) FY 2012-13
Total of All Line Items	Total	8 636 709	9 561 132	0	9 561 132	8 997 491	214 920	9 212 411	0	9 212 411	0
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	4 371 712	4 741 183	0	4 741 183	4 345 760	107 460	4 453 220	0	4 453 220	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	26 736	20 046	0	20 046	133 744	0	133 744	0	133 744	0
	CFE/RF	32 682	22 385	0	22 385	22 385	0	22 385	0	22 385	0
	FF	4 405 579	4 777 518	0	4 777 518	4 495 602	107 460	4 603 062	0	4 603 062	0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	8 636 709	9 561 132	0	9 561 132	8 997 491	214 920	9 212 411	0	9 212 411	0
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	4 371 712	4 741 183	0	4 741 183	4 345 760	107 460	4 453 220	0	4 453 220	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	26 736	20 046	0	20 046	133 744	0	133 744	0	133 744	0
	CFE/RF	32 682	22 385	0	22 385	22 385	0	22 385	0	22 385	0
	FF	4 405 579	4 777 518	0	4 777 518	4 495 602	107 460	4 603 062	0	4 603 062	0
<b>Non-Line Item Request:</b>		None									
<b>Letternote Revised Text:</b>		None									
<b>Cash or Federal Fund Name and COFRS Fund Number:</b>		FF Title XIX									
<b>Reappropriated Funds Source by Department and Line Item Name:</b>											
<b>Approval by OIT?</b>		Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/> N/A: <input type="checkbox"/>									
<b>Schedule 13s from Affected Departments:</b>		Department of Human Services Governor's Office of Information Technology									

**Schedule 13**  
**Change Request for FY 2011-12 Budget Request Cycle**

Decision Item FY 2011-12 <input checked="" type="checkbox"/>	Base Reduction Item FY 2011-12 <input type="checkbox"/>	Supplemental FY 2010-11 <input type="checkbox"/>	Budget Amendment FY 2011-12 <input type="checkbox"/>
<b>Request Title:</b> HCPF - CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements			
<b>Department:</b> Department of Human Services		<b>Dept. Approval by:</b> <i>[Signature]</i>	
<b>Priority Number:</b> NP-5		<b>OSP Approval:</b> <i>[Signature]</i>	
		<b>Date:</b> 10-21-10	
		<b>Date:</b> 10-25-10	

	Fund	1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual FY 2009-10	Appropriation FY 2010-11	Supplemental Request FY 2010-11	Total Revised Request FY 2010-11	Base Request FY 2011-12	Decision/Base Reduction FY 2011-12	November 1 Request FY 2011-12	Budget Amendment FY 2011-12	Total Revised Request FY 2011-12	Change from Base (Column 5) FY 2012-13
<b>Total of All Line Items</b>	<b>Total</b>	24,143,101	24,875,508	0	24,875,508	24,037,179	214,920	24,252,099	0	24,252,099	0
	FTE	42.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,987,896	6,138,426	0	6,138,426	6,135,426	0	6,135,426	0	6,135,426	0
	CF	1,183,809	1,158,436	0	1,158,436	939,086	0	939,086	0	939,086	0
	RF	8,762,227	9,359,525	0	9,359,525	8,997,489	214,920	9,212,409	0	9,212,409	0
	FF	8,209,169	8,219,121	0	8,219,121	7,965,178	0	7,965,178	0	7,965,178	0
	MCF	8,836,708	9,359,525	0	9,359,525	8,997,489	214,920	9,212,409	0	9,212,409	0
	MGF	4,535,015	4,641,210	0	4,641,210	4,345,760	107,460	4,453,220	0	4,453,220	0
	NGF	10,522,911	10,779,636	0	10,779,636	10,481,186	107,460	10,588,646	0	10,588,646	0
<b>(2) Office of Information Technology Services, Colorado Benefits Management System (CBMS)</b>	<b>Total</b>	24,143,101	24,875,508	0	24,875,508	24,037,179	214,920	24,252,099	0	24,252,099	0
	FTE	42.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	5,987,896	6,138,426	0	6,138,426	6,135,426	0	6,135,426	0	6,135,426	0
	CF	1,183,809	1,158,436	0	1,158,436	939,086	0	939,086	0	939,086	0
	RF	8,762,227	9,359,525	0	9,359,525	8,997,489	214,920	9,212,409	0	9,212,409	0
	FF	8,209,169	8,219,121	0	8,219,121	7,965,178	0	7,965,178	0	7,965,178	0
	MCF	8,836,708	9,359,525	0	9,359,525	8,997,489	214,920	9,212,409	0	9,212,409	0
	MGF	4,535,015	4,641,210	0	4,641,210	4,345,760	107,460	4,453,220	0	4,453,220	0
	NGF	10,522,911	10,779,636	0	10,779,636	10,481,186	107,460	10,588,646	0	10,588,646	0

**Non-Line Item Request:** None

**Letternote Revised Text for FY 2010-11:** None

**Letternote Text Requested for FY 2011-12:** None

**Cash or Federal Fund Name and COFRS Fund Number:**

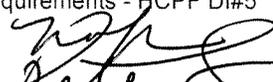
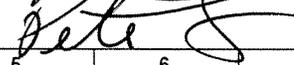
**Reappropriated Funds Source, by Department and Line Item Name:** Health Care Policy and Financing

**Approval by OIT?** Yes:  No:  N/A:

**Schedule 13s from Affected Departments:** Health Care Policy and Financing, Governor's Office of Information Technology

**Schedule 13**  
**Change Request for FY 2011-12 Budget Request Cycle**

Decision Item FY 2011-12  Base Reduction Item FY 2011-12  Supplemental FY 2010-11  Budget Amendment FY 2011-12

**Request Title:** HCPF - CBMS Compliance with Low Income Subsidy and DDS Federal Requirements - HCPF DI#5  
**Department:** Governor's Office of Information Technology **Dept. Approval by:**  **Date:** 10/21/10  
**Priority Number:** Corresponds to Human Services # NP-5 **OSPB Approval:**  **Date:** 10/25/10

	Fund	1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual FY 2009-10	Appropriation FY 2010-11	Supplemental Request FY 2010-11	Total Revised Request FY 2010-11	Base Request FY 2011-12	Decision/Base Reduction FY 2011-12	November 1 Request FY 2011-12	Budget Amendment FY 2011-12	Total Revised Request FY 2011-12	Change from Base (Column 5) FY 2012-13
<b>Total of All Line Items</b>	<b>Total</b>	0	30,192,910	0	30,192,910	23,951,792	214,920	24,166,712	0	24,166,712	0
	FTE	0.0	58.5	0.0	58.5	58.5	0.0	58.5	0.0	58.5	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	30,192,910	0	30,192,910	23,951,792	214,920	24,166,712	0	24,166,712	0
	FF	0	0	0	0	0	0	0	0	0	0
<b>(5) Office of Information Technology, (C)</b>	<b>Total</b>	0	30,192,910	0	30,192,910	23,951,792	214,920	24,166,712	0	24,166,712	0
Statewide Information Technology Services,	FTE	0.0	58.5	0.0	58.5	58.5	0.0	58.5	0.0	58.5	0.0
(9) Colorado Benefits Management System	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE/RF	0	30,192,910	0	30,192,910	23,951,792	214,920	24,166,712	0	24,166,712	0
	FF	0	0	0	0	0	0	0	0	0	0

**Non-Line Item Request:** None  
**Letternote Revised Text for FY 2010-11:** None  
**Letternote Text Requested for FY 2011-12:** None  
**Cash or Federal Fund Name and COFRS Fund Number:**  
**Reappropriated Funds Source, by Department and Line Item Name:** This amount shall be from user fees collected from other state agencies and deposited in the Information Technology Revolving Fund created in Section 24-37.5-112 )1)(a) C.R.S  
**Approval by OIT? Yes:**  **No:**  **N/A:**   
**Schedule 13s from Affected Departments:** HCPF, DHS

**CHANGE REQUEST for FY 2011-12 BUDGET REQUEST CYCLE**

Department:	Health Care Policy and Financing
Priority Number:	DI-5
Change Request Title:	CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements

**SELECT ONE (click on box):**

- Decision Item FY 2011-12
- Base Reduction Item FY 2011-12
- Supplemental Request FY 2010-11
- Budget Request Amendment FY 2011-12

**SELECT ONE (click on box):**

Supplemental or Budget Request Amendment Criterion:

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

Short Summary of Request:

The Department requests \$214,920 total funds and \$107,460 General Fund in FY 2011-12 for development costs for the Colorado Benefits Management System (CBMS) to create two interfaces for data that is transmitted from the Centers for Medicare and Medicaid Services (CMS). The first interface would make the process to assist Medicare clients in Colorado to apply for Medical Savings Programs that provide Medicare Part D prescription drug subsidies to low income clients more efficient. The change would help the Department to meet the federal application processing limit for the determination of client qualification for the low income Medical Savings Programs. The Department has struggled to meet these federal requirements, thereby putting federal financial participation at risk. The second interface would allow CBMS to match Social Security number data related to Supplemental Security Income (SSI) in CBMS with information that is provided to the vendor that is contracted to perform disability determination services for elderly, blind, and/or disabled clients to qualify for medical assistance through Medicaid. This change will keep the Department in compliance with Federal regulations and help to keep it out of court.

General Description of Request:

The Department requests \$214,920 total funds and \$107,460 General Fund in FY 2011-12 to complete the computer programming changes.

These changes to the CBMS system will help the Department to meet federal application processing requirements. Historically, as a result of shortcomings in the abilities of the CBMS, the Department has been struggling to meet the federal requirement on allocation processing time. The state's continuing failure to meet the federal deadlines put federal financial participation at risk, and increases the likelihood of the state defaulting on the CBMS settlement that would have cleared the State obligation from the previous lawsuit. The CBMS settlement was approved by the District Court, City and County of Denver, on January 3, 2008, and this court retains jurisdiction of the settlement for 36 months, or until January 3, 2011. As of August 18, 2010, the Plaintiffs in the settlement contend that HCPF was not in compliance with the settlement. On August 18, 2010, Plaintiffs filed a motion with the court to request Contempt, Enforcement, and Modification of the Stipulation and Order of Settlement

*CBMS Changes to Accept Required Federal Low Income Subsidy Data for Adult Clients*

The computer programming changes would create an interface to accept a daily data transmission from the federal Centers for Medicare and Medicaid Services containing information about Medicare clients living in Colorado who may qualify for the low income subsidy. The file information would initiate an application in CBMS to determine eligibility for a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualified Individual (QI). The computer programming changes would begin in FY 2011-12 and take approximately five months to complete. After the computer programming changes have been completed, the county departments would take over the function of finalizing the already initiated applications. Currently there is no funding in the total CBMS appropriation to pay for vendor staffing by the CBMS contractor to make the changes needed by this new undertaking. The pool of maintenance hours for making computer

programming changes has been already assigned to other projects equally as urgent. If funding is made available, the CBMS contractor would add staff to complete the changes.

The daily data transmission may not contain all of the information necessary to complete the application, so it is anticipated that most applicants will require further communication via letters mailed to the Medicare clients. CBMS already has processes in place to trigger the mailing of letters to clients, so no additional development costs would be incurred to change computer programming coding for the letters.

The Medicare Modernization Act of 2003 added a prescription drug benefit to Medicare effective in January 2006. This drug benefit is referred to as Medicare Part D. Medicare clients generally have to pay monthly premiums to Prescription Drug Plans to receive the benefit. The law also provides financial assistance with the cost of the Medicare Part D prescription drugs for Medicare beneficiaries with low incomes who meet certain income and asset qualifications. The financial assistance is called “extra help” or the “low income subsidy program.” The low income subsidy helps pay for some of a client’s Part D prescription drug plan costs, including Part D plan premiums, deductibles, and copayments. Depending on the client’s income and assets, the client may qualify for a full or partial subsidy.

Medicare clients who already qualify for a Medicare Savings Program automatically qualify for the low income subsidy. Clients in the eligibility categories of Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) automatically qualify. Other low income Medicare clients, who have not previously applied for State medical financial assistance, such as through the Medicaid program, may qualify for the low income subsidy, but those clients must apply separately for that determination. The federal Medicare program has required that state Medicaid programs assist the newly qualified Medicare clients in the determination of qualification for the low income subsidy. Caseload for these clients has grown every fiscal year from 12,908 in FY 2006-07 to a projected total of 18,427 in FY 2011-12, a growth of 48.8% in the six year time span. See Table 1 later in this request for the projected growth in caseload affected by this request. As the Baby Boomer generation continues to

retire and qualifies for Medicare, some will be in the low income category and will need this subsidy for prescription drug assistance, so the number of clients for Low Income Subsidy is expected to continue to increase for several years into the future.

When the Colorado Benefits Management System was developed, it was not anticipated that Medicare Part D would later exist or that a low income subsidy might be part of the Part D benefits, or even that the State would be required to assist low income Medicare clients to apply for the low income subsidy. Therefore, CBMS currently has no automated processes to receive a daily file containing information about newly qualified Medicare clients from the federal Centers for Medicare and Medicaid Services. The daily data transmission would be used to screen for low income subsidy qualification. Because of the lack of an automated process, the Department has been performing the screening and follow-up work manually. The manual approach is very time consuming and labor intensive, with the result that the Department does not meet the federal requirement to determine client qualification within 45 days in approximately one third of the cases. The manual process currently used by the Department receives no additional federal financial participation from CMS other than the federal match for Departmental staff salaries although no extra staff salaries are paid for this work despite the increased work load, but funding to create and operate an automated process through CBMS would receive federal financial participation of 50% for the developmental phase when the developmental phase actually occurs.

In addition to regular low income clients, the automated process developed in CBMS would also benefit clients referred to as Pickle clients. The Pickle Amendment, enacted in April 1977 established a separate category of Medicaid eligibility for former Supplemental Security Income (SSI) or Old Age Pension (OAP State supplement) recipients who would still be eligible for SSI or OAP if it were not for the cost of living adjustment (COLA) to their Title II Social Security Retirement, Survivors or Disability Insurance Benefit (RSDI). This law requires that an individual be deemed a recipient of SSI, and therefore eligible for Medicaid if the client still meets all eligibility criteria after disregarding the COLA. To be eligible for Medicaid as a Pickle client, the person must meet the following criteria in

addition to meeting all other requirements for Medicaid including disability, low income, and limited resources:

- Simultaneously entitled to receive both RSDI and SSI in at least one month since April 1977
- Currently eligible for and receiving RSDI
- Currently ineligible for SSI and
- Below the current SSI income standard after adding all countable income and disregarding all COLA since the last month the client was eligible for both SSI and RSDI.

This last step creates a frozen RSDI countable amount in determining Pickle eligibility. The frozen amount of the RSDI is the amount received in the last month the client was eligible for both SSI and RSDI. Each year the Social Security Administration sends two data files of potential Pickle clients that lost SSI for either a Title II income entitlement or a COLA to the Title II income. The Department is required to establish an annual review system that identifies the Pickle clients. Currently the Department has no way to identify these clients. For the past five years, the Department has not notified these individuals of their potential eligibility for Medicaid, so the Department is unable to determine how many of the clients are not receiving the Medicaid benefits to which they are entitled.

A second problem related to Pickle clients is that CBMS calculation does not disregard the correct COLA amount and therefore does not determine Pickle eligibility correctly. A CBMS request to change the computer programming to handle COLA and Pickle eligibility correctly was submitted to the CBMS vendor in 2006 and 2007, but that computer programming request has not been prioritized for work by the vendor. Recent correspondence was received from Colorado Legal Services that identified this issue as a serious concern for clients who have not received eligibility confirmations within federally required time frames. The correspondence from Colorado Legal Services emphasized the need for the Department to implement a timely solution. This correspondence also alerted the Department to the risk of a lawsuit.

Before the CBMS vendor begins work on the computer programming changes, staff in the Department will have completed the research and information gathering that is necessary to compile the detailed requirements for system changes. As a temporary measure, Departmental staff have been performing the processes manually to identify some of the adult clients, but not the Pickle clients, for the low income subsidy for over five years. Unfortunately, this manual process often causes eligibility determination to be delayed beyond the federally required time frame for completion because the manual process is so time consuming. Departmental staff is well qualified to specify what must be accomplished in the mechanized interface for the CMS file and the resulting application. No additional funding is requested for the requirements phase, since the requirements will be detailed by existing resources within the Department

After implementation of the low income subsidy mechanization in CBMS, workers in the county departments of social services would be trained, as needed, by State staff that already provide training to county workers on other CBMS changes. The training would be absorbed by existing resources, and no additional funding is requested for training related to this project.

*Disability Determination Services SSA Data Added to CBMS*

The Social Security Administration periodically sends a file containing social security numbers of applicants for SSI; however the file is not being utilized in a mechanized matter. The Department needs to act on utilizing the file from the Social Security Administration by putting in place a user interface process in CBMS. The file performs the matching of social security numbers for potential Medicaid applicants who are already qualified for SSI payments or who are concurrently applying for SSI qualification. Applicants who are found to be already eligible for SSI are automatically eligible for Medicaid, so a Medicaid application can be processed immediately. Applicants who have been denied SSI eligibility may still qualify for Medicaid depending on a further disability determination. Applicants who have a determination pending for SSI will require a follow up to confirm the results of that determination and whether additional qualification for Medicaid is necessary. Confirmation of the above status for clients would become part of

the electronic matching processes that this funding request would cover. The source of funding for the CBMS development and implementation of this project would be totally Medicaid.

Currently there is no funding in the total CBMS appropriation to pay for vendor staffing by the CBMS contractor to make the changes needed by this new undertaking. The pool of maintenance hours for making computer programming changes has been already assigned to other projects equally as urgent. If funding is made available, the CBMS contractor would add staff to complete the changes.

When CBMS was implemented, the Department did not anticipate that it would be expected by the federal government to screen Supplemental Security Income (SSI) clients for prior approval of SSI financial assistance when the same clients apply for Medicaid. The federal Social Security Administration is responsible for determining qualification for SSI by aged, blind, and disabled individuals. A person who qualifies for SSI automatically qualifies for Medicaid. In most states, the Social Security Administration contracts with a state agency to handle the SSI application and qualification processes. In Colorado, the Social Security Administration has contracted with the Colorado Department of Human Services (DHS), Disability Determination Services (DDS) to provide the determination and qualification for SSI.

At a hearing before the General Assembly's Joint Budget Committee on November 30, 2009, the Department of Human Services presented information about the SSI application process as managed by Disability Determination Services. Approximately 43% of SSI applicants are initially approved with approximately 57% initially denied. Of the 57% denied, approximately 44% appeal. Of the 44% that appeal, approximately 14% are granted approval after appeal. That process still leaves a substantial number of applicants who are not granted approval for SSI payments.

Some of the substantial number of applicants who are not approved for SSI payments may be approved for medical assistance through Medicaid despite not being approved for SSI benefits because they meet the disability criteria for Medicaid. This determination is made

by the vendor who has been contracted by the Department of Health Care Policy and Financing to perform the work that is described below. Thus, elderly, blind, and/or disabled individuals applying for Medicaid may be approved for Medicaid assistance concurrently with, before, or after SSI application. When a disability determination is required, as well as a Medicaid application, the combined time frame for processing the application within federal regulations is 90 days. HCPF continues to miss the deadline in approximately one third of the cases.

The disability determination consists of reviewing signs, symptoms, and physical or mental difficulties experienced by the applicant. The review also considers results of laboratory tests and other medical findings that would indicate the level and severity of the applicant's disability that imposes limitations on the person's everyday life. The time frame needed to collect all the information and complete the evaluation often takes six weeks or longer. If the Department can verify that the client has already been qualified for SSI payments, the Department could conclude the disability determination had already been done and would therefore not need to request that a second disability determination be made for Medicaid purposes. This is because the qualifications used for Medicaid disability determination are similar to the qualifications used for SSI disability determination. Not needing the second disability determination could save six weeks of processing the Medicaid application.

The potential clients who would be evaluated for needed medical services are in the Medicaid eligibility category of disabled individuals who qualify for Aid to the Needy Disabled and Aid to the Blind and are under the age of 60. Over 2,000 applicants are processed on an annual basis for inclusion into this category. However, not all applicants meet the medical qualifications for both the financial and medical assistance. At the same time, other clients who were previously in this category have aged into other categories for those aged 60 and older. In the Department's November 6, 2009 FY 2010-11 Budget Request, page EB-1 shows that caseload for this category has grown from 48,799 in FY 2006-07 to 53,264 in FY 2009-10, and it is projected to grow to 55,416 during FY 2010-11 with continued growth in FY 2011-12 to 61,280. Since the Department does not expect any significant decrease in the number of applications for SSI or Medicaid, the

need to match social security numbers is expected to continue into the foreseeable future. See Table 1 later in this request for growth in the caseload affected by this request.

As a temporary measure, the Department is checking social security numbers manually through CBMS. The manual process is cumbersome, time consuming, and increases the risk of error. Due to the large volume of applications, the manual checking of Social Security numbers adds one to two weeks to the disability determination process. Consequently, the State is at significant risk of not completing the medical evaluation within the federally required time limit. The federal limit is 45 days in most circumstances, but is 90 days when both a Medicaid application and a level of disability determination must be accomplished. The Department has struggled in consistently meeting the deadlines. For example, during June 2010, the Department estimates that approximately 35% of applications related to disability determinations were not completed within the federally required timeline. If this situation continues, the State risks incurring federal sanctions, including the loss of federal financial participation.

As documented in the Report of the State Auditor, “Access to Medicaid Home and Community-Based Long-Term Care Services,” published in January 2009, pages 29 through 32, eligibility processes are intended to run in coordinated fashion, including some that run concurrently to facilitate individuals’ access to services. In the past when both the Medicaid application process and the disability determination process have been necessary, the time span has frequently exceeded 90 days. Other difficulties have been:

- Delays in receiving evidence, such as a medical examination or documentation of the condition on which the disability is claimed;
- Applicant’s failure to provide information and/or documentation in a timely manner;
- Incomplete application information; and
- County delays in notifying the Department or the contracted vendor of a need for the Medicaid disability determination.

The Department has worked to remedy the above difficulties, but the matching of social security numbers for applicants who are applying or have applied for SSI with the social security numbers of applicants who need Medicaid disability determination remains an

ongoing challenge. The manual process puts additional strain on the Department and its contractor's ability to meet federal minimum requirements as pertains to application processing. Temporary workers have been used to ease the workload, but temporary workers add costs for the process and require extensive training to be effective in the job. The Department has even considered hiring additional FTE to complete the manual matching. The heavy workload and the need for temporary workers will continue until electronic matching development work can be funded.

Beginning in January 2010, the Social Security Administration has supplied a file of Social Security numbers for SSI applicants to CBMS, but the file cannot yet be used electronically. The interface would simplify the process of matching Social Security numbers of SSI applicants to the Social Security numbers of Medicaid applicants who would need a disability determination. Currently, CBMS is not capable of utilizing the file from the Social Security Administration. Therefore, the manual checking and matching process described earlier in this request will continue to be used until CBMS can be modified to effectively utilize the data provided by the Social Security Administration.

Departmental staff has begun gathering information and defining requirements to provide the CBMS contractor computer programming staff with the desired outcomes and a preliminary analysis of the changes in CBMS that need to be made.

The CBMS contractor work would begin with a detailed impact analysis to identify all changes that would need to occur within CBMS. The second step would be completing the computer programming changes and the unit testing phase. The third step by the CBMS contractor would be system testing. See Table 2 for specific costs for each step mentioned above to be completed by the CBMS contractor.

After the changes by the CBMS contractor staff have been completed, State staff would need to perform user acceptance testing to check for any modifications that might still need to be made in the computer programming changes. The CBMS contractor would make the modifications if needed after which implementation could occur. The final result would be quicker matching of Medicaid applicant social security numbers with social

security numbers on SSI completed or pending applications. A match would expedite the Medicaid application process and improve the probability of meeting the 90 days federal time limit on completing both the Medicaid application and the disability determination.

*CBMS Stipulation Agreement and Late Medical Assistance Applications*

The current CBMS Stipulation Agreement with plaintiffs who have not been timely determined for eligibility expires in January 2011. The Stipulation Agreement included a settlement with both HCPF and DHS. The Department has been engaged in CBMS mediation discussions regarding changing the terms and conditions of the agreement. Because of the recent CBMS performance issues with the system itself and the length of time that has been required to make necessary changes into CBMS, new applications submitted into CBMS are exceeding federal processing guidelines. Thus, the Department finds itself in a weakened negotiating position and risks the plaintiffs pursuing the legal remedies through District Court. Colorado Center on Law and Policy represents several clients that have been impacted by the lack of progress in making the necessary changes in CBMS. Colorado Center on Law and Policy and its clients are pursuing why it has taken so long to make changes into CBMS when the changes have been identified since the implementation of CBMS in 2004.

On August 18, 2010, the Colorado Center on Law and Policy filed a Motion for Contempt, Enforcement, and Modification of the Settlement with HCPF in District Court. The Center on Law and Policy is still negotiating with DHS. On pages five and six of the motion, the Colorado Center on Law and Policy alleges that a large percentage of initial applications and redeterminations continue to be late per the timeframes required by federal regulations.

Without these changes, the Department risks additional litigation in District Court and also risks Title XIX federal disallowances for federal financial participation that would have serious consequences for the entire CBMS appropriation. The funding in this request will not solve all deficiencies in CBMS, but the funding in this request would help the

Department to address the delayed completion of applications for Low Income Subsidy and the Disability Determination Services.

Consequences if Not Funded:

If no funding were to be received, the current time-consuming and labor-intensive processes would continue with the increased probability that the Department will be unable to complete the eligibility determinations within the federal 45 day limit. As a result the State would be out of compliance with a federal mandate to accept and process a mechanized daily file from CMS. The Department also risks adverse federal and State audit findings that could result in loss of federal financial participation. The Department is aware of risks for a lawsuit by Colorado Center on Law and Policy on behalf of clients who are not being correctly deemed eligible for Medicaid and the potential liability created by a lawsuit.

Furthermore, if this request is not funded, the manual process of checking for matches of social security numbers in CBMS for SSI applicants and Medicaid disability determination applicants would continue, and the Department would continue to struggle to meet the federal 90 days limit for the combined Medicaid application and disability level determination. If it were not possible to check social security numbers for matching with already approved or pending SSI applications, the Department's disability determination contractor might inadvertently complete extra unnecessary disability determinations and thereby drive up the cost of the disability determination contract with the vendor. If processing limits are exceeded, the Department would be out of federal compliance and federal financial participation would be at risk.

Calculations for Request:

<b>Summary of Request FY 2011-12 for Health Care Policy and Financing</b>	<b>Total Funds</b>	<b>General Fund</b>	<b>Federal Funds</b>
Total Request	\$214,920	\$107,460	\$107,460
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services – Medicaid Funding, Colorado Benefits Management System	\$214,920	\$107,460	\$107,460

<b>Table 1: Medicaid Caseload Growth</b>						
<b>Fiscal Year</b>	<b>FY 2006-07 Actual</b>	<b>FY 2007-08 Actual</b>	<b>FY 2008-09 Actual</b>	<b>FY 2009-10 Actual</b>	<b>FY 2010-11 Projected</b>	<b>FY 2011-12 Projected</b>
<b>Partially Dual Eligible Clients for Low Income Subsidy</b>						
<b>Caseload</b>	12,908	14,217	15,075	15,919	17,177	18,427
<b>Year to Year Growth</b>	16.37%	10.12%	6.06%	5.60%	7.90%	7.28%
<b>Elderly, Blind and Disabled Clients for Disability Determination Services</b>						
<b>Caseload</b>	48,799	49,933	51,355	53,265	55,416	61,280
<b>Year to Year Growth</b>	1.97%	2.32%	2.85%	3.72%	4.04%	10.58%

<b>Table 2: How CBMS Vendor Will Use the Funding</b>		
<b>Fiscal Year</b>	<b>Low Income Subsidy Interface</b>	<b>Dollars</b>
FY 2011-12	Detailed Impact Analysis by CBMS Vendor: 200 Hours at \$108 per Hour	\$21,600
	Computer Programming Coding and Unit Testing by CBMS Vendor: 900 Hours at \$108 per Hour	\$97,200
	System Testing by CBMS Vendor: 240 Hours at \$108 per Hour	\$25,920
	<b>Subtotal FY 2011-12</b>	<b>\$144,720</b>
FY 2011-12	<b>Disability Determination Services Interface</b>	
	Detailed Impact Analysis by CBMS Vendor: 100 Hours at \$108 per Hour	\$10,800
	Computer Programming coding and Unit Testing by CBMS Vendor: 400 Hours at \$108 per Hour	\$43,200
	System Testing by CBMS Vendor: 150 Hours at \$108 per Hour	\$16,200
	<b>Subtotal FY 2011-12</b>	<b>\$70,200</b>
	<b>Grand Total FY 2011-12</b>	<b>\$214,920</b>

Cash Funds Projections:

Not applicable.

Assumptions for Calculations:

The Department assumes that this request primarily affects Medicare clients who qualify for Medicaid assistance through the Medicare Savings Programs for dual eligible clients or through the Elderly, Blind, and Disabled clients category, so no financial participation has been sought from the Department of Human Services which usually shares the costs for the CBMS work.

It is further assumed that:

- The federal financial participation rate is 50%, as is usual for most Medicaid administrative eligibility functions.
- The work by the CBMS contract vendor will be completed during FY 2011-12.

- The vendor cost per hours is \$108 for developments costs to make computer programming changes during FY 2011-12. This hourly rate is part of the CBMS vendor contract.
- The estimated hours of work contained in the Order of Magnitude letter from the CBMS vendor for this project will be sufficient to complete all tasks to be contracted by CBMS vendor.
- Departmental staff, rather than the CBMS contract vendor, will complete the project requirements on which the contract vendor will base the work.
- State staff, rather than the vendor will be responsible for the follow-up training with county workers after implementation of CBMS changes.

Impact on Other Government Agencies:

The \$214,920 total funding, including \$107,460 General Fund, would be added to the CBMS line item appropriation in both the Department of Human Services and the Governor’s Office of Information Technology as Reappropriated Funds because all CBMS funding also passes through those Departments.

<b>Summary of Request FY 2011-12 for Department of Human Services</b>	<b>Total Funds</b>	<b>Reappropriated Funds</b>
Total Request	\$214,920	\$214,920
<u>(2) Office of Information Technology Services; Office of Information Technology, Colorado Benefits Management System</u>	\$214,920	\$214,920

<b>Summary of Request FY 2011-12 for Governor-Lieutenant Governor- State Planning and Budgeting</b>	<b>Total Funds</b>	<b>Reappropriated Funds</b>
Total Request	\$214,920	\$214,920
<u>(5) Office of Information Technology Services: (C) Statewide Information Technology Services, (9) Colorado Benefits Management System</u>	\$214,920	\$214,920

Cost Benefit Analysis:

<b>Cost</b>	<b>Benefits</b>
<p>\$214,920 total funds, including \$107,460 General Fund.</p>	<p>Increases possibility that lawsuit by Colorado Center on Law and Policy, including the August 18, 2010 Motion for Contempt, Enforcement, and Modification of the Settlement can be renegotiated.</p>
	<p>Increases the Department's ability to process client applications within federally required timeframes, reducing the likelihood of incurring federal sanctions, including the loss of federal financial participation.</p>
	<p>Meets federal mandate obligations to receive and work with mechanized files from federal Centers for Medicare and Medicaid Services. The CMS files and interfaces will expedite processing of applications.</p>
	<p>Increases the probability that the client applications will be completed within the time limit required by federal regulations.</p>
	<p>Increases client satisfaction and provides relief to client out of pocket medical costs when the time limit is met.</p>
	<p>Alleviates need for time consuming labor intensive manual process used recently for matching Social Security numbers. Reduces potential for error inherent in manual processes.</p>
	<p>Avoids adding further delay if Medicaid disability determination is not necessary because SSI disability determination can be verified as having already occurred.</p>
	<p>Allows eligibility workers more time for dealing with policy issues and client's unusual needs rather than manual work that should be mechanized.</p>

Implementation Schedule for Both Interfaces:

<b>Task</b>	<b>Completed by Whom</b>	<b>Month/Year</b>
Prepare Requirements for Computer Programming Changes to Achieve	Departmental Staff	May 2011
Amendment to CBMS Contract Written and Fully Approved	Departmental Staff and CBMS Contractor in agreement with Department of Human Services, Governor's Office of Information Technology, and State Controller's Office	June 30, 2011
Detailed Impact Analysis Written	CBMS Contractor Staff	July 2011
Approval of Detailed Impact Analysis	Departmental Staff	August 2011
Computer Programming Coding and Unit Testing	CBMS Contractor Staff	September 2011
User Acceptance Testing	Departmental Staff	October 2011
Implementation	CBMS Contractor Staff	November 2011
Training on Changes as Needed and Ongoing	Departmental Staff Assisted by Staff from Department of Human Services	December 2011 and Going Forward

Statutory and Federal Authority:

25.5-4-105, C.R.S. (2010) *Nothing in this article or articles 5 and 6 of this title shall prevent the state department from complying with federal requirements for a program of medical assistance order for the state of Colorado to qualify for federal funds under Title XIS of the social security act and to maintain a program within the limits of available appropriations.*

25.5-5-503, C.R.S. (2010) (1) *The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients.*

42 C.F.R. §435.120 *Except as allowed under §435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who are receiving or are deemed to be receiving SSI.*

42 C.F.R. §435.135-136 (135) (a) *If an agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or State supplements, it must provide Medicaid to individuals who – (1) Are receiving OASDI; 2) Were eligible for and receiving SSI or State supplements but became ineligible for those payments after April 1977; and (3) Would still be eligible for SSI or State supplements if the amount of OASDI cost-of-living increases paid under section 215(i) of the Act, after the last month after April 1977 for which those individuals were both eligible for and received SSI or a State supplement and were entitled to OASDI, were deducted from current OASDI benefits. (b) Cost-of-living increases include the increases received by the individual or his or her financially responsible spouse or other family member (e.g., a parent). (c) If the agency adopts more restrictive eligibility requirements than those under SSI, it must provide Medicaid to individuals specified in paragraph (a) of this section on the same basis as Medicaid is provided to individuals continuing to receive SSI or State supplements. If the individual incurs enough medical expenses to reduce his or her income to the financial eligibility standard for the categorically needy, the agency must cover that individual as categorically needy. In determining the amount of his or her income, the agency may deduct the cost-of-living increases paid under section 215(i) after the last month after April 1977 for which that individual was both eligible for and received SSI or a State supplement and was entitled to OASDI, up to the amount that made him or her ineligible for SSI.*

(136) *An agency must-- (a) Provide a one-time notice of potential Medicaid eligibility under Sec. 435.135 to all individuals who meet the requirements of Sec. 435.135 (a) or (c) who were not receiving Medicaid as of March 9, 1984; and (b) Establish an annual review system to identify individuals who meet the requirements of Sec. 435.135 (a) or (c) and who lose categorically needy eligibility for Medicaid because of a loss of SSI. States without medically needy programs must send notices of potential*

*eligibility for Medicaid to these individuals for 3 consecutive years following their identification through the annual review system.*

*42 C.F.R §435.541 (2) The agency may not make an independent determination of disability if S[ocial] S[ecurity] A[dministration] has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application.*

*42 C.F.R §435.910 (a) The agency must require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish each of his or her social security numbers (SSN). (b) The agency must advise the applicant of (2) the statute or other authority under which the agency is requesting the applicant's SSN; and (3) the uses the agency will make of each SSN, including its use for verifying income, eligibility, and amount of medical assistance payments.*

*42 C.F.R §435.911 (a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed— (1) Ninety days for applicants who apply for Medicaid on the basis of disability; and (2) Forty-five days for all other applicants.*

Performance Measures:

Although the Department has no performance measure specifically related to the Colorado Benefits Management System, the Department believes that approval and implementation of this request would improve access to and the quality of health care for clients by assisting low income clients to afford their prescription drugs, and to improve the Medicaid application and disability determination processes for elderly, blind, and disabled clients.