Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Request for Medical Service Premiums

Priority Number: R-1

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$3,543,863,749	$0	$3,559,795,929	$330,806,255	$523,061,697
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	$129,303,556	$197,083,919
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$0	$534,529,617	$36,238,486	$34,573,726
	RF	$6,388,059	$0	$3,101,708	$303,982	$534,292
	FF	$1,746,144,065	$0	$1,756,668,882	$164,960,231	$290,869,760
(2) Medical Services Premiums	Total	$3,543,863,749	$0	$3,559,795,929	$330,806,255	$523,061,697
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	$129,303,556	$197,083,919
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$0	$534,529,617	$36,238,486	$34,573,726
	RF	$6,388,059	$0	$3,101,708	$303,982	$534,292
	FF	$1,746,144,065	$0	$1,756,668,882	$164,960,231	$290,869,760

Letternote Text Revision Required? Yes: [x] No: [ ] **If yes, describe the Letternote Text Revision:** See Exhibit D.

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

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

Approval by OIT? Yes: [ ] No: [ ] Not Required: [x]

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Mental Health Community Programs

Priority Number: R-2

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$276,400,984	$0	$277,590,898	$36,614,308	$67,573,083
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$127,777,722	$0	$128,194,192	$21,388,240	$33,044,853
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	$0	$10,510,223	($3,087,673)	$725,348
	RF	$13,544	$0	$13,544	($13,544)	($13,544)
	FF	$138,099,495	$0	$138,872,939	$18,327,285	$33,816,426
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	Total	$272,492,157	$0	$273,682,071	$36,100,428	$66,757,272
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$125,823,308	$0	$126,239,778	$21,131,301	$32,636,948
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	$0	$10,510,223	($3,087,673)	$725,348
	RF	$13,544	$0	$13,544	($13,544)	($13,544)
	FF	$136,145,082	$0	$136,918,526	$18,070,344	$33,408,520
(3) Medicaid Mental Health Community Programs; Medicaid Mental Health Fee for Services Payments	Total	$3,908,827	$0	$3,908,827	$513,880	$815,811
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,954,414	$0	$1,954,414	$256,939	$407,905
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,954,413	$0	$1,954,413	$256,941	$407,906

Letternote Text Revision Required? Yes: [x] No: [ ] **If yes, describe the Letternote Text Revision:**

See Exhibit BB for cash fund splits.

Cash or Federal Fund Name and COFRS Fund Number: Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D); Hospital Provider Fee Cash Fund (24A). FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name: Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund.

Approval by OIT? Yes: [ ] No: [ ] **Not Required:** [x]

Schedule 13s from Affected Departments: None.

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Children's Basic Health Plan Medical and Dental Costs

Priority Number: R-3

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$213,086,149	$0	$187,766,874	($3,434,456)	($3,434,456)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$0	$40,206,188	($862,887)	($862,887)
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$0	$122,048,467	($2,571,569)	($2,571,569)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$213,086,149	$0	$187,766,874	($3,434,456)	($3,434,456)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$0	$40,206,188	($862,887)	($862,887)
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$0	$122,048,467	($2,571,569)	($2,571,569)

Letternote Text Revision Required? Yes: [x] No: [ ] **If yes, describe the Letternote Text Revision:**

FY 2012-13: Of this amount, ~~$27,555,780~~ $27,714,771 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $1 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; ~~$12,188,707~~ $11,166,829 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.; and $461,700 shall be from the Colorado Immunization Fund created in 25-4-2301, C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Hospital Provider Fee Cash Fund 24A and Colorado Immunization Fund; FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: [ ] No: [ ] Not Required: [x]

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-3
Request Title: Children's Basic Health Plan Medical Premium and Dental Benefit Costs

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Children's Basic Health Plan Medical and Dental Costs	($3,434,456)	$0	0.0

Request Summary:
The Department is requesting to adjust the Children's Basic Health Plan Medical and Dental Costs line item to account for updated caseload and per capita estimates. The FY 2012-13 request is a decrease of $3,434,456 from the FY 2012-13 Base Request, and includes $867,851 cash funds and $2,580,789 federal funds. The updated FY 2011-12 estimate is lower than the current appropriation by $29,617,060 total funds, of which $10,057,404 is cash funds and $19,559,656 is federal funds. The FY 2011-12 estimate is provided for informational purposes only.

The Department is not requesting any change to appropriations for the Children's Basic Health Plan Administration line item, though updated appropriations for internal administration (Personal Services, Operating Costs, Medicaid Management Information System, etc.) are incorporated in the Department's analysis of the Children's Basic Health Plan Trust Fund.

The Department's decreased estimate for funding for the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+), for FY 2011-12 is the result of two factors. First, the caseload decrease during FY 2010-11 left caseload at a low starting point for FY 2011-12. To account for this downwards level shift, the Department's latest caseload estimate is lower than its previous forecast. Second, the Department has revised its per capita estimates for FY 2011-12 downwards due to lower than forecasted per capita expenditures in FY 2010-11, combined with the actuarially calculated capitation rates for FY 2011-12.

The Department is requesting a decrease in FY 2012-13 from the base request. The Department's FY 2012-13 caseload forecast for CHP+ is also lower than its previous forecast as the downwards level shift from FY 2010-11 is carried forward into out-years. The Department's final caseload includes two bottom line adjustments from SB 11-008 and SB 11-250. SB 11-008 expands eligibility for children aged 6 through 18 in Medicaid to 133% of the Federal Poverty Level (FPL). SB 11-250 expands eligibility for pregnant women in Medicaid to 185% FPL. These expansions will take effect in January 2013, impacting CHP+ caseload negatively as these clients become eligible for and enroll in Medicaid.

The bottom line adjustments have been updated from the SB 11-008 and SB 11-250 estimates to account for the revised caseload forecasts with the same methodology used by the Department to estimate the fiscal impact for these bills. These updated negative adjustments are smaller due to the reduced caseload projections relative to the Department's November 2011 forecast, which

reduces the number of clients in these lower income categories.

The Department is also adjusting its FY 2011-12 and FY 2012-13 per capita estimates to account for the actual FY 2010-11 per capita costs and the actuarially set FY 2011-12 capitation rates. The updated medical per capita estimates for children and prenatal women are lower than the Department's previous estimate, while the dental per capita estimates are higher.

The Department is requesting a decrease in the appropriation for the Children's Basic Health Plan Medical and Dental Costs from the Department's FY 2012-13 base request to true up its latest expenditures forecast.

Anticipated Outcomes:
This request would result in an appropriation to the Children's Basic Health Plan Medical and Dental Costs line item that accounts for the Department's latest expenditures forecast.

Assumptions for Calculations:
Please see Attachment A and Exhibits C.1 through C.8 for detailed descriptions of the assumptions and calculations for this request.

Consequences if not Funded:
Not applicable. Under the Patient Protection and Affordable Care Act of 2009, there is a Maintenance of Effort provision on CHP+ eligibility until September 31, 2019. As such, CHP+ resembles an entitlement program like Medicaid. If the funding were not appropriated to support the increased costs, the entire CHP+ program would have to be eliminated.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Current Statutory Authority or Needed Statutory Change:
Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj).

The Children's Basic Health Plan Trust fund is created by 25.5-8-105 C.R.S. (2011).

An "eligible person" for the program is defined in 25.5-8-103 (4) C.R.S. (2011).

25.5-8-107 (1) (a) (II), C.R.S. (2011) allows the Department to provide dental benefits though the Children's Basic Health Plan.

Attachment A
Children's Basic Health Plan Medical and Dental Costs

General Description of Request

The Children's Basic Health Plan, marketed as the Child Health Plan *Plus* or CHP+, is a program that provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 250% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration. The federal government implemented this program in 1997, giving states an enhanced match on State expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. The Plan also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization. All pregnant women enrolled in the Plan receive services through the State's self-funded network.

This request seeks:

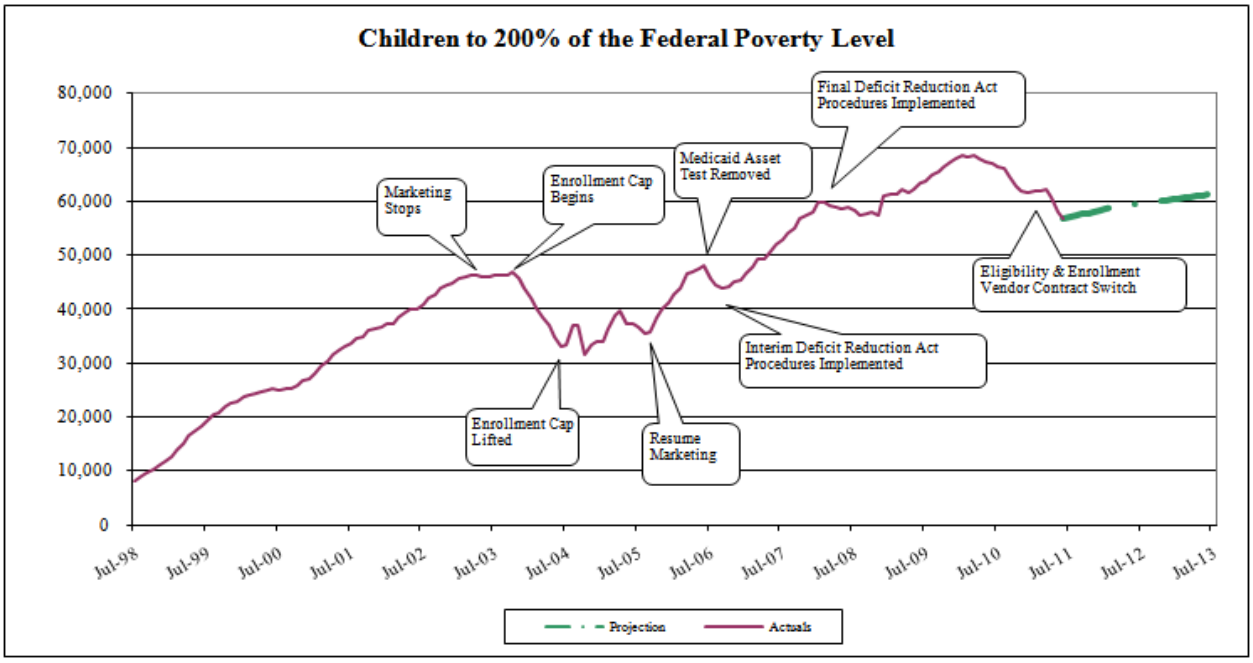
- To adjust the projected enrollment for children and pregnant women in the Plan; and,
- To adjust the per capita costs for medical and dental services in accordance with actuarial projections.

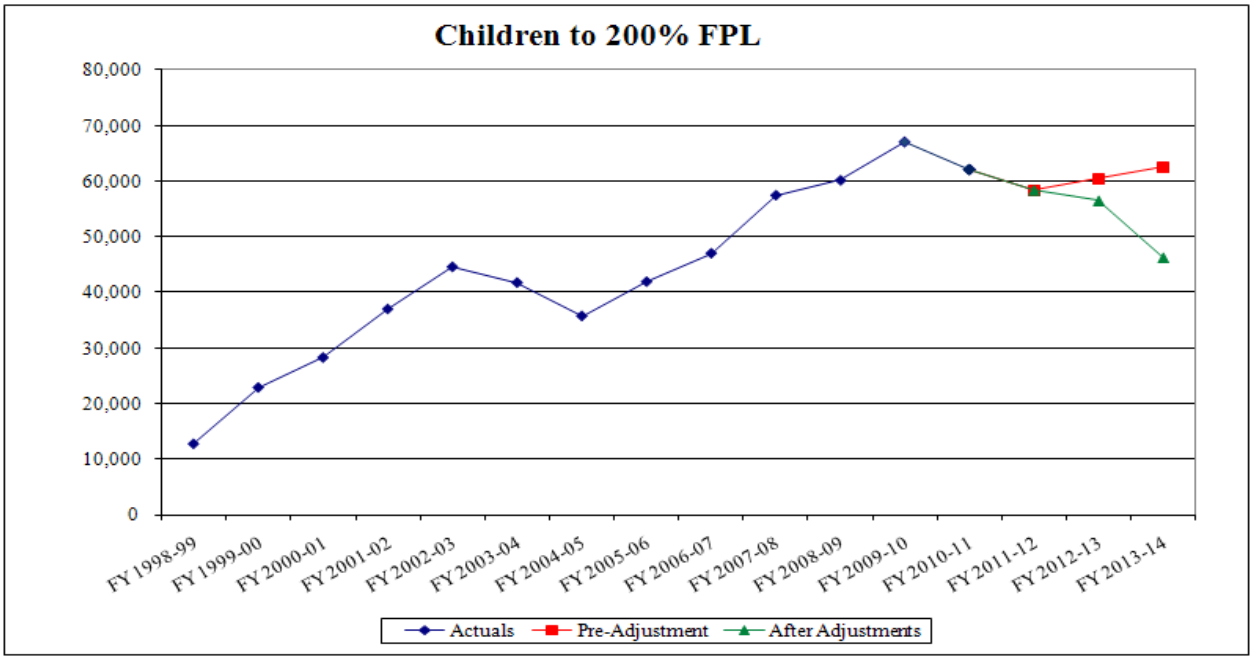
Please note that the Department is only requesting to adjust the FY 2012-13 budget and all FY 2011-12 estimates are provided for informational purposes only.

I. Description of Request Related to Children's Premiums

Children's Caseload Projections (Exhibit C.6)

Children to 200% FPL





- The Department is combining the traditional children's (up to 185% of federal poverty line (FPL)) caseload forecast with the children's expansion to 200% FPL caseload forecast into one category beginning this year. The expansion to 200% FPL was implemented in July 2005, and is now exhibiting trends similar to the traditional children's caseload. Thus, the Department is forecasting these categories together as "Children to 200% FPL."
- Growth in children to 200% FPL in FY 2010-11 was significantly lower than the Department's November 2010 forecast in which annual caseload was projected to be 68,377 and average monthly growth was projected to be 304. The actual caseload for FY 2010-11 decreased by an average of 849 children per month. The declines in caseload at the end of calendar year 2010 were due to a backlog of applications which resulted from the change in the program's eligibility and enrollment vendor from Affiliated Computer Services to Maximus in late 2010. Once Maximus was able to resolve this backlog, the caseload began increasing as anticipated. During the past few months, however, the caseload has decreased significantly. The Department is currently investigating this unexpected decrease in caseload. Initial research suggests that some of this decrease is due to children in low-income FPL categories moving from CHP+ into Medicaid at a rate greater than the historical average.
- The selected trend for FY 2011-12 for children to 200% FPL is lower than the Department's November 2010 forecast and would result in average growth of **230 per month**. This lower forecast is reflective of the monthly caseload decreases and moderate monthly growth seen over the course of FY 2010-11. The Department believes that projected economic conditions give no indication that caseload will not begin growing at a moderate pace as economic conditions improve over the next few years. The negative forecasted trend for FY 2011-12 is due to the level shift experienced at the end of FY 2010-11, which leaves caseload at a low starting point for the year.
- There is a bottom-line adjustment to CHP+ children's caseload from SB 11-008, which increases Medicaid eligibility for children from six to 18 years of age to 133% FPL beginning in January 2013. This is expected to have a negative impact on CHP+ caseload as children that are currently in CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-008

estimate to account for the revised caseload forecasts with the same methodology used to estimate the fiscal impact of SB 11-008.

Children to 200% FPL			
	Actuals	**Monthly Change**	**% Change**
Jun-09	63,261	-	-
Jul-09	63,817	556	0.88%
Aug-09	64,918	1,101	1.73%
Sep-09	65,594	676	1.04%
Oct-09	66,515	921	1.40%
Nov-09	67,312	797	1.20%
Dec-09	67,962	650	0.97%
Jan-10	68,378	416	0.61%
Feb-10	68,085	(293)	-0.43%
Mar-10	68,406	321	0.47%
Apr-10	67,985	(421)	-0.62%
May-10	67,354	(631)	-0.93%
Jun-10	66,940	(414)	-0.61%
Jul-10	66,321	(619)	-0.92%
Aug-10	66,126	(195)	-0.29%
Sep-10	64,632	(1,494)	-2.26%
Oct-10	62,786	(1,846)	-2.86%
Nov-10	61,919	(867)	-1.38%
Dec-10	61,662	(257)	-0.42%
Jan-11	61,925	263	0.43%
Feb-11	61,822	(103)	-0.17%
Mar-11	62,097	275	0.44%
Apr-11	60,829	(1,268)	-2.04%
May-11	58,089	(2,740)	-4.50%
Jun-11	56,754	(1,335)	-2.30%

	Caseload	**% Change**	**Level Change**
FY 1999-00	22,935	-	-
FY 2000-01	28,321	23.48%	5,386
FY 2001-02	37,042	30.79%	8,721
FY 2002-03	44,600	20.40%	7,558
FY 2003-04	41,786	-6.31%	(2,814)
FY 2004-05	35,800	-14.33%	(5,986)
FY 2005-06	41,946	17.17%	6,146
FY 2006-07	47,047	12.16%	5,101
FY 2007-08	57,465	22.14%	10,418
FY 2008-09	60,137	4.65%	2,672
FY 2009-10	66,939	11.31%	6,802
FY 2010-11	62,080	-7.26%	(4,859)
FY 2011-12	58,376	-5.97%	(3,704)
FY 2012-13	60,443	3.54%	2,067
FY 2013-14	62,513	3.42%	2,070

Monthly Average Growth Comparisons		
FY 2010-11 1st Half	(880)	-1.36%
FY 2010-11 2nd Half	(818)	-1.36%
November 2010 Forecast	304	0.45%
FY 2011-12 Forecast	230	0.40%
November 2010 Forecast	255	0.35%
FY 2012-13 Forecast	144	0.24%
November 2010 Forecast	193	0.26%

Actuals		
	Monthly Change	**% Change**
6-month average	(818)	-1.36%
12-month average	(849)	-1.36%
18-month average	(623)	-0.99%
24-month average	(271)	-0.44%

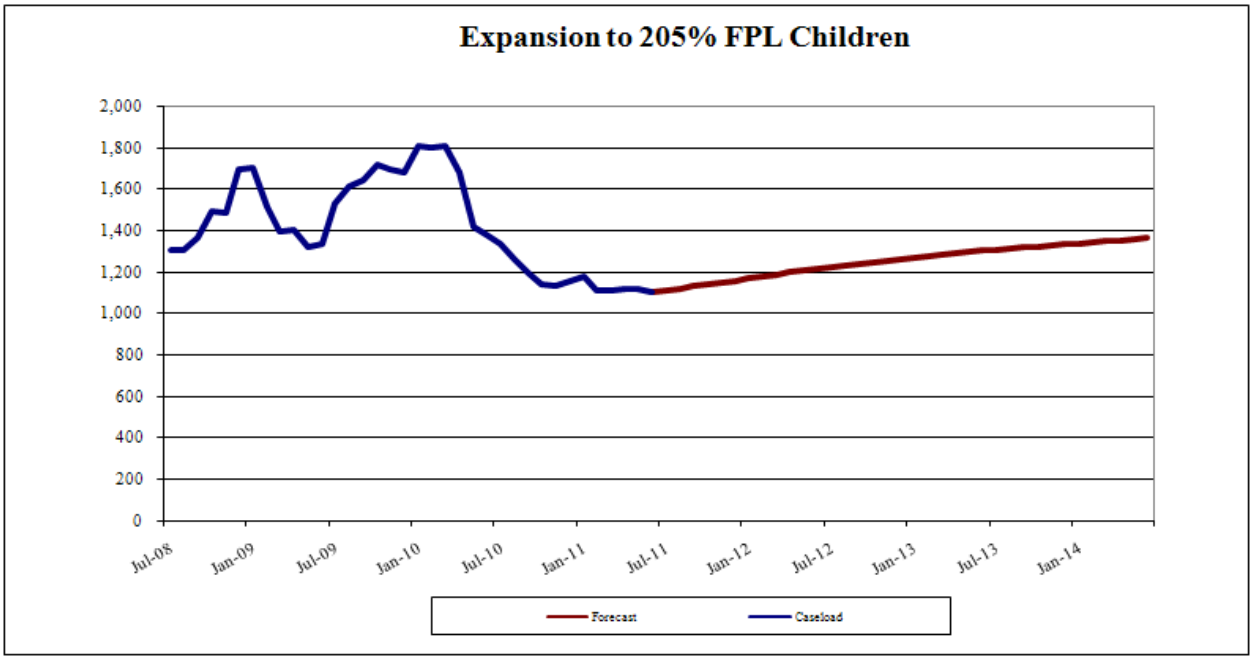
Adjustments (SB 11-008)	
FY 2011-12	0
FY 2012-13	(3,951)
FY 2013-14	(16,333)

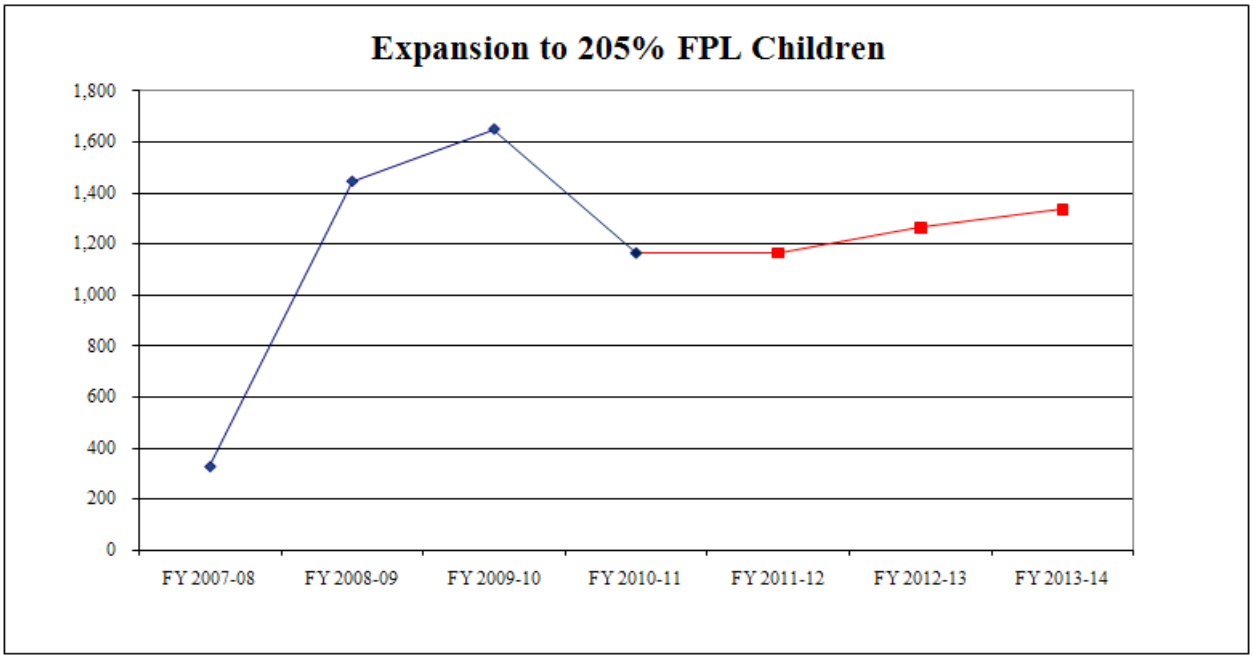
November 2010 Trend Selections			
FY 2010-11	68,377	2.15%	1,438
FY 2011-12	72,672	6.28%	4,295
FY 2012-13	74,988	3.19%	2,316

Projections After Adjustments			
FY 2011-12	58,376	-5.97%	(3,704)
FY 2012-13	56,492	-3.23%	(1,884)
FY 2013-14	46,180	-18.25%	(10,312)

Base trend from June 2011 level			
FY 2011-12	56,754	-8.58%	(5,326)

Expansion to 205% FPL Children





- This population was created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family income between 201-205% FPL.
- Growth in Expansion to 205% FPL children in FY 2010-11 was lower than the Department's November 2010 forecast, in which annual caseload was projected to be 1,504 and average monthly growth was projected to be 18. Similar to the caseload for Children to 200% FPL, the FY 2010-11 caseload for this population also decreased, albeit at a slower rate of an average of 1.83% per month. This population also exhibited fewer months of caseload declines compared to the Children to 200% FPL caseload. This population was also affected by the change in the program's eligibility and

enrollment vendor from Affiliated Computer Services to Maximus in late 2010. Once Maximus was able to resolve the backlog in application processing, the caseload began increasing as anticipated.

- The selected trend for FY 2011-12 for Expansion to 205% FPL children is lower than the Department's November 2010 forecast, and would result in average growth of **10 per month**. This is based on the average positive monthly growth ranging between 0.27% and 1.94% during FY 2010-11, adjusted for expectations for slightly improving economic conditions. The Department does not believe the caseload will continue to decrease as it did in FY 2010-11 as monthly declines have become more moderate or even reversed during the past few months. Growth is forecasted to average 0.83% per month in FY 2011-12 and 0.54% per month in FY 2012-13.

Expansion to 205% FPL Children

	Actuals	Monthly Change	% Change
Jun-09	1,337	-	-
Jul-09	1,532	195	14.58%
Aug-09	1,613	81	5.29%
Sep-09	1,645	32	1.98%
Oct-09	1,719	74	4.50%
Nov-09	1,699	(20)	-1.16%
Dec-09	1,678	(21)	-1.24%
Jan-10	1,808	130	7.75%
Feb-10	1,802	(6)	-0.33%
Mar-10	1,806	4	0.22%
Apr-10	1,678	(128)	-7.09%
May-10	1,417	(261)	-15.55%
Jun-10	1,385	(32)	-2.26%
Jul-10	1,338	(47)	-3.39%
Aug-10	1,263	(75)	-5.61%
Sep-10	1,192	(71)	-5.62%
Oct-10	1,144	(48)	-4.03%
Nov-10	1,134	(10)	-0.87%
Dec-10	1,156	22	1.94%
Jan-11	1,178	22	1.90%
Feb-11	1,110	(68)	-5.77%
Mar-11	1,108	(2)	-0.18%
Apr-11	1,118	10	0.90%
May-11	1,121	3	0.27%
Jun-11	1,104	(17)	-1.52%

Base trend from June 2011 level			
FY 2011-12	1,104	-5.15%	(60)

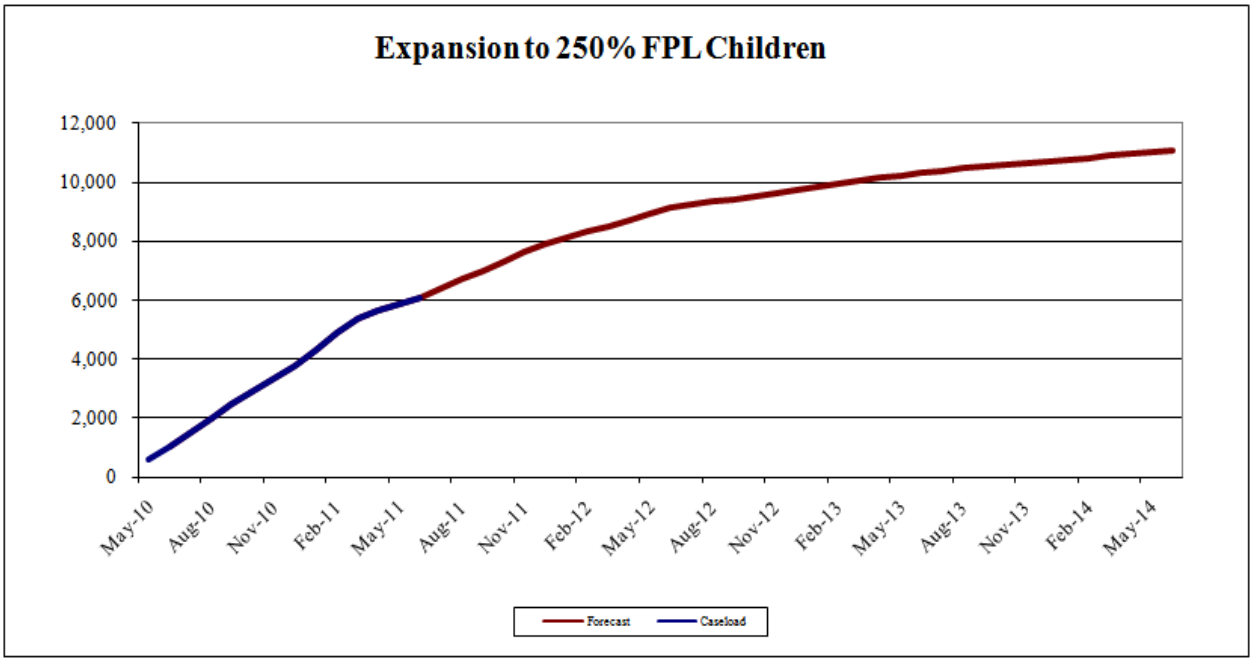
	Caseload	% Change	Level Change
FY 2007-08	330	-	-
FY 2008-09	1,445	337.88%	1,115
FY 2009-10	1,649	14.12%	204
FY 2010-11	1,164	-29.41%	(485)
FY 2011-12	1,165	0.09%	1
FY 2012-13	1,265	8.58%	100
FY 2013-14	1,336	5.61%	71

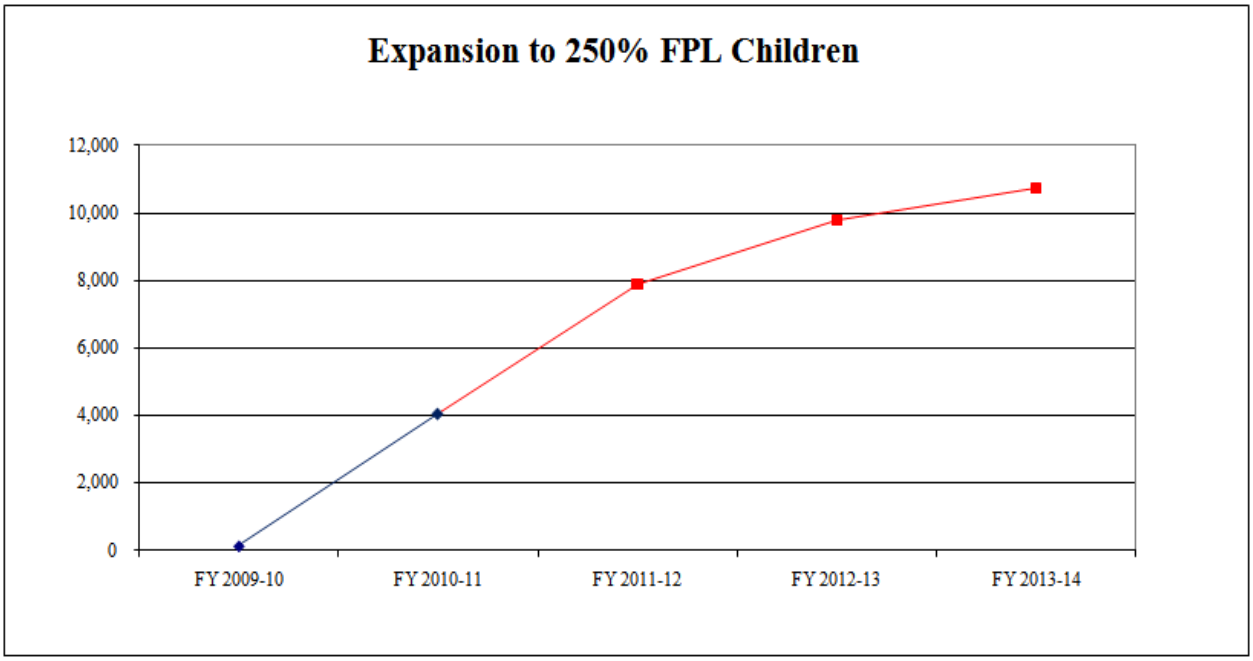
Monthly Average Growth Comparisons		
FY 2010-11 1st Half	(38)	-2.93%
FY 2010-11 2nd Half	(9)	-0.73%
November 2010 Forecast	18	1.19%
FY 2011-12 Forecast	10	0.83%
November 2010 Forecast	14	0.83%
FY 2012-13 Forecast	7	0.54%
November 2010 Forecast	10	0.54%

Actuals		
	Monthly Change	% Change
6-month average	(9)	-0.73%
12-month average	(23)	-1.83%
18-month average	(32)	-2.18%
24-month average	(10)	-0.64%

November 2010 Trend Selections			
FY 2010-11	1,504	-8.79%	(145)
FY 2011-12	1,691	12.43%	187
FY 2012-13	1,828	8.10%	137

Expansion to 250% FPL Children





- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family income between 206-250% of the federal poverty level.
- Growth in FY 2010-11 was lower than the Department's November 2010 estimates in which annual caseload was projected to be 6,860 and average monthly growth was projected to be 897. As a result, the Department has decreased its caseload growth forecast. The selected trend for FY 2011-12 for Expansion to 250% FPL children is lower than the Department's November 2010 forecast, and would result in average growth of **253 per month**. This is based on the average monthly growth from between March 2011 and June 2011. This trend is expected to moderate further in the out-years, resulting in average monthly growth of 101 in FY 2012-13.

Expansion to 250% Children			
	Actuals	Monthly Change	% Change
May-10	600	-	-
Jun-10	1,029	429	71.50%
Jul-10	1,511	482	46.84%
Aug-10	2,018	507	33.55%
Sep-10	2,505	487	24.13%
Oct-10	2,935	430	17.17%
Nov-10	3,342	407	13.87%
Dec-10	3,759	417	12.48%
Jan-11	4,316	557	14.82%
Feb-11	4,888	572	13.25%
Mar-11	5,358	470	9.62%
Apr-11	5,674	316	5.90%
May-11	5,872	198	3.49%
Jun-11	6,098	226	3.85%

	Caseload	% Change	Level Change
FY 2009-10	136	-	-
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	7,891	96.15%	3,868
FY 2012-13	9,785	24.00%	1,894
FY 2013-14	10,737	9.73%	952

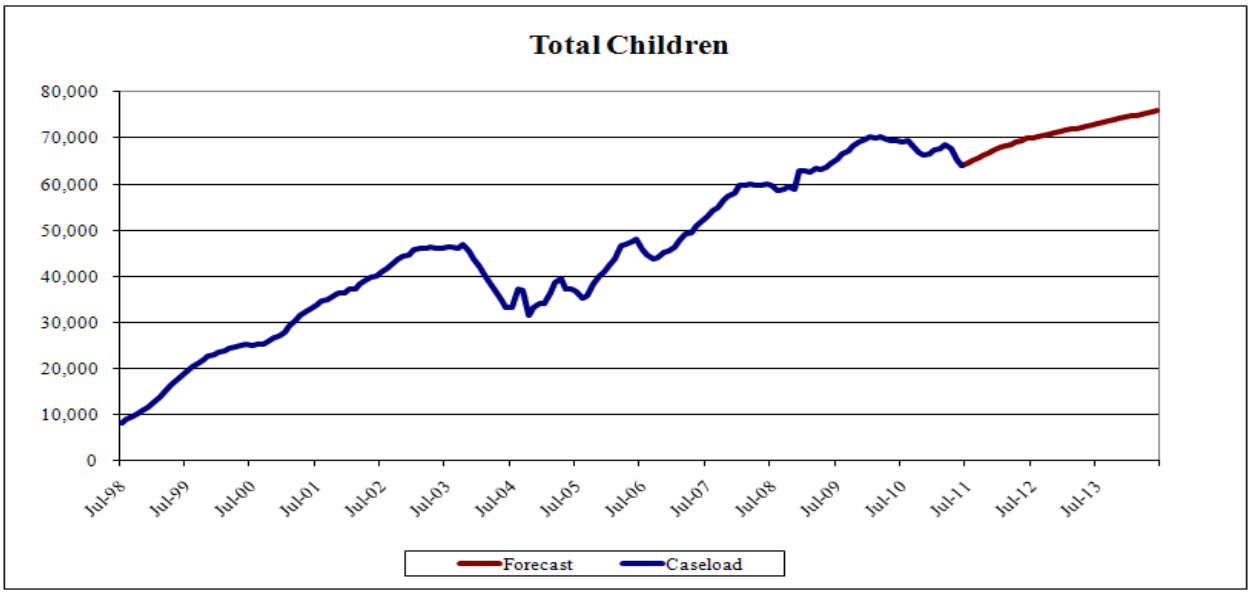
Monthly Average Growth Comparisons		
FY 2010-11 1st Half	455	24.67%
FY 2010-11 2nd Half	390	8.49%
November 2010 Forecast	897	24.13%
FY 2011-12 Forecast	253	3.42%
November 2010 Forecast	205	1.59%
FY 2012-13 Forecast	101	1.04%
November 2010 Forecast	79	0.54%

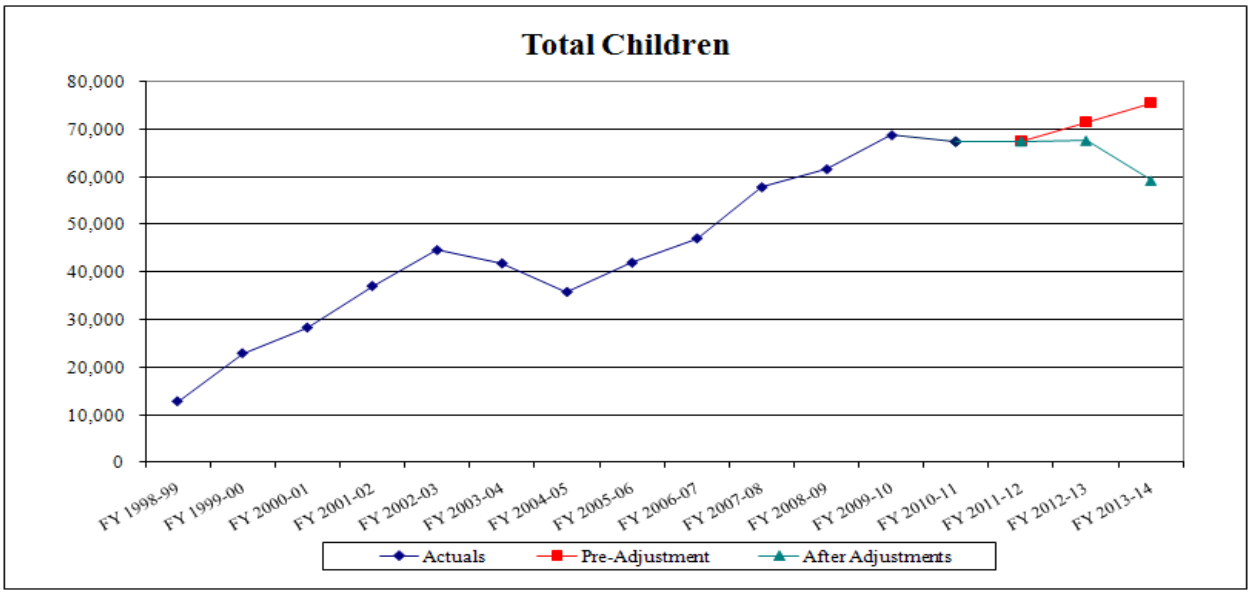
November 2010 Trend Selections			
FY 2010-11	6,860	4944.12%	6,724
FY 2011-12	13,126	91.34%	6,266
FY 2012-13	14,796	12.72%	1,670

Actuals		
	Monthly Change	% Change
6-month average	390	8.49%
12-month average	422	16.58%

Base trend from June 2011 level			
FY 2011-12	6,098	51.58%	2,075

Total Children





- In January 2011, the Department implemented a change to the Colorado Benefits Management System that allows the Department to remain in compliance with federal regulations, specifically Section 211 of the Children's Health Insurance Program Reauthorization Act of 2009. This section expands Medicaid citizenship documentation requirements in the Deficit Reduction Act of 2005 to CHP+, thus requiring clients who declare to be a U.S. citizen or nation to present satisfactory documentary evidence of this before enrolling or re-enrolling in the program. The Department has included the effects of this new documentation requirement in this caseload forecast.
- The FY 2011-12 children's caseload forecast is 67,432, a 0.25% increase over the FY 2010-11 caseload of 67,267. This forecast results in average increases of **492** (**0.74%**) **per month** in FY 2011-12. The FY 2012-13 caseload is projected to increase by 6.02% to 71,493, and FY 2013-14 caseload is forecasted to grow 4.32% to 74,584. Total children's caseload is projected to increase by 0.35% (252 clients) per month in FY 2012-13 and 0.36% (257 clients) per month in FY 2013-14.
- There is a bottom-line adjustment to the CHP+ children's caseload from SB 11-008, which increases

Medicaid eligibility for children from six to 18 years of age up to 133% FPL beginning in January 2013. This is expected to have a negative impact on CHP+ caseload as children that are currently in CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-008 estimate to account for the revised caseload forecasts using the same methodology used by the Department to estimate the fiscal impact of SB 11-008. This adjustment decreases the FY 2012-13 caseload projection to 67,543 which is a 0.16% increase over FY 2011-12 forecast. This adjustment decreases the FY 2013-14 caseload projection to 58,251 which is a 13.76% decrease from the adjusted FY 2012-13 projection.

- As part of the Department's efforts to increase administrative efficiencies, it is implementing Express Lane Eligibility in FY 2011-12. This will allow the program to take utilize information in the Colorado Benefits Management System gathered for the free/reduced price lunch program to expedite eligibility processing for children potentially eligible for CHP+. The Department estimates that any caseload increases resulting from this initiative are negligible and has included them in its caseload forecast.

Total Children			
	Actuals	**Monthly Change**	**% Change**
Jun-09	64,598	-	-
Jul-09	65,349	751	1.16%
Aug-09	66,531	1,182	1.81%
Sep-09	67,239	708	1.06%
Oct-09	68,234	995	1.48%
Nov-09	69,011	777	1.14%
Dec-09	69,640	629	0.91%
Jan-10	70,186	546	0.78%
Feb-10	69,887	(299)	-0.43%
Mar-10	70,212	325	0.47%
Apr-10	69,663	(549)	-0.78%
May-10	69,371	(292)	-0.42%
Jun-10	69,354	(17)	-0.02%
Jul-10	69,170	(184)	-0.27%
Aug-10	69,407	237	0.34%
Sep-10	68,329	(1,078)	-1.55%
Oct-10	66,865	(1,464)	-2.14%
Nov-10	66,395	(470)	-0.70%
Dec-10	66,577	182	0.27%
Jan-11	67,419	842	1.26%
Feb-11	67,820	401	0.59%
Mar-11	68,563	743	1.10%
Apr-11	67,621	(942)	-1.37%
May-11	65,082	(2,539)	-3.75%
Jun-11	63,956	(1,126)	-1.73%

	Caseload	**% Change**	**Level Change**
FY 1998-99	12,825	-	-
FY 1999-00	22,935	78.83%	10,110
FY 2000-01	28,321	23.48%	5,386
FY 2001-02	37,042	30.79%	8,721
FY 2002-03	44,600	20.40%	7,558
FY 2003-04	41,786	-6.31%	(2,814)
FY 2004-05	35,800	-14.33%	(5,986)
FY 2005-06	41,946	17.17%	6,146
FY 2006-07	47,047	12.16%	5,101
FY 2007-08	57,795	22.85%	10,748
FY 2008-09	61,582	6.55%	3,787
FY 2009-10	68,725	11.60%	7,142
FY 2010-11	67,267	-2.12%	(1,457)
FY 2011-12	67,432	0.25%	165
FY 2012-13	71,493	6.02%	4,061
FY 2013-14	74,586	4.32%	3,091

Monthly Average Growth Comparisons		
FY 2010-11 1st Half	(463)	-0.67%
FY 2010-11 2nd Half	(437)	-0.65%
November 2010 Forecast	1,239	1.63%
FY 2011-12 Forecast	492	0.74%
November 2010 Forecast	474	0.55%
FY 2012-13 Forecast	252	0.35%
November 2010 Forecast	240	0.26%

November Trend Selections			
FY 2010-11	76,741	13.79%	9,474
FY 2011-12	87,489	14.01%	10,748
FY 2012-13	91,612	4.71%	4,123

Adjustments (SB 11-008)	
FY 2011-12	0
FY 2012-13	(3,951)
FY 2013-14	(16,333)

Actuals		
	Monthly Change	**% Change**
6-month average	(437)	-0.65%
12-month average	(450)	-0.66%
18-month average	(316)	-0.46%
24-month average	(27)	-0.03%

Projections After Adjustments			
FY 2011-12	67,432	0.25%	165
FY 2012-13	67,542	0.16%	111
FY 2013-14	58,253	-13.76%	(9,292)

Base trend from June 2011 level			
FY 2011-12	63,956	(3,311)	-4.92%

Children's Per Capita (Exhibit C.5)

CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor.

For projecting FY 2011-12 SMCN rates, the contracted actuary used actual claims data for FY 2008-09 and FY 2009-10. Following two years of large annual cost trends, the contracted actuary found a negative annual cost trend of 15.9% for FY 2011-12. This trend is driven primarily by the change in inpatient and outpatient reimbursement methodologies that occurred in July 2009, when the Department lowered its reimbursement to hospitals for these services from 66% to 44% of billed charges. Additionally, the reimbursement for the majority of CHP+ providers previously granted reimbursement exceptions was negotiated to 90% of Medicare Resource Based Relative Value Scale (RBRVS), effective November 2009. These decreases outweighed the increase in ambulatory services from 83% of Medicare RBRVS to 90% to result in a negative annual cost trend. The contracted actuary also reviewed published studies to determine industry norms for current and projected health care cost trends, which ranged from 4.40% to 11.20%. The actuarially set combined utilization and unit cost base trend across services is 17.7% for FY 2011-12.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they were be paid 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. This change in reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative trend in the children's per capita cost in FY 2010-11.

In July 2011, the Department is moving from a 30% discount of Cost-to-Charge ratio to a 30.7% discount. Actuarial analysis shows a 29% savings in outpatient claims and a 36% savings for inpatient claims, or a total decrease of 22.01% in the base monthly rate for children in the SMCN due to reimbursement changes.

The final FY 2011-12 SMCN children's per member per month rate is $167.99, which includes administrative costs of $24.22 for claims administration and case management and $0.52 for medical home incentive payments. This is a 3.97% decrease from the final FY 2010-11 blended rate. The rate decrease is the result of fully accounting for the change in hospital reimbursement methodologies.

Effective July 1, 2011, the Department is implementing the 3% HMO rate cut that was part of its FY 2011-12 BRI-4 "CHP+ Program Reductions." To ensure that this reduced rate is reasonable, the Department asked the contracted actuary to set an actuarial sound rate range for HMO capitation rates for FY 2011-12 rather than a point estimate only. For projecting the FY 2011-12 HMO capitation rate, the contracted actuary used actual HMO experience in FY 2009-10 combined with published studies of health care cost trends. The range for the annual per member per month trend is 5.4% to 9.8%, with higher trends for both utilization and cost in both inpatient and outpatient hospital services due to long-term utilization patterns being high in these services.

After consultation with the HMOs, the Department decided to maintain the same administrative costs of $12.11 from the previous year, which are estimated to be 8.5% of total costs based on expenses reported by the four HMOs operating in FY 2009-10. The final FY 2011-12 HMO children's per member per month

rate is $151.82, which includes the 3% reduction taken from the base rate at the top of the calculated rate range which results in projected claims costs of $139.32, administrative costs of $12.11 and $0.39 for medical home incentive payments. This is a 4.82% increase from the final FY 2010-11 blended rate.

For FY 2011-12, the Department estimates that approximately 30% of children will be served in the self-funded network and the remaining 70% will be enrolled in an HMO. This is based on historical experience as well as the expectation that the percentage of children in an HMO will continue to increase as the Plan's HMO expand to geographic areas that were previously served only by the SMCN. Applying these weights to the actuarial rates yields a blended rate of $156.67 for all children in FY 2011-12. This is an increase of 1.44% over the final FY 2010-11 blended rate of $154.45 (calculated based on actual caseload shares between HMOs and the self-funded network). See Exhibit C.5, page C.5-2 for calculations.

The Department's FY 2011-12 forecasted per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that the capitation rate for the self-funded network is indeed in line with the costs incurred for these children, and that other factors that may affect per capita costs remain constant from FY 2010-11. Examples of other factors that may affect per capita costs include the length of stay in the program, enrollment mix between the more expensive self-funded network and HMOs, and the average length of time taken for a child to enroll in an HMO.

The growth in the FY 2011-12 blended capitation rate is used to project the FY 2011-12 per capita. The base growth of 1.44% is applied to the calculated FY 2010-11 per capita to estimate a base per capita of $2,129.17. There are no bottom line adjustments to the FY 2010-11 per capita at this time.

Since the Department instituted various reimbursement decreases that affected the FY 2011-12 SMCN rate, the Department is using the base growth in the HMO capitation rate in FY 2011-12 to project the FY 2012-13 blended rate. This results in an increase of 4.82% for FY 2012-13 from the FY 2012-13 base rate.

Similar to the FY 2011-12 per capita, the projected growth in the FY 2012-13 blended capitation rate is used to project the FY 2012-13 per capita as there are no signs that this trend will not continue. The Department applies the projected 4.82% growth to the FY 2011-12 estimated per capita of $2,129.17 for a projected FY 2012-13 per capita of $2,231.79. There are currently no adjustments to the FY 2012-13 per capita for programmatic changes.

The dental vendor contract was re-bid for FY 2007-08, and a new contract was executed with Delta Dental. As part of the re-bid process, Delta Dental was able to offer an increased benefits package. These changes include increasing the cap on dental benefits from $500 to $600 per year, removing the age limit on sealants and fluoride varnishes, and increasing the cap on fluoride varnishes from one to two per year.

The Department also asked the contracted actuary to set an actuarial sound rate range for dental rates for FY 2011-12. For the development of the FY 2011-12 dental capitation rate, the contracted actuary based the annual trend rate between 0.0% and 4.0%. The high end of this range is slightly lower than industry trends (between 4.2% and 6.6%). Combined with the projected change in the age and income distribution in the Plan, the projected capitation rate range is $15.25 to $15.98. The suggested actuarial rate of $15.27 is a 6.04% decrease over the FY 2010-11 rate. The FY 2011-12 monthly rate includes $1.12 in administrative costs.

The Department's FY 2011-12 forecasted per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that other factors that may affect per capita costs, such as the length of stay in the Children's Basic Health Plan and the average length of time taken for a child to receive dental benefits,

remain constant from FY 2009-10 base period. Base growth of 6.04% from the capitation rate is applied to the calculated FY 2010-11 per capita of $159.35, resulting in a projected FY 2011-12 per capita of $168.97.

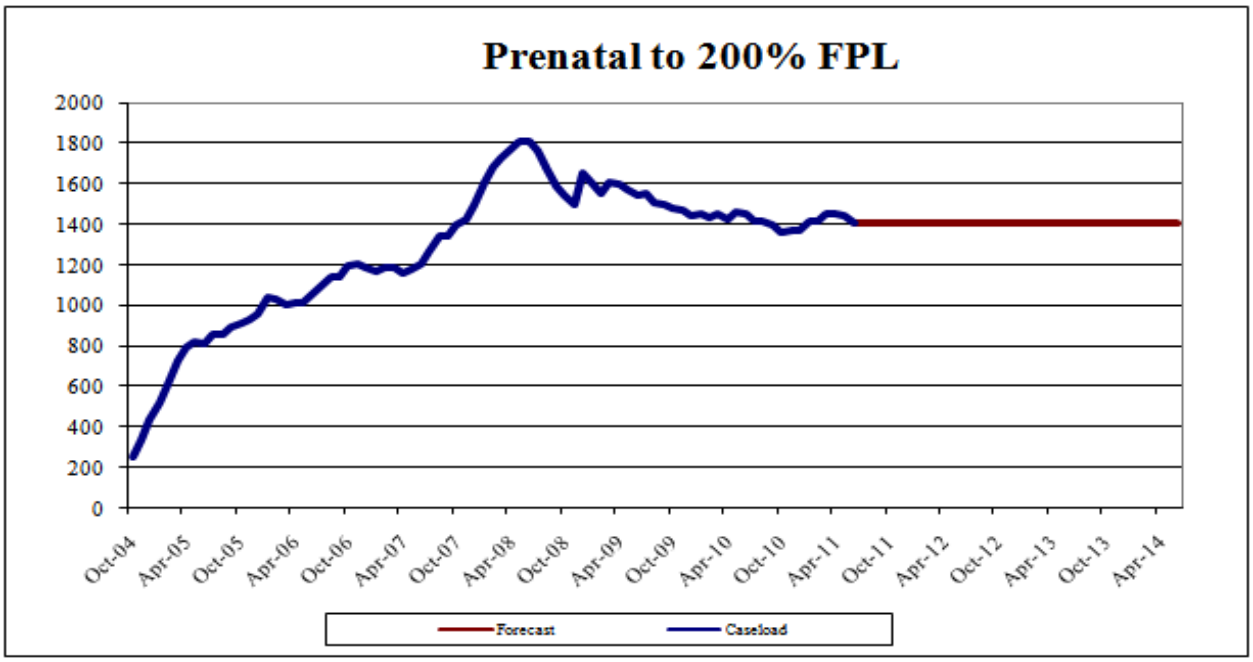
While discussing dental capitation rates with the contracted actuary, the Department performed an analysis of the dental rate expenditures and trends, which implied in a lower trend than the contracted actuary's calculations. The Department believes that the FY 2009-10 dental claims data include anomalies that are not expected to continue in the future, and that the use of the FY 2009-10 claims data as the base year from which the rate is projected, as well as part of the calculation of the trend, is resulting in a capitation rate that is much higher than anticipated claims costs plus administration and an acceptable risk margin in FY 2011-12. After discussions with Delta Dental, the Department has included a provision in their contract that will assure a risk margin for Delta Dental but will allow the Department to recuperate reimbursements made above this risk margin. Per the contract between the Department and Delta Dental, if the amount paid in CHP+ dental claims for FY 2011-12 is less than 91.7% of the total per member per month capitation paid to Delta Dental in FY 2011-12, Delta Dental will return the difference to the Department. If that amount is greater than 91.7% there is no action. The Department believes this that measure protects the State from unnecessary expenditures while ensuring that Delta Dental receives an acceptable and agreed upon risk margin for the CHP+ line of business.

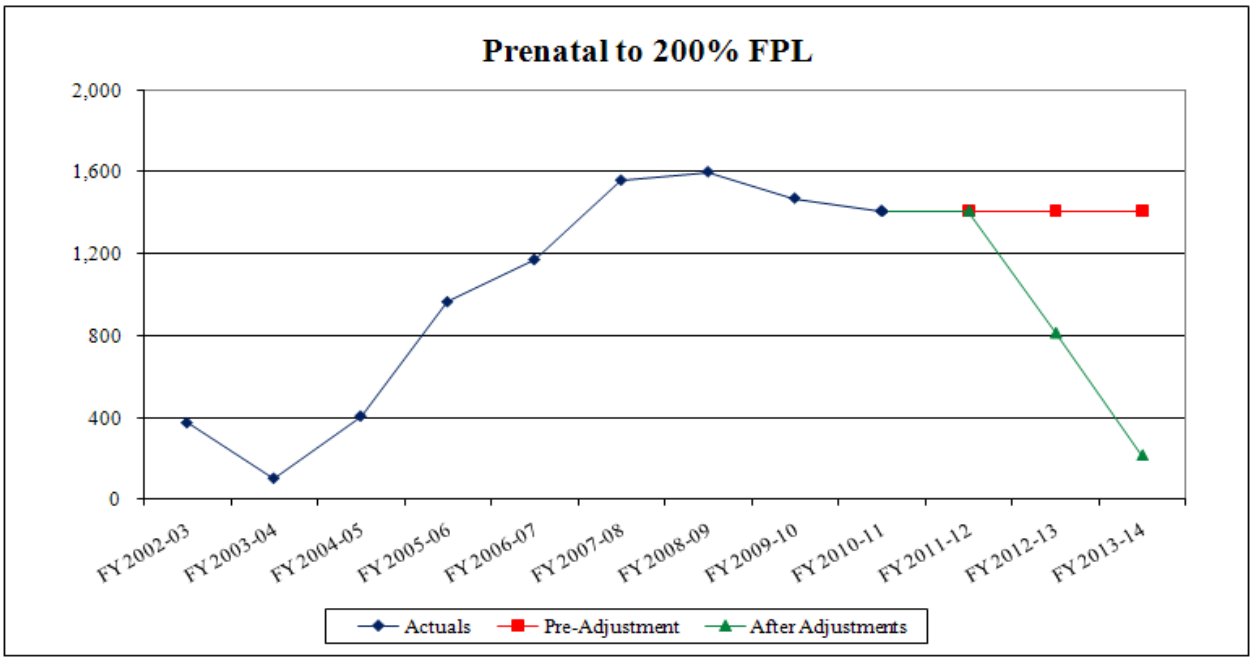
To estimate the FY 2012-13 per capita trends, the Department analyzed the historical growth in the dental rates. The Department has assumed that the growth rate for FY 2012-13 will approximate the average growth found in the literature, which averages at 4.0%. The projected FY 2012-13 per capita is $175.73. There are no per capita adjustments for the dental program.

II. Description of Request Related to the Prenatal Program

Prenatal Caseload Projections (Exhibit C.7)

Prenatal to 200% FPL





- The Department is combining the traditional prenatal (up to 185% FPL) caseload forecast with the prenatal expansion to 200% FPL caseload to create a new FPL category beginning this year. The expansion to 200% FPL was implemented in July 2005 and is now exhibiting trends similar to the Traditional Prenatal caseload. Thus, the Department is forecasting these categories together as "Prenatal to 200% FPL."
- Caseload growth in prenatal to 200% FPL in FY 2010-11 was lower than the Department's November 2010 forecast, in which annual caseload was projected to be 1,459 and average monthly growth was projected to be 1. The caseload for FY 2010-11 actually decreased by an average of 4 women per month. The declines in caseload at the end of calendar year 2010 were due to a backlog of applications which resulted from the change in the program's eligibility and enrollment vendor from Affiliated Computer Services to Maximus in late 2010. Due to the size of the prenatal caseload compared to the entire CHP+ caseload, this change did not affect prenatal caseload to the extent it affected the children's caseload. Once Maximus was able to resolve this backlog, the caseload began increasing as anticipated. The Department is currently investigating the unexpected decrease in caseload which has occurred during the past few months.
- The Department is modeling the FY 2011-12 forecast for the prenatal to 200% FPL population on the monthly growth experienced between May 2010 and June 2011, during which caseload declined by an average of 0.08% per month. This forecast is lower than that from the Department's November 2010 forecast, and would yield average growth of **0 per month**. The Department's forecast assumes that the FY 2012-13 trend will continue in out years, with zero growth on average. Caseload in this eligibility type has been volatile for 3 years, as can be seen in the tables on the next page. While the cause of the volatility is unknown at this time, the Department does not anticipate that it will continue.
- There is a bottom-line adjustment to the CHP+ prenatal caseload from SB 11-250, which increases Medicaid eligibility for pregnant women from 133% FPL to 185% FPL beginning in January 2013. This is expected to have a negative impact on CHP+ caseload as pregnant women currently in CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-250 estimate to account for the revised caseload forecasts using the same methodology used by the Department to estimate the fiscal impact of SB 11-250.

Prenatal to 200% FPL

	Actuals	Monthly Change	% Change
Jun-09	1,547	-	-
Jul-09	1,555	8	0.52%
Aug-09	1,505	(50)	-3.22%
Sep-09	1,499	(6)	-0.40%
Oct-09	1,478	(21)	-1.40%
Nov-09	1,471	(7)	-0.47%
Dec-09	1,443	(28)	-1.90%
Jan-10	1,453	10	0.69%
Feb-10	1,437	(16)	-1.10%
Mar-10	1,448	11	0.77%
Apr-10	1,428	(20)	-1.38%
May-10	1,460	32	2.24%
Jun-10	1,452	(8)	-0.55%
Jul-10	1,419	(33)	-2.27%
Aug-10	1,417	(2)	-0.14%
Sep-10	1,396	(21)	-1.48%
Oct-10	1,357	(39)	-2.79%
Nov-10	1,367	10	0.74%
Dec-10	1,370	3	0.22%
Jan-11	1,413	43	3.14%
Feb-11	1,415	2	0.14%
Mar-11	1,453	38	2.69%
Apr-11	1,452	(1)	-0.07%
May-11	1,443	(9)	-0.62%
Jun-11	1,409	(34)	-2.36%

Actuals		
	Monthly Change	% Change
6-month average	7	0.49%
12-month average	(4)	-0.23%
18-month average	(2)	-0.12%
24-month average	(6)	-0.38%

November 2010 Trend Selections			
FY 2010-11	1,459	-0.68%	(10)
FY 2011-12	1,471	0.82%	12
FY 2012-13	1,483	0.82%	12

	Caseload	% Change	Level Change
FY 2002-03	372	-	-
FY 2003-04	101	-72.85%	(271)
FY 2004-05	405	300.99%	304
FY 2005-06	963	137.78%	558
FY 2006-07	1,169	21.39%	206
FY 2007-08	1,557	33.19%	388
FY 2008-09	1,598	2.63%	41
FY 2009-10	1,469	-8.07%	(129)
FY 2010-11	1,409	-4.08%	(60)
FY 2011-12	1,409	0.00%	0
FY 2012-13	1,409	0.00%	0
FY 2013-14	1,409	0.00%	0

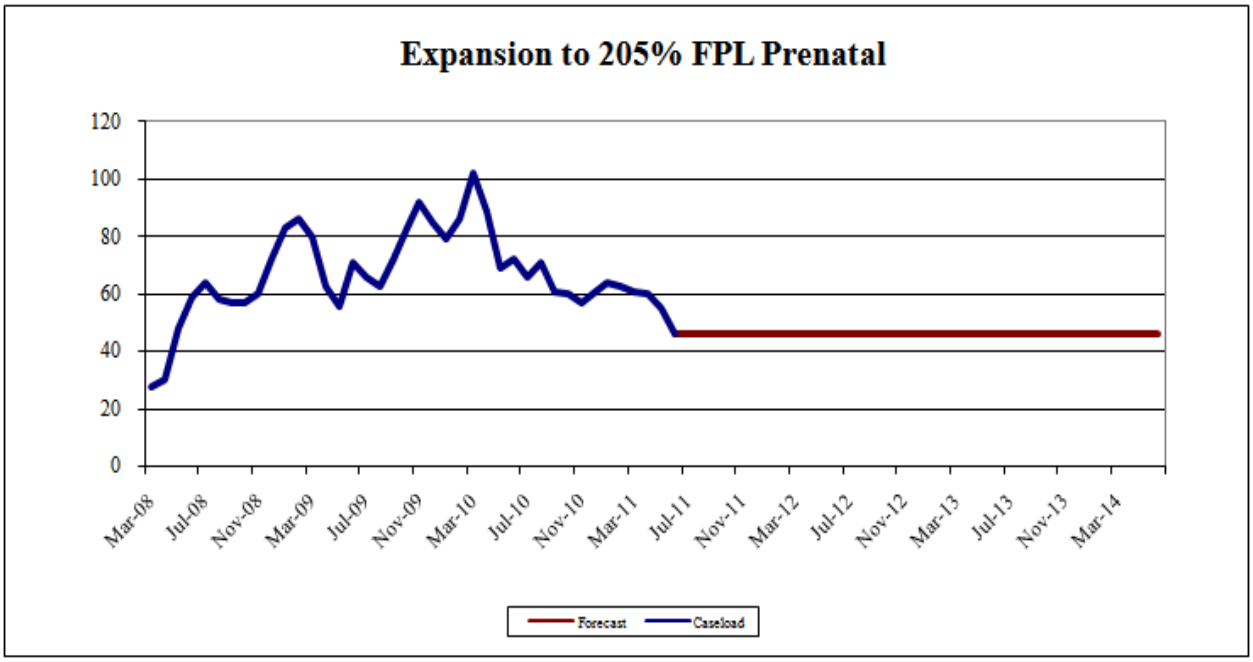
Monthly Average Growth Comparisons		
FY 2010-11 1st Half	(14)	-0.96%
FY 2010-11 2nd Half	7	0.49%
November 2010 Forecast	1	0.07%
FY 2011-12 Forecast	0	0.00%
November 2010 Forecast	1	0.07%
FY 2012-13 Forecast	0	0.00%
November 2010 Forecast	1	0.07%

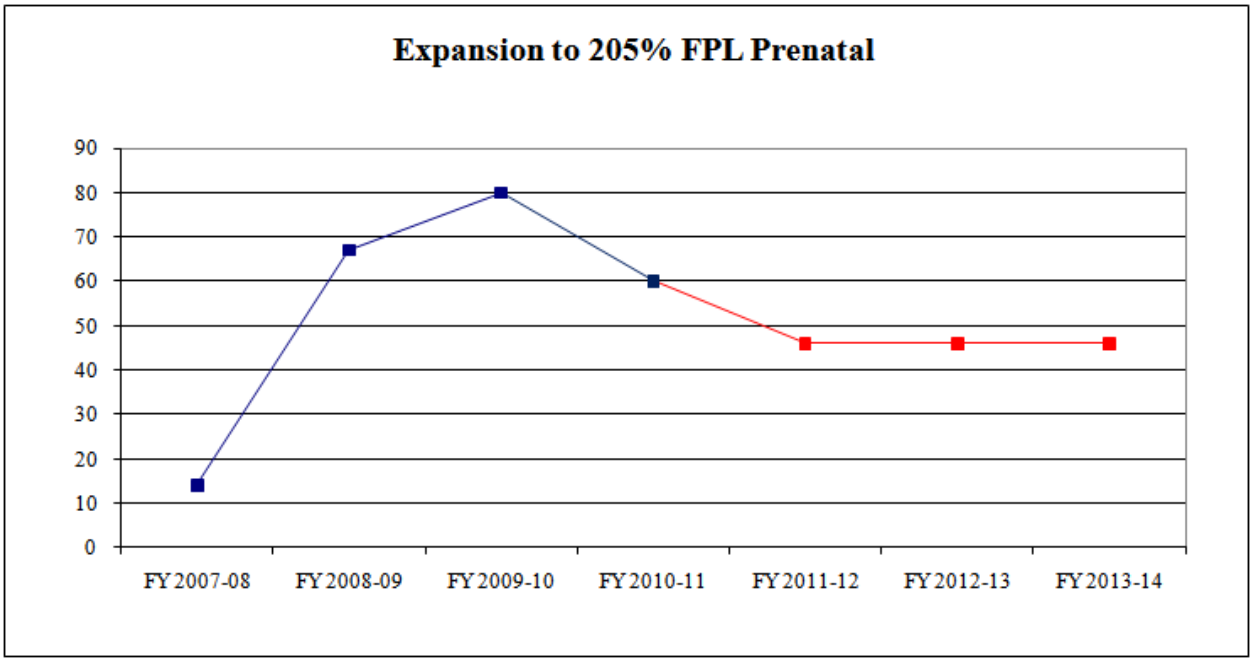
Adjustments (SB 11-250)	
FY 2011-12	0
FY 2012-13	(597)
FY 2013-14	(1,194)

Projections After Adjustments			
FY 2011-12	1,409	0.00%	0
FY 2012-13	812	-42.37%	(597)
FY 2013-14	215	-73.54%	(597)

Base trend from June 2011 level			
FY 2011-12	1,409	0	0.00%

Expansion to 205% Prenatal





- Along with the Expansion to 205% FPL children, this population was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this population have family income between 201-205% of the federal poverty level.
- Growth in Expansion to 205% FPL prenatal in FY 2010-11 was lower than the Department's November 2010 forecast in which annual caseload was projected to be 76 and average monthly growth was forecasted to be 1. The selected trend for FY 2011-12 for Expansion to 205% FPL prenatal is lower than the Department's November 2010 forecast, and would result in average growth **0 per month**. This is based on the average monthly caseload decrease of 0.02% that was experienced between July 2008

and June 2011. The negative forecasted trend for FY 2011-12 is due to the level shift experienced at the end of FY 2010-11, which leaves caseload at a low starting point for the year.

- The Department's forecast assumes that the FY 2012-13 trend will continue in out-years, with zero growth on average.

Expansion to 205% FPL Prenatal			
	Actuals	Monthly Change	% Change
Jun-09	71	-	-
Jul-09	66	(5)	-7.04%
Aug-09	63	(3)	-4.55%
Sep-09	72	9	14.29%
Oct-09	83	11	15.28%
Nov-09	92	9	10.84%
Dec-09	85	(7)	-7.61%
Jan-10	79	(6)	-7.06%
Feb-10	86	7	8.86%
Mar-10	102	16	18.60%
Apr-10	89	(13)	-12.75%
May-10	69	(20)	-22.47%
Jun-10	72	3	4.35%
Jul-10	66	(6)	-8.33%
Aug-10	71	5	7.58%
Sep-10	61	(10)	-14.08%
Oct-10	60	(1)	-1.64%
Nov-10	57	(3)	-5.00%
Dec-10	61	4	7.02%
Jan-11	64	3	4.92%
Feb-11	63	(1)	-1.56%
Mar-11	61	(2)	-3.17%
Apr-11	60	(1)	-1.64%
May-11	55	(5)	-8.33%
Jun-11	46	(9)	-16.36%

Base trend from June 2011 level			
FY 2011-12	46	(14)	-23.33%

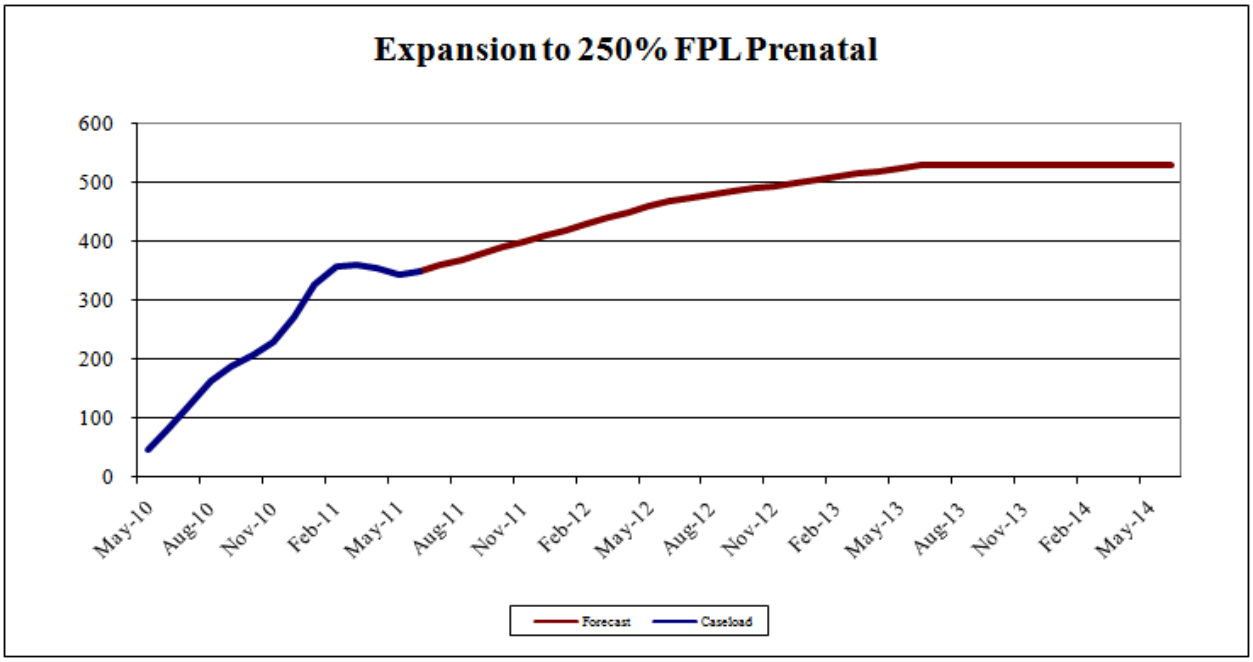
	Caseload	% Change	Level Change
FY 2007-08	14	-	-
FY 2008-09	67	378.57%	53
FY 2009-10	80	19.40%	13
FY 2010-11	60	-25.00%	(20)
FY 2011-12	46	-23.33%	(14)
FY 2012-13	46	0.00%	0
FY 2013-14	46	0.00%	0

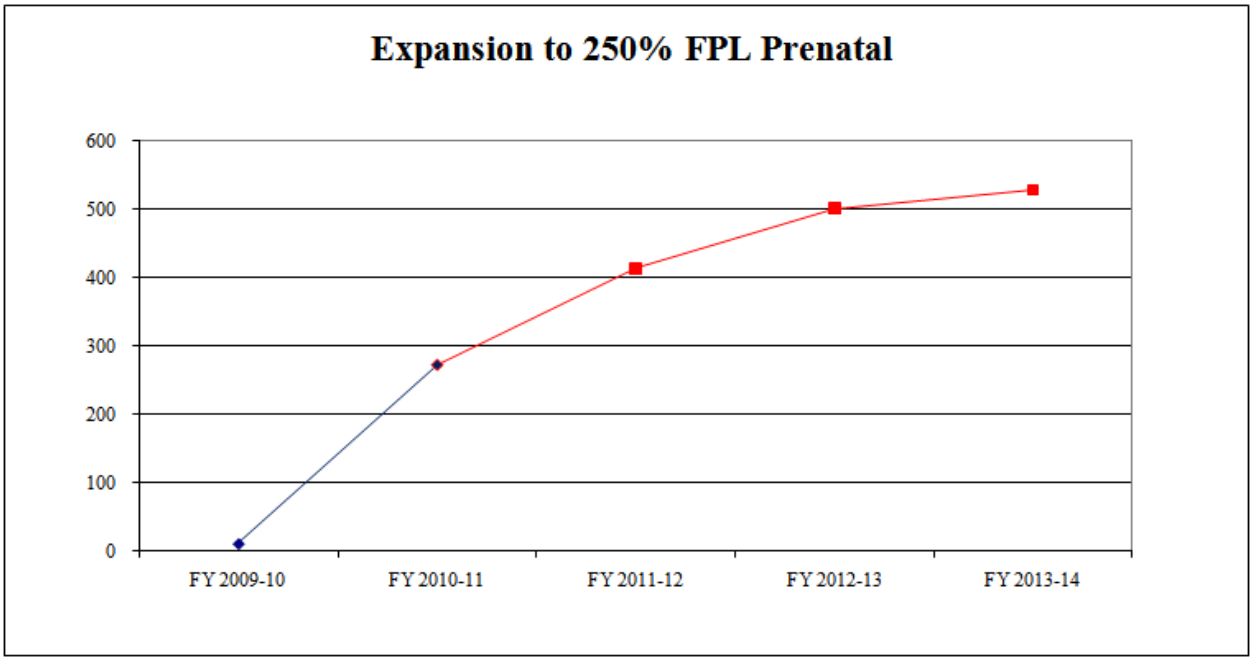
Actuals		
	Monthly Change	% Change
6-month average	(3)	-4.36%
12-month average	(2)	-3.38%
18-month average	(2)	-2.84%
24-month average	(1)	-1.24%

November 2010 Trend Selections			
FY 2010-11	76	-5.00%	(4)
FY 2011-12	82	7.89%	6
FY 2012-13	88	7.32%	6

Monthly Average Growth Comparisons		
FY 2010-11 1st Half	(2)	-2.41%
FY 2010-11 2nd Half	(3)	-4.36%
November 2010 Forecast	1	0.67%
FY 2011-12 Forecast	0	0.00%
November 2010 Forecast	1	0.62%
FY 2012-13 Forecast	0	0.00%
November 2010 Forecast	1	0.58%

Expansion to 250% FPL Prenatal





- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206-250% of the federal poverty level.
- Growth in FY 2010-11 was lower than the Department's November 2010 estimates in which annual caseload was projected to be 858 and average monthly growth was projected to be 119. The Department has decreased its caseload growth forecast to account for this lower growth.
- The selected trend for FY 2011-12 for Expansion to 250% FPL prenatal is lower than the Department's November 2010 forecast, and would result in average growth of **10 per month**. This is based on the

average monthly growth between January 2011 and June 2011, adjusted for expectations for slightly improving economic conditions. This trend is expected to moderate further in the out-years, resulting in average monthly growth of 5 in FY 2012-13.

Expansion to 250% Prenatal			
	Actuals	**Monthly Change**	**% Change**
May-10	46	-	-
Jun-10	83	37	80.43%
Jul-10	124	41	49.40%
Aug-10	162	38	30.65%
Sep-10	187	25	15.43%
Oct-10	206	19	10.16%
Nov-10	228	22	10.68%
Dec-10	270	42	18.42%
Jan-11	325	55	20.37%
Feb-11	357	32	9.85%
Mar-11	361	4	1.12%
Apr-11	355	(6)	-1.66%
May-11	342	(13)	-3.66%
Jun-11	349	7	2.05%

	Caseload	**% Change**	**Level Change**
FY 2009-10	11	-	-
FY 2010-11	272	2372.73%	261
FY 2011-12	414	52.21%	142
FY 2012-13	502	21.26%	88
FY 2013-14	529	5.38%	27

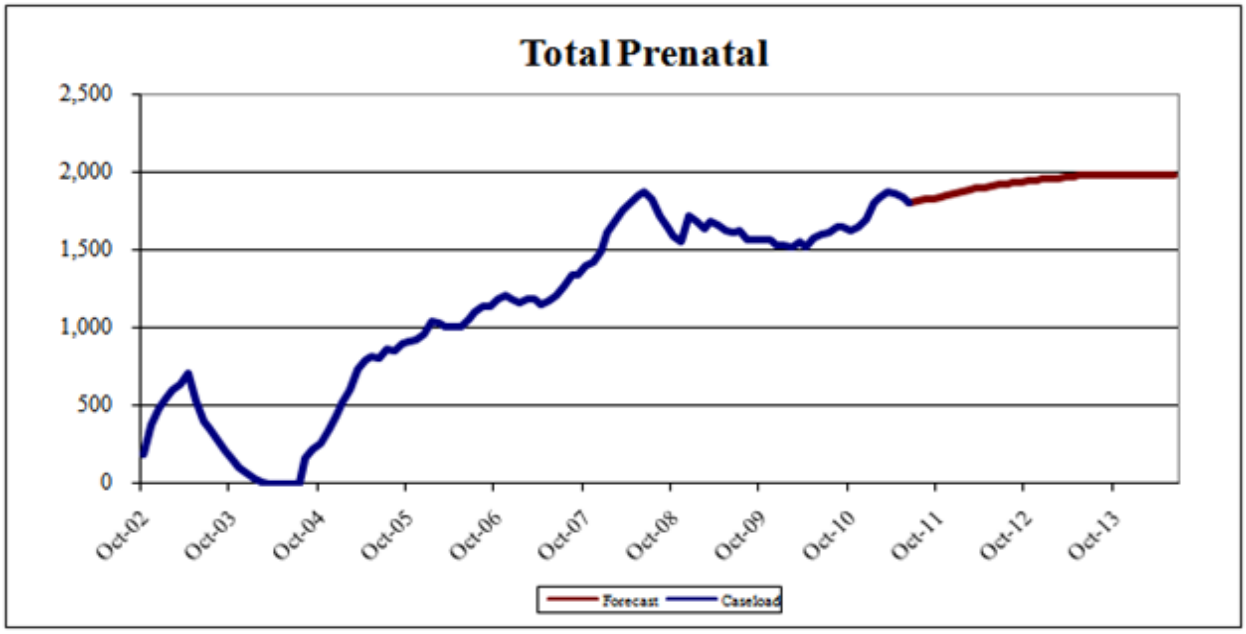
November 2010 Trend Selections			
FY 2010-11	858	1598.11%	847
FY 2011-12	1,750	103.96%	892
FY 2012-13	2,020	15.43%	270

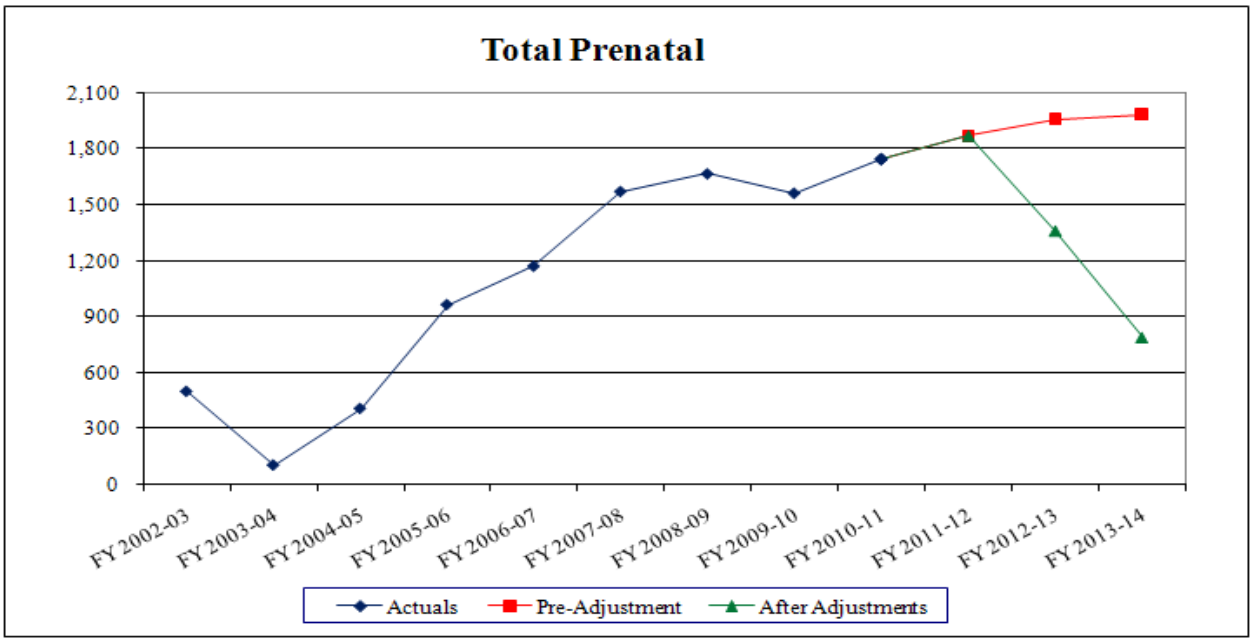
Actuals		
	Monthly Change	**% Change**
6-month average	13	4.68%
12-month average	22	13.57%

Base trend from June 2011 level			
FY 2011-12	349	77	28.31%

Monthly Average Growth Comparisons		
FY 2010-11 1st Half	31	22.46%
FY 2010-11 2nd Half	13	4.68%
November 2010 Forecast	119	31.10%
FY 2011-12 Forecast	10	2.49%
November 2010 Forecast	36	2.13%
FY 2012-13 Forecast	5	1.01%
November 2010 Forecast	35	1.66%

Total Prenatal





- In January 2011, the Department implemented a change to the Colorado Benefits Management System that allows the Department to remain in compliance with federal regulations, specifically Section 211 of the Children's Health Insurance Program Reauthorization Act of 2009. This section expands Medicaid citizenship documentation requirements in the Deficit Reduction Act of 2005 to CHP+, thus requiring clients who declare to be a U.S. citizen or nation to present satisfactory documentary evidence of this before enrolling or re-enrolling in the program. The Department has included the effects of this new documentation requirement in this caseload forecast.

- The FY 2011-12 total prenatal caseload forecast is 1,869, a 7.29% increase over the FY 2010-11 caseload of 1,742. This forecast includes average increases of **10** (**0.54%**) **per month**. The FY 2012-

13 caseload is projected to increase 4.71% to 1,957, and FY 2013-14 caseload is forecasted to grow 1.38% to 1,984. Total prenatal caseload is projected to increase by 0.26% (5 clients) per month in FY 2012-13 and 0.11% (2 clients) per month in FY 2013-14.

- There is a bottom-line adjustment to the CHP+ prenatal caseload from SB 11-250, which increases Medicaid eligibility for pregnant women from 133% FPL to 185% FPL beginning in January 2013. This is expected to have a negative impact on CHP+ caseload as pregnant women currently in CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-250 estimate to account for the revised caseload forecasts using the same methodology used by the Department to estimate the fiscal impact of SB 11-250. This adjustment decreases the FY 2012-13 caseload projection to 1,360 which is a 27.24% decrease over the FY 2011-12 forecast. This adjustment decreases the FY 2013-14 caseload projection to 790 which is a 41.92% decrease from the adjusted FY 2012-13 projection.

Total Prenatal			
	Actuals	**Monthly Change**	**% Change**
Jun-09	1,618	-	-
Jul-09	1,621	3	0.19%
Aug-09	1,568	(53)	-3.27%
Sep-09	1,571	3	0.19%
Oct-09	1,561	(10)	-0.64%
Nov-09	1,563	2	0.13%
Dec-09	1,528	(35)	-2.24%
Jan-10	1,532	4	0.26%
Feb-10	1,523	(9)	-0.59%
Mar-10	1,550	27	1.77%
Apr-10	1,517	(33)	-2.13%
May-10	1,575	58	3.82%
Jun-10	1,607	32	2.03%
Jul-10	1,609	2	0.12%
Aug-10	1,650	41	2.55%
Sep-10	1,644	(6)	-0.36%
Oct-10	1,623	(21)	-1.28%
Nov-10	1,652	29	1.79%
Dec-10	1,701	49	2.97%
Jan-11	1,802	101	5.94%
Feb-11	1,835	33	1.83%
Mar-11	1,875	40	2.18%
Apr-11	1,867	(8)	-0.43%
May-11	1,840	(27)	-1.45%
Jun-11	1,804	(36)	-1.96%

	Caseload	**% Change**	**Level Change**
FY 2002-03	497	-	-
FY 2003-04	101	-79.68%	(396)
FY 2004-05	405	300.99%	304
FY 2005-06	963	137.78%	558
FY 2006-07	1,169	21.39%	206
FY 2007-08	1,570	34.30%	401
FY 2008-09	1,665	6.05%	95
FY 2009-10	1,561	-6.25%	(104)
FY 2010-11	1,742	11.60%	181
FY 2011-12	1,869	7.29%	127
FY 2012-13	1,957	4.71%	88
FY 2013-14	1,984	1.38%	27

Monthly Average Growth Comparisons		
FY 2010-11 1st Half	16	0.96%
FY 2010-11 2nd Half	17	1.02%
November 2010 Forecast	121	6.06%
FY 2011-12 Forecast	10	0.54%
November 2010 Forecast	66	2.26%
FY 2012-13 Forecast	5	0.26%
November 2010 Forecast	13	0.36%

Actuals		
	Monthly Change	**% Change**
6-month average	17	1.02%
12-month average	16	0.99%
18-month average	15	0.95%
24-month average	8	0.48%

Adjustments (SB 11-250)	
FY 2011-12	0
FY 2012-13	(597)
FY 2013-14	(1,194)

November 2010 Trend Selections			
FY 2010-11	2,393	53.30%	832
FY 2011-12	3,303	38.03%	910
FY 2012-13	3,591	8.72%	288

Projections After Adjustments			
FY 2011-12	1,869	7.29%	127
FY 2012-13	1,360	-27.24%	(509)
FY 2013-14	790	-41.92%	(570)

Base trend from June 2011 level			
FY 2011-12	1,804	62	3.56%

Prenatal Per Capita (Exhibit C.5)

All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

Similar to the SMCN children annual trend, the prenatal cost trend from FY 2008-09 to FY 2009-10 was -14.7%. This is a substantial drop from the large, positive annual cost trends from the previous two years. This trend is driven primarily by inpatient and outpatient reimbursement reduction that occurred in July 2009 when the Department lowered its reimbursement to hospitals for these services from 66% to 44% of billed charges. Additionally, the reimbursement for the majority of CHP+ providers previously granted reimbursement exceptions was negotiated to 90% of Medicare Resource Based Relative Value Scale (RBRVS), effective November 2009. These decreases outweighed the increase in ambulatory services from 83% of Medicare RBRVS to 90%. The contracted actuary also reviewed published studies to determine industry norms for current and projected health care cost trends, which ranged from 4.40% to 11.20%. The actuarially set combined utilization and unit cost base trend across services is 17.9% for FY 2011-12.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they were be paid 135% of the Colorado Medicaid DRGs for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. In July 2011, the Department is moving from a 30% discount of Cost-to-Charge ratio to a 30.7% discount. Actuarial analysis shows a 42% savings in outpatient claims and a 14% savings for inpatient claims, or a total decrease of 19.10% in the base monthly rate for pregnant women in the SMCN due to all reimbursement changes.

The final FY 2011-12 SMCN prenatal per member per month rate is $1,144.27, which includes administrative costs of $24.22 for claims administration and case management. This is a 4.70% increase from the final FY 2010-11 rate.

The Department's FY 2011-12 forecasted per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that the capitation rate for the self-funded network is indeed in line with the costs incurred for the women and that length of stay in the program remains constant from FY 2009-10. The base growth of 4.70% is applied to the calculated FY 2010-11 per capita of $14,571.85 to estimate a base per capita of $15,256.50. There are no bottom line adjustments to the FY 2011-12 per capita at this time.

The Department has used the FY 2011-12 per capita growth rate to project the FY 2012-13 self-funded rate as there are no signs that this trend will not continue. Similar to the FY 2012-13 per capita, the projected growth in the FY 2012-13 capitation rate is used to project the FY 2012-13 per capita. The Department applies the projected 4.70% growth to the FY 2011-12 estimated per capita of $15,256.50 for a projected FY 2012-13 per capita of $15,973.31. There are currently no adjustments to the FY 2011-12 per capita for programmatic changes.

Table of Contents
Exhibits for R-3, "Children's Basic Health Plan Medical and Dental Costs"

Exhibit C.1 - Children's Basic Health Plan Trust Fund Analysis

		Actual	Actual	Actual	Actual	Actual	Actual	Actual	Estimated	Requested	Estimated	
	PROGRAM REVENUES	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Source**
A	Beginning Balance	$5,389,901	$9,025,270	$4,411,882	$7,776,123	$9,231,077	$6,608,063	$599,735	$7,745,026	$9,008,683	$7,302,543	Actual and R
B	General Fund Appropriations/Request to Trust[1]	$3,296,346	$2,000,000	$11,243,215	$5,564,404	$1,000,000	$2,710,779	$20,873,073	$0	$0	$0	Footnote 1
C	Direct General Fund Appropriations[1]	$0	$0	$0	$0	$0	$0	$0	$29,824,302	$25,066,119	$16,494,002	Footnote 1
D	January 2006 transfer from the State Controller	$0	$900,000	$0	$0	$0	$0	$0	$0	$0	$0	Actual
E	Tobacco Master Settlement Funds to Trust [2]	$20,629,548	$20,927,529	$19,214,822	$22,851,718	$24,832,639	$25,814,362	$26,910,570	$28,667,602	$28,240,818	$28,393,806	Footnote 2
F	Annual Enrollment Fees	$122,626	$191,726	$232,136	$283,367	$328,499	$346,589	$428,326	$474,720	$521,805	$551,320	Exhibits C.2, C.3
G	Interest Earnings	$587,893	$752,518	$367,880	$623,549	$447,522	$98,725	($1,693)	$0	$0	$0	Exhibit C.1
H	Accounts Payable Reversions from Prior Year	$156,901	$45,896	$10,591	$3,180	$0	$0	$36,191	$0	$0	$0	Actual
I	Supplemental Tobacco Litigation Settlement Account [2,3]	$0	$0	$0	$480,157	$1,841,459	$0	$0	$0	$0	$0	Footnotes 2, 3
J	Colorado Immunization Fund [4]	$0	$0	$0	$90,795	$171,251	$461,700	$461,700	$461,700	$461,700	$461,700	Footnote 4
K	Tobacco Tax to Trust [5]	$0	$0	$0	$0	$0	$0	$1,500,000	$446,100	$446,100	$446,100	Footnote 5
	Federal Match Earnings [6]	$40,591,092	$50,509,127	$65,616,702	$76,574,384	$88,044,043	$118,688,001	$117,426,204	$122,597,428	$123,157,685	$83,807,173	Footnote 6
L	**Total Revenues**	**$30,183,215**	**$33,842,939**	**$35,480,526**	**$37,673,294**	**$37,852,448**	**$36,040,218**	**$50,807,901**	**$67,619,450**	**$63,745,225**	**$53,649,471**	Sum A:K
	PROGRAM EXPENDITURES											
M	Program Expenditures from Trust Fund [6]	$21,157,945	$21,331,057	$27,704,403	$27,962,060	$29,862,571	$34,978,783	$42,601,175	$58,149,067	$55,980,982	$45,803,571	Footnote 6
N	Program Expenditures from Supplemental Tobacco Litigation Settlement Account [3,6]	$0	$0	$0	$480,157	$1,381,814	$0	$0	$0	$0	$0	Footnotes 3, 6
O	Estimated Program Expenditure from Colorado Immunization Fund [5,6]	$0	$0	$0	$90,795	$171,251	$461,700	$461,700	$461,700	$461,700	$461,700	Footnotes 4, 6
	Federal Match Expenditures [6]	$40,591,092	$50,509,127	$65,616,702	$76,574,384	$88,044,043	$118,688,001	$117,426,204	$122,597,428	$123,157,685	$83,807,173	Footnote 6
P	SB 05-211 Transfer to General Fund	$0	$8,100,000	$0	$0	$0	$0	$0	$0	$0	$0	Actual
Q	**Total Expenditures**	**$21,157,945**	**$29,431,057**	**$27,704,403**	**$28,442,217**	**$31,244,385**	**$35,440,483**	**$43,062,875**	**$58,610,767**	**$56,442,682**	**$46,265,271**	Sum M:P
R	**Remaining Balance in Trust Fund**	**$9,025,270**	**$4,411,882**	**$7,776,123**	**$9,231,077**	**$6,608,063**	**$599,735**	**$7,745,026**	**$9,008,683**	**$7,302,543**	**$7,384,200**	L - Q

[1] FY 2004-05 to FY 2010-11 are actual appropriations to the Trust Fund. During the 2011 Legislative Session, JBC Staff recommended that General Fund appropriations for Children's Basic Health Plan expenditures be made directly to the Children's Basic Health Plan Medical and Dental Costs line item beginning in FY 2011-12.

[2] FY 2004-05 to FY 2010-11 are actual revenue transferred. SB 11-216 increased the amount of Master Tobacco Settlement Tier 1 monies into the Trust from 24% to 27% and Tier 2 monies from 13.5% to 14.5% beginning in FY 2011-12. FY 2011-12 and FY 2012-13 are forecasts from Legislative Council (January 2011).

[3] FY 2007-08 and FY 2008-09 are actual revenues transferred from the Supplemental Tobacco Litigation Settlement Account created in SB 07-097 for Supplemental Expansion clients as well as estimated State expenditures for early intervention services. This Account was eliminated in FY 2009-10 through SB 09-210, and revenues are now transfered directly to the Children's Basic Health Plan Trust Fund.

[4] FY 2007-08, FY 2009-10 and FY 2010-11 are actual revenues transferred from the Colorado Immunization Fund for the cervical cancer immunization. FY 2011-12 and FY 2012-13 are projections historical revenues.

[5] FY 2010-11 is additional revenue transfered from the Health Care Expansion Fund. SB 11-216 diverts 0.3% of tobacco tax funds from the Pediatric Specialty Hospital Fund beginning in FY 2011-12. FY 2011-12 and FY 2012-13 are forecasts from Legislative Council (January 2011).

[6] Figures for FY 2004-05 through FY 2010-11 are actuals, while figures for FY 2011-12 through FY 2013-14 are projections. See Exhibits C.2 and C.3.

Exhibit C.1 - Children's Basic Health Plan Trust Fund Interest Earnings

Estimation of Interest Earnings to the Trust Fund	
FY 2006-07- Actual	
Interest Earned	$367,880
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$35,102,055
Ratio of Interest Earned	1.05%
FY 2007-08- Actual	
Interest Earned	$623,549
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$36,475,612
Ratio of Interest Earned	1.71%
FY 2008-09- Actual	
Interest Earned	$447,522
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$35,392,215
Ratio of Interest Earned	1.26%
FY 2009-10- Actual	
Interest Earned	$98,725
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$35,479,793
Ratio of Interest Earned	0.28%
FY 2010-11- Actual	
Interest Earned	($1,693)
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$48,811,703
Ratio of Interest Earned	0.00%
FY 2011-12- Projection	
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$66,711,650
Estimated Ratio of Interest Earned	0.00%
Estimated Interest Earnings (adjusted for partial years where applicable)	$0
FY 2012-13- Projection	
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$62,837,425
Ratio of Interest Earned	0.00%
Estimated Interest Earnings (adjusted for partial years where applicable)	$0
* Actual Interest earnings as reported in the Colorado Financial Reporting System.	

Exhibit C.2 - FY 2011-12 Expenditures

FY 2011-12 Children's Medical, Prenatal, Dental, Administration Request and Funding Splits					
	Reference	Caseload up to 200% FPL [1]	Expansion to 205% FPL [1]	Expansion to 250% FPL [2]	Total
FY 2011-12 CBHP Children's Medical Expenditures					
FY 2011-12 Enrollment Estimate	Exhibit C.6	58,376	1,165	7,891	67,432
Medical Per Capita	Exhibit C.5	$2,129.17	$2,129.17	$2,129.17	$2,129.17
Dental Per Capita	Exhibit C.5	$168.97	$168.97	$168.97	$168.97
Total Children's Expenditures		**$134,156,221**	**$2,677,333**	**$18,134,623**	**$154,968,177**
Annual Enrollment Fee Collection Per Enrollee [3]		$5.32	$18.11	$18.11	$7.04
Total Annual Enrollment Fee Collections (Cash Funds [4])		$310,755	$21,093	$142,872	$474,720
Expenditures to Be Matched by Federal Funds		$133,845,466	$2,656,240	$17,991,751	$154,493,457
Title XXI Federal Funds		$86,999,553	$1,726,556	$11,694,638	$100,420,747
State Funds		$46,845,913	$929,684	$6,297,113	$54,072,710
FY 2011-12 CBHP Prenatal Services Expenditures					
FY 2011-12 Prenatal Enrollment Estimate	Exhibit C.7	1,409	46	414	1,869
Prenatal Medical Per Capita	Exhibit C.5	$15,256.50	$15,256.50	$15,256.50	$15,256.50
Total Prenatal Medical Expenditures		**$21,496,409**	**$701,799**	**$6,316,191**	**$28,514,399**
Title XXI Federal Funds		$13,972,666	$456,169	$4,105,524	$18,534,359
State Funds		$7,523,743	$245,630	$2,210,667	$9,980,040
FY 2012-13 Children's Basic Health Plan Premiums Costs		**$155,652,630**	**$3,379,132**	**$24,450,814**	**$183,482,576**
Title XXI Federal Funds		$100,972,219	$2,182,725	$15,800,162	$118,955,106
State Funds [5]		$54,680,411	$1,196,407	$8,650,652	$64,527,470
FY 2011-12 Children's Basic Health Plan Administration					
FY 2011-12 External Administration Expenditures	Exhibit C.4	**$4,869,577**	**$0**	**$24,833**	**$4,894,410**
Title XXI Federal Funds		$964,301	$0	$16,141	$980,442
Title XIX Federal Funds		$1,693,020	$0	$0	$1,693,020
State Funds		$2,212,256	$0	$8,692	$2,220,948
FY 2011-12 Internal Administration Expenditures	Exhibit C.4	**$1,490,554**	**$0**	**$0**	**$1,490,554**
Title XXI Federal Funds		$968,860	$0	$0	$968,860
State Funds		$521,694	$0	$0	$521,694
FY 2011-12 Children's Basic Health Plan Expenditures		**$162,012,761**	**$3,379,132**	**$24,475,647**	**$189,867,540**
Title XXI and Title XIX Federal Funds		$104,598,400	$2,182,725	$15,816,303	$122,597,428
State Funds		$57,414,361	$1,196,407	$8,659,344	$67,270,112

[1] Clients up to 205% of the federal poverty level are funded from the Children's Basic Health Plan Trust Fund.

[2] Expansion clients between 206% and 250% of the federal poverty level are funded from the Hospital Provider Fee (HB 09-1293).

[3] Annual enrollment fees per enrollee for clients is the weighted average estimates by federal poverty level category. These estimates are based on the actual collections in FY 2010-11, adjusted for the projected share of clients required to pay the fee. The annual enrollment fee in the Total column is the weighted average for all clients.

[4] Annual enrollment fees are not eligible for a federal match.

[5] This amount includes the enrollment fees, as all enrollment fees collected are appropriated from the Trust Fund for use in the Premiums Costs.

Exhibit C.3 - FY 2012-13 Expenditures

FY 2012-13 Children's Medical, Prenatal, Dental, Administration Request and Funding Splits					
	Reference	**Caseload up to 200% FPL[1]**	**Expansion to 205% FPL[1]**	**Expansion to 250% FPL[2]**	**Total**
FY 2012-13 CBHP Children's Medical Expenditures					
FY 2012-13 Enrollment Estimate	Exhibit C.6	56,492	1,265	9,785	67,542
Medical Per Capita	Exhibit C.5	$2,231.79	$2,231.79	$2,231.79	$2,231.79
Dental Per Capita	Exhibit C.5	$175.73	$175.73	$175.73	$175.73
Total Children's Medical Expenditures		**$136,005,620**	**$3,045,513**	**$23,557,583**	**$162,608,716**
Annual Enrollment Fee Collection Per Enrollee [3]		$5.70	$18.11	$18.11	$7.73
Total Annual Enrollment Fee Collections (Cash Funds [4])		$321,725	$22,905	$177,175	$521,805
Expenditures to Be Matched by Federal Funds		$135,683,895	$3,022,608	$23,380,408	$162,086,911
Title XXI Federal Funds		$88,194,532	$1,964,695	$15,197,265	$105,356,492
State Funds		$47,489,363	$1,057,913	$8,183,143	$56,730,419
FY 2012-13 CBHP Prenatal Services Expenditures					
FY 2012-13 Prenatal Enrollment Estimate	Exhibit C.7	812	46	502	1,360
Prenatal Medical Per Capita	Exhibit C.5	$15,973.31	$15,973.31	$15,973.31	$15,973.31
Total Prenatal Medical Expenditures		**$12,970,328**	**$734,772**	**$8,018,602**	**$21,723,702**
Title XXI Federal Funds		$8,430,713	$477,602	$5,212,091	$14,120,406
State Funds		$4,539,615	$257,170	$2,806,511	$7,603,296
FY 2012-13 Children's Basic Health Plan Premiums Costs		**$148,975,948**	**$3,780,285**	**$31,576,185**	**$184,332,418**
Title XXI Federal Funds		$96,625,245	$2,442,297	$20,409,356	$119,476,898
State Funds [5]		$52,350,703	$1,337,988	$11,166,829	$64,855,520
FY 2012-13 Children's Basic Health Plan Administration					
FY 2012-13 Children's Basic Health Plan Administration	Exhibit C.4	**$4,871,577**	**$0**	**$26,745**	**$4,898,322**
Title XXI Federal Funds		$965,601	$0	$17,384	$982,985
Title XIX Federal Funds		$1,693,020	$0	$0	$1,693,020
State Funds		$2,212,956	$0	$9,361	$2,222,317
FY 2012-13 Internal Administration Expenditures	Exhibit C.8	**$1,545,818**	**$0**	**$0**	**$1,545,818**
Title XXI Federal Funds		$1,004,782	$0	$0	$1,004,782
State Funds		$541,036	$0	$0	$541,036
FY 2012-13 Children's Basic Health Plan Expenditures		**$155,393,343**	**$3,780,285**	**$31,602,930**	**$190,776,558**
Title XXI and Title XIX Federal Funds		$100,288,648	$2,442,297	$20,426,740	$123,157,685
State Funds		$55,104,695	$1,337,988	$11,176,190	$67,618,873

[1] Clients up to 205% of the federal poverty level are funded from the Children's Basic Health Plan Trust Fund.

[2] Expansion clients between 206% and 250% of the federal poverty level are funded from the Hospital Provider Fee (HB 09-1293).

[3] Annual enrollment fees per enrollee for clients is the weighted average estimates by federal poverty level category. These estimates are based on the actual collections in FY 2010-11, adjusted for the projected share of clients required to pay the fee. The annual enrollment fee in the Total column is the weighted average for all clients.

[4] Annual enrollment fees are not eligible for a federal match.

[5] This amount includes the enrollment fees, as all enrollment fees collected are appropriated from the Trust Fund for use in the Premiums Costs.

Exhibit C.4 - Children's Basic Health Plan Administration

Children's Basic Health Plan Administration Line Item							
Line	**External Administration Costs**	**FY 2011-12 Appropriation**	**FY 2011-12 Supplemental Request**	**FY 2011-12 Total Request**	**FY 2012-13 Base Request**	**FY 2012-13 Incremental Request**	**FY 2012-13 Total Request**
	Costs paid through the Children's Basic Health Plan Trust Fund						
1	Children's Operating Costs	$3,692,612	$0	$3,692,612	$3,692,612	$0	$3,692,612
2	Prenatal Operational Costs	$126,478	$0	$126,478	$126,478	$0	$126,478
3	Customer Service	$101,500	$0	$101,500	$101,500	$0	$101,500
4	**Subtotal Primary Administration (sum of Lines 1 - 3)**	**$3,920,590**	**$0**	**$3,920,590**	**$3,920,590**	**$0**	**$3,920,590**
5	Actuarial Services	$169,000	$0	$169,000	$171,000	$0	$171,000
6	Quality Assurance	$217,597	$0	$217,597	$217,597	$0	$217,597
7	Claims Audit, Miscellaneous Administrative Costs	$62,390	$0	$62,390	$62,390	$0	$62,390
8	**Subtotal Professional Services (sum of Lines 5 - 7)**	**$448,987**	**$0**	**$448,987**	**$450,987**	**$0**	**$450,987**
9	Hospital Provider Fee Administration	$24,833	$0	$24,833	$26,745	$0	$26,745
10	Outreach	$500,000	$0	$500,000	$500,000	$0	$500,000
11	**Total External Administration (Line 4 + Line 8 + Line 9 + Line 10)**	**$4,894,410**	**$0**	**$4,894,410**	**$4,898,322**	**$0**	**$4,898,322**
12	Federal Funds	$2,673,462	$0	$2,673,462	$2,676,005	$0	$2,676,005
13	Cash Funds	$2,220,948	$0	$2,220,948	$2,222,317	$0	$2,222,317

Exhibit C.4 - Children's Basic Health Plan Administration

FY 2011-12 External Administration Funding Splits						
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**Federal Funds @ 65%**	**State Funds @ 35%**	**Fund Source**
Children's Operating Costs (Line 1)	$3,692,612	12.0%	$443,115	$288,025	$155,090	Trust
Prenatal Operating Costs (Line 2)	$126,478	100.0%	$126,478	$82,211	$44,267	Trust
Customer Service (Line 3)	$101,500	77.3%	$78,459	$50,998	$27,461	Trust
Professional Services (Line 8)	$448,987	100.0%	$448,987	$291,842	$157,145	Trust
Hospital Provider Fee Administration (Line 9)	$24,833	100.0%	$24,833	$16,141	$8,692	Hospital Fee
Outreach (Line 10)	$500,000	77.3%	$386,500	$251,225	$135,275	General Fund
Total Title XXI	$4,894,410		$1,508,372	$980,442	$527,930	
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**Federal Funds @ 50%**	**State Funds @ 50%**	
Eligibility and Enrollment (Line 1)	$3,692,612	88.0%	$3,249,497	$1,624,749	$1,624,748	Trust
Prenatal Operating Costs (Line 2)	$126,478	0.0%	$0	$0	$0	Trust
Customer Service (Line 3)	$101,500	22.7%	$23,041	$11,521	$11,520	Trust
Professional Services (Line 8)	$448,987	0.0%	$0	$0	$0	Trust
Hospital Provider Fee Administration (Line 9)	$24,833	0.0%	$0	$0	$0	Hospital Fee
Outreach (Line 10)	$500,000	22.7%	$113,500	$56,750	$56,750	General Fund
Total Title XIX	$4,894,410		$3,386,038	$1,693,020	$1,693,018	
	Total Funds	**FF**	**Total State**	**General Fund**	**Trust Fund**	**Hospital Fee**
Total FY 2011-12 Appropriation Fund Splits	$4,894,410	$2,673,462	$2,220,948	$192,025	$2,020,231	$8,692

FY 2012-13 External Administration Funding Splits						
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**Federal Funds @ 65%**	**State Funds @ 35%**	**Fund Source**
Children's Operating Costs (Line 1)	$3,692,612	12.0%	$443,115	$288,025	$155,090	Trust
Prenatal Operating Costs (Line 2)	$126,478	100.0%	$126,478	$82,211	$44,267	Trust
Customer Service (Line 3)	$101,500	77.3%	$78,459	$50,998	$27,461	Trust
Professional Services (Line 8)	$450,987	100.0%	$450,987	$293,142	$157,845	Trust
Hospital Provider Fee Administration (Line 9)	$26,745	100.0%	$26,745	$17,384	$9,361	Hospital Fee
Outreach (Line 10)	$500,000	77.3%	$386,500	$251,225	$135,275	General Fund
Total Title XXI	$4,898,322		$1,512,284	$982,985	$529,299	
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**Federal Funds @ 50%**	**State Funds @ 50%**	
Eligibility and Enrollment (Line 1)	$3,692,612	88.0%	$3,249,497	$1,624,749	$1,624,748	Trust
Prenatal Operating Costs (Line 2)	$126,478	0.0%	$0	$0	$0	Trust
Customer Service (Line 3)	$101,500	22.7%	$23,041	$11,521	$11,520	Trust
Professional Services (Line 8)	$450,987	0.0%	$0	$0	$0	Trust
Hospital Provider Fee Administration (Line 9)	$26,745	0.0%	$0	$0	$0	Hospital Fee
Outreach (Line 10)	$500,000	22.7%	$113,500	$56,750	$56,750	General Fund
Total Title XIX	$4,898,322		$3,386,038	$1,693,020	$1,693,018	
	Total Funds	**FF**	**Total State**	**General Fund**	**Trust Fund**	**Hospital Fee**
Total FY 2012-13 Request Fund Splits	$4,898,322	$2,676,005	$2,222,317	$192,025	$2,020,931	$9,361

Exhibit C.4 - Children's Basic Health Plan Administration

Internal Administration Appropriation and Request			
Funds From Children's Basic Health Plan Trust Fund	**FY 2011-12 Year-to-date Appropriation**	**FY 2012-13 Request**	**Source**
General Administration; Personal Services	$252,721	$252,721	FY 11-10 Letternotes to SB 11-209 (Long Bill) Plus Special Bills FY 2012-13: Base Request Plus Decision Items
General Administration; Operating Expenses	$768	$768	
General Administration; Legal Service and Third Party Recovery Legal Services	$6,933	$6,933	
Information Technology Contracts and Projects	$246,755	$246,828	
Provider Audits and Services, Professional Audit Contracts	$0	$0	
Colorado Benefits Management System	$14,428	$14,834	
Colorado Benefits Management System - SAS 70 Audit	$89	$89	
Colorado Benefits Management System Client Services Improvement Project	$0	$0	
Total from the Children's Basic Health Plan Trust Fund	**$521,694**	**$529,545**	
Matching Federal Funds	$968,860	$983,441	
Total Internal Administration Costs	**$1,490,554**	**$1,512,986**	

Exhibit C.5 - Per Capita Costs History and Projections

Children's Medical	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Cash-based Expenditures [1]	$43,330,612	$56,713,621	$65,205,431	$91,693,631	$100,411,637	$150,306,188	$141,195,482		
Caseload [2]	35,800	41,945	47,047	57,795	61,582	68,725	67,267	67,432	67,542
Per Capita	$1,210.35	$1,352.09	$1,385.96	$1,586.53	$1,630.54	$2,187.07	$2,099.03	$2,129.17	$2,231.79
% Per Capita Change	0.05%	11.71%	2.51%	14.47%	2.77%	34.13%	-4.03%	1.44%	4.82%
Blended Base Rate [2]	$92.01	$102.12	$105.85	$119.78	$122.11	$145.34	$154.45	$156.67	$164.22
% Blended Rate Change	4.44%	10.99%	3.65%	13.16%	1.94%	19.03%	6.27%	1.44%	4.82%
Children's Dental	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Cash-based Expenditures [1]	$4,656,589	$5,707,513	$6,888,782	$8,735,185	$9,876,754	$10,766,208	$10,718,975		
Caseload	35,800	41,945	47,047	57,795	61,582	68,725	67,267	67,432	67,542
Per Capita	$130.07	$136.07	$146.42	$151.14	$160.38	$156.66	$159.35	$168.97	$175.73
% Per Capita Change	0.55%	4.61%	7.61%	3.22%	6.11%	-2.32%	1.72%	6.04%	4.00%
Rate	$11.31	$11.82	$13.30	$13.84	$14.66	$14.81	$14.40	$15.27	$15.88
% Rate Change	3.29%	4.51%	12.52%	4.06%	5.92%	1.02%	-2.77%	6.04%	4.00%
Prenatal Medical	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Cash-based Expenditures [1]	$6,685,402	$11,612,272	$16,892,791	$17,798,749	$19,437,577	$17,356,024	$25,369,597		
Caseload	472	963	1,170	1,570	1,665	1,561	1,741	1,869	1,360
Per Capita	$14,163.99	$12,058.43	$14,438.28	$11,336.78	$11,674.22	$11,118.53	$14,571.85	$15,256.50	$15,973.31
% Per Capita Change	16.64%	-14.87%	19.74%	-21.48%	2.98%	-4.76%	31.06%	4.70%	4.70%
Base Rate	$888.49	$816.97	$1,045.44	$864.09	$915.80	$821.35	$1,092.92	$1,144.27	$1,198.03
% Rate Change	-	-8.05%	27.97%	-17.35%	5.98%	-10.31%	33.06%	4.70%	4.70%

[1] Cash-based expenditures from the Colorado Financial Reporting System (COFRS). In children's medical only, the reversal of the FY 2005-06 accounts receivable in the amount of $4,661,297 artificially pushed expenditures from FY 2005-06 to FY 2006-07. The FY 2005-06 accounts receivable accounted for approximately 5.2% of the accrual-based expenditures in FY 2006-07. The FY 2006-07 cash-based expenditures for children's medical from COFRS are decreased by a like amount in order to approximate the FY 2006-07 expenditures without the artificial inflation. The FY 2006-07 expenditures reported here are adjusted.

[2] Calculated blended rate for FY 2004-05 through FY 2010-11 based on final caseload shares in the ASO and HMOs. Projected blended base rates for FY 2011-12 and FY 2012-13 assume that 30.0% of children will be in the State's managed care network, with the remainder in HMOs.

Exhibit C.5 - Per Capita Costs History and Projections

FY 2011-12 Capitation Rates					
	Kids- ASO	Kids- HMO	Kids- Blended [1]	Prenatal	Dental
FY 2010-11 Base Rate (Includes Facility and Physician Reimbursement Changes)	$174.93	$144.84	$154.45	$1,092.92	$14.40
FY 2011-12 Base Rate (Includes Facility and Physician Reimbursement Changes)	$167.99	$151.82	$156.67	$1,144.27	$15.27
FY 2011-12 Base Growth	-3.97%	4.82%	1.44%	4.70%	6.04%
Total FY 2011-12 Rate	$167.99	$151.82	$156.67	$1,144.27	$15.27

FY 2011-12 Per Capita Calculations			
	Kids (Blended)	Prenatal	Dental
FY 2010-11 Total Per Capita	$2,099.03	$14,571.85	$159.35
FY 2011-12 Base Growth	1.44%	4.70%	6.04%
Projected FY 2011-12 Base Per Capita	**$2,129.17**	**$15,256.50**	**$168.97**
Projected FY 2011-12 Final Per Capita	**$2,129.17**	**$15,256.50**	**$168.97**

[1] Projected blended rates for FY 2011-12 assume that 30.0% of children will be in the State's managed care network, with the remainder in HMOs.

FY 2012-13 Per Capita Calculations			
	Kids (Blended)	Prenatal	Dental
FY 2011-12 Total Per Capita	$2,129.17	$15,256.50	$168.97
FY 2012-13 Base Growth Projection	4.82%	4.70%	4.00%
Projected FY 2012-13 Base Per Capita	**$2,231.79**	**$15,973.31**	**$175.73**
Projected FY 2012-13 Final Per Capita	**$2,231.79**	**$15,973.31**	**$175.73**

Exhibit C.6 - Children's Caseload History and Projections

Historical Monthly Caseload												
	FY 1998-99	**FY 1999-00**	**FY 2000-01**	**FY 2001-02**	**FY 2002-03**	**FY 2003-04**	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**
Average Monthly Caseload	**12,825**	**22,935**	**28,321**	**37,042**	**44,600**	**41,786**	**35,800**	**41,945**	**47,047**	**57,795**	**61,582**	**68,725**
Annual Growth	**-**	**78.83%**	**23.48%**	**30.79%**	**20.40%**	**-6.31%**	**-14.33%**	**17.16%**	**12.16%**	**22.85%**	**6.55%**	**11.60%**

	Historical Monthly Caseload				**Projections**							
	FY 2010-11				**FY 2011-12**				**FY 2012-13**			
	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Children	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Children	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Children
July	**66,321**	**1,338**	**1,511**	**69,170**	57,024	1,113	6,401	64,538	59,656	1,226	9,229	70,111
August	**66,126**	**1,263**	**2,018**	**69,407**	57,295	1,122	6,704	65,121	59,798	1,233	9,330	70,361
September	**64,632**	**1,192**	**2,505**	**68,329**	57,568	1,131	7,007	65,706	59,940	1,240	9,431	70,611
October	**62,786**	**1,144**	**2,935**	**66,865**	57,842	1,140	7,310	66,292	60,083	1,247	9,532	70,862
November	**61,919**	**1,134**	**3,342**	**66,395**	58,117	1,149	7,613	66,879	60,226	1,254	9,633	71,113
December	**61,662**	**1,156**	**3,759**	**66,577**	58,394	1,159	7,916	67,469	60,369	1,261	9,734	71,364
January	**61,925**	**1,178**	**4,316**	**67,419**	58,579	1,169	8,118	67,866	60,513	1,268	9,835	71,616
February	**61,822**	**1,110**	**4,888**	**67,820**	58,765	1,179	8,320	68,264	60,657	1,275	9,936	71,868
March	**62,097**	**1,108**	**5,358**	**68,563**	58,951	1,189	8,522	68,662	60,801	1,282	10,037	72,120
April	**60,829**	**1,118**	**5,674**	**67,621**	59,138	1,199	8,724	69,061	60,946	1,289	10,138	72,373
May	**58,089**	**1,121**	**5,872**	**65,082**	59,326	1,209	8,926	69,461	61,091	1,296	10,239	72,626
June	**56,754**	**1,104**	**6,098**	**63,956**	59,514	1,219	9,128	69,861	61,236	1,303	10,340	72,879
Average Monthly Caseload	**62,080**	**1,164**	**4,023**	**67,267**	**58,376**	**1,165**	**7,891**	**67,432**	**60,443**	**1,265**	**9,785**	**71,493**
Annual Growth				**-2.12%**	**-5.97%**	**0.09%**	**96.15%**	**0.25%**	**3.54%**	**8.58%**	**24.00%**	**6.02%**
SB 11-008 Adjustments[1]									(3,951)	0	0	(3,951)
Final Caseload with Adjustments									**56,492**	**1,265**	**9,785**	**67,542**
Annual Growth									**-3.23%**	**8.58%**	**24.00%**	**0.16%**

[1] Adjustment for SB 11-008 is added to the children to 200% FPL population beginning in FY 2012-13. This bill increases Medicaid eligibility for children aged 6 to 18 to 185% FPL, resulting in decreased enrollment in the Children's Basic Health Plan. See Appendix A for details.

Exhibit C.6 - Children's Caseload History and Projections

FY 2011-12 Projection

	Prior Month Caseload to 200% FPL Caseload	Caseload to 200% FPL Base Growth [1]	Caseload to 200% FPL Monthly Change	Caseload to 200% FPL Children Projection	Prior Month Expansion to 205% FPL Caseload	Expansion to 205% FPL Base Growth [2]	Expansion to 205% FPL Monthly Change	Expansion to 205% FPL Children Projection	Prior Month Expansion to 250% FPL Caseload	Expansion to 250% FPL Base Growth [3]	Expansion to 250% FPL Monthly Change	Expansion to 250% FPL Children Projection	FY 2011-12 Total Children's Caseload (Pre-adjustments)
July	56,754	0.5%	270	57,024	1,104	0.8%	9	1,113	6,098	5.0%	303	6,401	64,538
August	57,024	0.5%	271	57,295	1,113	0.8%	9	1,122	6,401	4.7%	303	6,704	65,121
September	57,295	0.5%	273	57,568	1,122	0.8%	9	1,131	6,704	4.5%	303	7,007	65,706
October	57,568	0.5%	274	57,842	1,131	0.8%	9	1,140	7,007	4.3%	303	7,310	66,292
November	57,842	0.5%	275	58,117	1,140	0.8%	9	1,149	7,310	4.1%	303	7,613	66,879
December	58,117	0.5%	277	58,394	1,149	0.9%	10	1,159	7,613	4.0%	303	7,916	67,469
January	58,394	0.3%	185	58,579	1,159	0.9%	10	1,169	7,916	2.6%	202	8,118	67,866
February	58,579	0.3%	186	58,765	1,169	0.9%	10	1,179	8,118	2.5%	202	8,320	68,264
March	58,765	0.3%	186	58,951	1,179	0.8%	10	1,189	8,320	2.4%	202	8,522	68,662
April	58,951	0.3%	187	59,138	1,189	0.8%	10	1,199	8,522	2.4%	202	8,724	69,061
May	59,138	0.3%	188	59,326	1,199	0.8%	10	1,209	8,724	2.3%	202	8,926	69,461
June	59,326	0.3%	188	59,514	1,209	0.8%	10	1,219	8,926	2.3%	202	9,128	69,861
Average Monthly Caseload		0.4%	230	58,376		0.8%	10	1,165		3.4%	253	7,891	67,432
Growth Rate				-6.0%				0.1%				96.1%	0.2%

FY 2012-13 Projection

	Prior Month Caseload to 200% FPL Caseload	Caseload to 200% FPL Base Growth [1]	Caseload to 200% FPL Monthly Change	Caseload to 200% FPL Children Projection	Prior Month Expansion to 205% FPL Caseload	Expansion to 205% FPL Base Growth [2]	Expansion to 205% FPL Monthly Change	Expansion to 205% FPL Children Projection	Prior Month Expansion to 250% FPL Caseload	Expansion to 250% FPL Base Growth [3]	Expansion to 250% FPL Monthly Change	Expansion to 250% FPL Children Projection	FY 2012-13 Total Children's Caseload (Pre-adjustments)
July	59,514	0.2%	142	59,656	1,219	0.6%	7	1,226	9,128	1.1%	101	9,229	70,111
August	59,656	0.2%	142	59,798	1,226	0.6%	7	1,233	9,229	1.1%	101	9,330	70,361
September	59,798	0.2%	142	59,940	1,233	0.6%	7	1,240	9,330	1.1%	101	9,431	70,611
October	59,940	0.2%	143	60,083	1,240	0.6%	7	1,247	9,431	1.1%	101	9,532	70,862
November	60,083	0.2%	143	60,226	1,247	0.6%	7	1,254	9,532	1.1%	101	9,633	71,113
December	60,226	0.2%	143	60,369	1,254	0.6%	7	1,261	9,633	1.0%	101	9,734	71,364
January	60,369	0.2%	144	60,513	1,261	0.6%	7	1,268	9,734	1.0%	101	9,835	71,616
February	60,513	0.2%	144	60,657	1,268	0.6%	7	1,275	9,835	1.0%	101	9,936	71,868
March	60,657	0.2%	144	60,801	1,275	0.5%	7	1,282	9,936	1.0%	101	10,037	72,120
April	60,801	0.2%	145	60,946	1,282	0.5%	7	1,289	10,037	1.0%	101	10,138	72,373
May	60,946	0.2%	145	61,091	1,289	0.5%	7	1,296	10,138	1.0%	101	10,239	72,626
June	61,091	0.2%	145	61,236	1,296	0.5%	7	1,303	10,239	1.0%	101	10,340	72,879
Average Monthly Caseload		0.2%	144	60,443		0.6%	7	1,265		1.0%	101	9,785	71,493
Growth Rate				3.5%				8.6%				24.0%	6.0%

[1] The FY 2011-12 children's caseload up to 200% FPL is forecasted to increase by an average of 0.4% per month. This forecast is based on statistical analysis of caseload data since FY 2002-03. The FY 2012-13 caseload is forecasted to increase an average of 0.2% per month. See Appendix A for details.

[2] The Expansion to 205% FPL Children caseload is forecasted to increase by an average of 0.8% per month in FY 2011-12. The FY 2012-13 forecast assumes that monthly growth would decrease to an average of 0.6% per month. See Appendix A for details.

Exhibit C.7 - Prenatal Caseload History and Projections

Historical Monthly Caseload												
						FY 2008-09			FY 2009-10			
	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	Caseload to 200% FPL	Expansion to 205% FPL	Total Prenatal	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Prenatal
July	**347**	**0**	**859**	**1,098**	**1,264**	**1,766**	**64**	**1,830**	**1,555**	**66**	**0**	**1,621**
August	**284**	**157**	**852**	**1,138**	**1,342**	**1,660**	**58**	**1,718**	**1,505**	**63**	**0**	**1,568**
September	**212**	**221**	**894**	**1,142**	**1,341**	**1,590**	**57**	**1,647**	**1,499**	**72**	**0**	**1,571**
October	**148**	**254**	**915**	**1,191**	**1,398**	**1,539**	**57**	**1,596**	**1,478**	**83**	**0**	**1,561**
November	**105**	**337**	**928**	**1,206**	**1,425**	**1,497**	**60**	**1,557**	**1,471**	**92**	**0**	**1,563**
December	**69**	**430**	**954**	**1,184**	**1,496**	**1,651**	**72**	**1,723**	**1,443**	**85**	**0**	**1,528**
January	**34**	**516**	**1,039**	**1,167**	**1,611**	**1,599**	**83**	**1,682**	**1,453**	**79**	**0**	**1,532**
February	**12**	**606**	**1,031**	**1,182**	**1,683**	**1,551**	**86**	**1,637**	**1,437**	**86**	**0**	**1,523**
March	**0**	**729**	**1,006**	**1,184**	**1,754**	**1,609**	**80**	**1,689**	**1,448**	**102**	**0**	**1,550**
April	**0**	**791**	**1,011**	**1,154**	**1,801**	**1,596**	**63**	**1,659**	**1,428**	**89**	**0**	**1,517**
May	**0**	**816**	**1,007**	**1,178**	**1,857**	**1,568**	**56**	**1,624**	**1,460**	**69**	**46**	**1,575**
June	**0**	**809**	**1,060**	**1,207**	**1,872**	**1,547**	**71**	**1,618**	**1,452**	**72**	**83**	**1,607**
Average Monthly Caseload	**101**	**472**	**963**	**1,170**	**1,570**	**1,598**	**67**	**1,665**	**1,470**	**80**	**11**	**1,561**
Annual Growth	**-79.68%**	**367.33%**	**104.03%**	**21.50%**	**34.19%**			**6.05%**	**-8.01%**	**19.40%**		**-6.25%**

	Historical Monthly Caseload				Projections							
	FY 2010-11				FY 2011-12				FY 2012-13			
	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Prenatal	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Prenatal	Caseload to 200% FPL	Expansion to 205% FPL	Expansion to 250% FPL	Total Prenatal
July	**1,419**	**66**	**124**	**1,609**	1,409	46	359	1,814	1,409	46	474	1,929
August	**1,417**	**71**	**162**	**1,650**	1,409	46	369	1,824	1,409	46	479	1,934
September	**1,396**	**61**	**187**	**1,644**	1,409	46	379	1,834	1,409	46	484	1,939
October	**1,357**	**60**	**206**	**1,623**	1,409	46	389	1,844	1,409	46	489	1,944
November	**1,367**	**57**	**228**	**1,652**	1,409	46	399	1,854	1,409	46	494	1,949
December	**1,370**	**61**	**270**	**1,701**	1,409	46	409	1,864	1,409	46	499	1,954
January	**1,413**	**64**	**325**	**1,802**	1,409	46	419	1,874	1,409	46	504	1,959
February	**1,415**	**63**	**357**	**1,835**	1,409	46	429	1,884	1,409	46	509	1,964
March	**1,453**	**61**	**361**	**1,875**	1,409	46	439	1,894	1,409	46	514	1,969
April	**1,452**	**60**	**355**	**1,867**	1,409	46	449	1,904	1,409	46	519	1,974
May	**1,443**	**55**	**342**	**1,840**	1,409	46	459	1,914	1,409	46	524	1,979
June	**1,409**	**46**	**349**	**1,804**	1,409	46	469	1,924	1,409	46	529	1,984
Average Monthly Caseload	**1,409**	**60**	**272**	**1,741**	**1,409**	**46**	**414**	**1,869**	**1,409**	**46**	**502**	**1,957**
Annual Growth	**-4.15%**	**-25.00%**	**2372.73%**	**11.53%**	**0.00%**	**-23.33%**	**52.21%**	**7.35%**	**0.00%**	**0.00%**	**21.26%**	**4.71%**
SB 11-250 Adjustments[1]									(597)	0	0	(597)
Final Caseload with Adjustments									**812**	**46**	**502**	**1,360**
Annual Growth									**-42.37%**	**0.00%**	**21.26%**	**-27.23%**

[1] Adjustment for SB 11-250 is added to the Prenatal to 200% FPL population beginning in FY 2012-13. This bill increases Medicaid eligibility for pregnant women up to 185% FPL, resulting in decreased enrollment in the Children's Basic Health Plan. See Appendix A for details.

Exhibit C.7 - Prenatal Caseload History and Projections

FY 2011-12 Projection

	Prior Month Caseload to 200% FPL Caseload	Caseload to 200% FPL Base Growth [1]	Caseload to 200% FPL Monthly Change	Caseload to 200% FPL Prenatal Projection	Prior Month Expansion to 205% FPL Caseload	Expansion to 205% FPL Base Growth [2]	Expansion to 205% FPL Monthly Change	Expansion to 205% FPL Prenatal Projection	Prior Month Expansion to 250% FPL Caseload	Expansion to 250% FPL Base Growth [3]	Expansion to 250% FPL Monthly Change	Expansion to 250% FPL Prenatal Projection	FY 2011-12 Total Prenatal Caseload
July	1,409	0.0%	0	1,409	46	0.0%	0	46	349	2.9%	10	359	1,814
August	1,409	0.0%	0	1,409	46	0.0%	0	46	359	2.8%	10	369	1,824
September	1,409	0.0%	0	1,409	46	0.0%	0	46	369	2.7%	10	379	1,834
October	1,409	0.0%	0	1,409	46	0.0%	0	46	379	2.6%	10	389	1,844
November	1,409	0.0%	0	1,409	46	0.0%	0	46	389	2.6%	10	399	1,854
December	1,409	0.0%	0	1,409	46	0.0%	0	46	399	2.5%	10	409	1,864
January	1,409	0.0%	0	1,409	46	0.0%	0	46	409	2.4%	10	419	1,874
February	1,409	0.0%	0	1,409	46	0.0%	0	46	419	2.4%	10	429	1,884
March	1,409	0.0%	0	1,409	46	0.0%	0	46	429	2.3%	10	439	1,894
April	1,409	0.0%	0	1,409	46	0.0%	0	46	439	2.3%	10	449	1,904
May	1,409	0.0%	0	1,409	46	0.0%	0	46	449	2.2%	10	459	1,914
June	1,409	0.0%	0	1,409	46	0.0%	0	46	459	2.2%	10	469	1,924
Average Monthly Caseload		0.0%	0	1,409		0.0%	0	46		2.5%	10	414	1,869
Annual Growth				0.0%				-23.3%				52.2%	19.7%

FY 2012-13 Projection

	Prior Month Caseload to 200% FPL Caseload	Caseload to 200% FPL Base Growth [1]	Caseload to 200% FPL Monthly Change	Caseload to 200% FPL Prenatal Projection	Prior Month Expansion to 205% FPL Caseload	Expansion to 205% FPL Base Growth [2]	Expansion to 205% FPL Monthly Change	Expansion to 205% FPL Prenatal Projection	Prior Month Expansion to 250% FPL Caseload	Expansion to 250% FPL Base Growth [3]	Expansion to 250% FPL Monthly Change	Expansion to 250% FPL Prenatal Projection	FY 2012-13 Total Prenatal Caseload
July	1,409	0.0%	0	1,409	46	0.0%	0	46	469	1.1%	5	474	1,929
August	1,409	0.0%	0	1,409	46	0.0%	0	46	474	1.1%	5	479	1,934
September	1,409	0.0%	0	1,409	46	0.0%	0	46	479	1.0%	5	484	1,939
October	1,409	0.0%	0	1,409	46	0.0%	0	46	484	1.0%	5	489	1,944
November	1,409	0.0%	0	1,409	46	0.0%	0	46	489	1.0%	5	494	1,949
December	1,409	0.0%	0	1,409	46	0.0%	0	46	494	1.0%	5	499	1,954
January	1,409	0.0%	0	1,409	46	0.0%	0	46	499	1.0%	5	504	1,959
February	1,409	0.0%	0	1,409	46	0.0%	0	46	504	1.0%	5	509	1,964
March	1,409	0.0%	0	1,409	46	0.0%	0	46	509	1.0%	5	514	1,969
April	1,409	0.0%	0	1,409	46	0.0%	0	46	514	1.0%	5	519	1,974
May	1,409	0.0%	0	1,409	46	0.0%	0	46	519	1.0%	5	524	1,979
June	1,409	0.0%	0	1,409	46	0.0%	0	46	524	1.0%	5	529	1,984
Average Monthly Caseload		0.0%	0	1,409		0.0%	0	46		1.0%	5	502	1,957
Annual Growth				0.0%				0.0%				21.3%	4.7%

[1] The FY 2011-12 Prenatal caseload to 200% FPL is forecasted to decrease by slightly less than an average of 0.0% per month. This forecast is based on growth experienced between January 2009 and July 2010. The FY 2012-13 monthly growth rate is projected to remain the same at slightly below 0.0%. See Appendix A for details.

[2] The Expansion to 205% FPL Prenatal caseload is forecasted to increase by an average of 0% per month. This forecast is based on experience from July 2009 and June 2011. The FY 2012-13 forecast assumes that monthly growth would remain the same. See Appendix A for details.

[3] The Expansion to 250% FPL Prenatal caseload is forecasted to increase by an average of 2.5% per month in FY 2011-12. Growth is anticipated to decrease to an average of 0.9% per month in FY 2012-13. See Appendix A for details.

Exhibit C.8 - SCHIP Federal Allotment Forecast

SCHIP Federal Allotment Forecast for Colorado as of November 1, 2011										
State Fiscal Year (July 1 - June 30)	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Children's Medical Premiums										
Children's Caseload [1]	47,047	57,795	61,582	68,725	67,267	67,432	67,542	58,253	61,527	63,256
Caseload Growth Rate [2]	12.16%	22.85%	6.55%	11.60%	-2.12%	0.25%	0.16%	-13.75%	5.62%	2.81%
Children's Per Capita [1]	$1,385.96	$1,586.53	$1,630.54	$2,187.07	$2,099.03	$2,129.17	$2,231.79	$2,326.98	$2,426.23	$2,529.71
Per Capita Growth Rate [3]	2.51%	14.47%	2.77%	34.13%	-4.03%	1.44%	4.82%	4.27%	4.27%	4.27%
Subtotal Children's Premiums	$65,205,260	$91,693,501	$100,411,914	$150,306,188	$141,195,482	$143,574,191	$150,739,560	$135,553,566	$149,278,213	$160,018,633
Less Annual Enrollment Fees (No Federal Match)	$232,136	$283,367	$328,499	$346,589	$428,326	$474,720	$521,805	$410,100	$475,334	$445,319
Children's Dental Premiums										
Children's Caseload [1,2]	47,047	57,795	61,582	68,725	67,267	67,432	67,542	58,253	61,527	63,256
Dental Per Capita [1]	$146.42	$151.14	$160.38	$156.66	$159.35	$168.97	$175.73	$183.22	$191.03	$199.18
Per Capita Growth Rate [3]	7.61%	3.22%	6.11%	-2.32%	1.72%	6.04%	4.00%	4.27%	4.27%	4.27%
Subtotal Children's Dental	$6,888,622	$8,735,136	$9,876,521	$10,766,208	$10,718,975	$11,393,985	$11,869,156	$10,673,115	$11,753,468	$12,599,275
Prenatal And Delivery Costs										
Prenatal Caseload [1]	1,170	1,570	1,665	1,561	1,741	1,869	1,360	790	801	807
Caseload Growth Rate[2]	21.50%	34.19%	6.05%	-6.25%	11.53%	7.35%	-27.23%	-41.91%	1.38%	0.69%
Prenatal Per Capita [1]	$14,438.28	$11,336.78	$11,674.22	$11,118.53	$14,571.85	$15,256.50	$15,973.31	$16,654.57	$17,364.89	$18,105.50
Per Capita Growth Rate [3]	19.74%	-21.48%	2.98%	-4.76%	31.06%	4.70%	4.70%	4.27%	4.27%	4.27%
Subtotal Prenatal and Delivery Costs	$16,892,788	$17,798,745	$19,437,576	$17,356,024	$25,369,597	$28,514,399	$21,723,702	$13,157,110	$13,909,277	$14,611,139
Subtotal Medical Expenses	$88,986,670	$118,227,382	$129,726,011	$178,428,420	$177,284,054	$183,482,575	$184,332,418	$159,383,791	$174,940,958	$187,229,047
Administration										
Annual Administration increase [4]								2.17%	2.17%	2.17%
Administration Expenditures	$6,151,625	$6,621,395	$7,577,554	$6,792,199	$6,209,573	$6,384,964	$6,444,140	$6,477,684	$6,477,684	$6,477,684
Total Program Costs	$95,138,295	$124,848,777	$137,303,565	$185,220,619	$183,493,627	$189,867,539	$190,776,558	$165,861,475	$181,418,642	$193,706,731
Federal Funds at 65%	$61,839,892	$81,151,705	$89,247,317	$120,393,402	$119,270,858	$123,413,900	$124,004,763	$107,809,959	$117,922,117	$125,909,375
Federal Fiscal Year (October 1 - September 30)	**FFY 2007**	**FFY 2008**	**FFY 2009**	**FFY 2010**	**FFY 2011**	**FFY 2012**	**FFY 2013**	**FFY 2014**	**FFY 2015**	**FFY 2016**
Total Program Costs [5]	$101,409,555	$126,894,270	$157,460,910	$177,848,289	$183,493,627	$189,867,539	$190,776,558	$165,861,475	$181,418,642	$193,706,731
Federal Funds [5]	$65,916,210	$82,481,275	$102,349,530	$115,601,855	$119,270,858	$123,413,900	$124,004,763	$107,809,959	$117,922,117	$125,909,375
Federal Allotment [6]	$71,544,798	$71,544,798	$100,696,200	$122,851,760	$123,498,650	$129,930,082	$136,916,333	$144,373,944	$152,325,257	$158,821,929
Redistributions [7]	($5,707,946)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Available from Prior Years	$99,770,178	$99,690,820	$88,754,343	$87,101,013	$94,350,918	$98,578,710	$105,094,892	$118,006,462	$154,570,447	$188,973,587
Total Federal Funds Available	$165,607,030	$171,235,618	$189,450,543	$209,952,773	$217,849,568	$228,508,792	$242,011,225	$262,380,406	$306,895,704	$347,795,516
Unspent / (Amount needed)	**$99,690,820**	**$88,754,343**	**$87,101,013**	**$94,350,918**	**$98,578,710**	**$105,094,892**	**$118,006,462**	**$154,570,447**	**$188,973,587**	**$221,886,141**

[1] Caseload and per capitas for FY 2011-12 and FY 2012-13 are from Exhibits C.2 and C.3.

[2] Caseload growth for both children and prenatal women in FY 2014-15 is assumed to be the same as projected growth in FY 2013-14 before bottom-line adjusments from SB 11-008 and SB 11-250 which increased Medicad eligibility for children and pregnant women. The FY 2015-16 caseload is assumed to decrease by 50% from the forecasted FY 2014-15 growth.

[3] The inflation rate used for medical premiums is the average Consumer Price Index for medical costs between 2001 and 2010 for Denver-Boulder-Greeley. The FY 2012-13 per capita projections are increased by this percent to estimate FY 2013-14 through FY 2015-16.

[4] The administration expenditures for FY 2006-07 to FY 2010-11 include the Administration line item and the allocation of other Internal Administration expenses. FY 2011-12 and FY 2012-13 estimates are taken from Exhibit C.4. The inflation rate used for administrative expenses are based on Consumer Price Index for all items between 2001 and 2010 for Denver-Boulder-Greeley. The FY 2012-13 administration estimate is increased by the 5-year average percent to estimate internal administration through FY 2015-16.

[5] For FFY 2006 through 2010, Total and Federal Funds are actuals from CMS-21 Reports. Forecasts for federal funds expenditures are estimated using 75% of one State Fiscal Year and 25% of the next.

[6] FFY 2011 allocation from CMS. FFY 2012 is rebased to FFY 2011 expenditures increased by the FFY 2011-FFY 2012 inflation factor. FFY 2014 is rebased to FFY 2013 expenditures increased by the FFY 2012-FFY 2013 inflation factor. FFY 2013 through FFY 2016 allotments are based on prior year increased by the respective inflation factor.

[7] The negative distribution in FFY 2007 is per the National Institutes of Health Reform Act of 2006, and reflects an early partial redistribution of FFY 2005 federal funds.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

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

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

- [x] 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	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
Total of All Line Items	Total	$91,156,720	$0	$91,156,720	$5,518,142	$5,518,142
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	$0	$60,127,929	$5,518,142	$5,518,142
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$0	$31,028,791	$0	$0
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$91,156,720	$0	$91,156,720	$5,518,142	$5,518,142
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	$0	$60,127,929	$5,518,142	$5,518,142
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$0	$31,028,791	$0	$0

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

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-4
Medicare Modernization Act of 2003 State Contribution Payment

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
MMA State Contribution Payment	$5,518,142	$5,518,142	0.0

Request Summary:
This request is for additional General Fund totaling $5,518,142 in FY 2012-13 for the Medicare Modernization Act of 2003 State Contribution Payment line item. This request is the result of a projected increase in the caseload of dual-eligible individuals in conjunction with a projected increase in the per-member per-month (PMPM) rate paid by the State as required by federal regulations. The Department estimates that the General Fund need in FY 2011-12 will be $2,356,099. This estimate is provided for informational purposes only.

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Medicare Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients (individuals eligible for both Medicare and Medicaid). In lieu of the states' obligation to cover prescription drugs for this population, CMS began requiring states to pay a portion of what their anticipated dual-eligible drug cost would have been had this cost shift not occurred.

In January 2006, states began to pay CMS these "clawback" payments. The payments were calculated by taking 90% of the federal portion of each state's average PMPM dual-eligible drug benefit from calendar year 2003, inflated to 2006 using the average growth rate from the National Health Expenditure (NHE) per-capita drug expenditures. This inflated PMPM amount is then multiplied by the number of dual-eligible clients, including retroactive clients, back to January 2006. As each calendar year passes, the 90% factor is lowered by 1.67% each year – which is known as the phase-down percentage – until it reaches 75%, where it will remain beginning in 2015. In addition, CMS inflates each state's PMPM rates based on either NHE growth or actual growth in Part D expenditures.

With new data available, the Department has recalculated its estimate for FY 2011-12 and projects the MMA clawback payment will total $93,512,819, which is $2,356,099 higher than the FY 2011-12 appropriation.

For FY 2012-13, the Department estimates the total clawback payment will equal $96,674,862, which is $5,518,142 more than the base request. This difference is a result of a projected increase in caseload and a projected increase in the PMPM rate.
On July 26, 2011, CMS released the National Health Expenditure Projections for 2010-2020, which the Department is currently analyzing to determine the impact these projections may have on the MMA State Contribution Payment line item. While the Department's analysis is ongoing, initial results indicate that MMA FY

2012-13 total expenditures could increase by as much as 6.5%.

Anticipated Outcomes:
Approval of this request would allow the Department to meet its obligation to the federal government and ensure the Department would not have the amount of payment plus interest deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under-funded to provide services and would necessitate a General Fund appropriation or program cuts to make up the difference, as Medicaid is an entitlement program in which the Department cannot cap enrollment.

Assumptions for Calculations:
The Department assumes the changes in the PMPM rate paid by the Department will be based on the growth in the 2009 NHE prescription-drug per-capita estimates between years 2012 and 2013 and offset by the corresponding phase-down percent. The Department further assumes the changes in dual-eligible caseload will follow a trend of 3.75% annual growth, as has been evidenced historically.

Tables detailing these calculations are attached in Appendix A.

Current Statutory Authority or Needed Statutory Change:
42 C.F.R. §423.910 (a) (2011) General rule: *Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.*

25.5-5-503, C.R.S. (2011) *(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. (2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.*

Appendix A: Medicare Modernization Act of 2003 State Contribution Calculation

The Department estimates the per-member per-month (PMPM) rate for CY 2012 to be $125.58 and $128.49 for CY 2013. To estimate the 2012 PMPM rate (Table 1), the Department followed the procedure outlined by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) using the National Health Expenditure (NHE) estimates of per-capita drug-expenditures growth for the period 2005 to 2008 listed in CMS's NHE Projections from 2008 and from 2009. This estimate also includes the CY 2012 annual percentage increase in the average per-capita aggregate Part D expenditures from CMS. That figure is then multiplied by the phasedown rate for CY 2012, once the state share is taken into account.

Table 1: CY 2012 PMPM Rate		
From NHE Projections 2008-2018 (Table 11)		
	Estimated 2005 Per-Capita Prescription Drug Expenditures	$674
	Projected 2008 Per-Capita Prescription Drug Expenditures	$772
	Percentage Growth	14.54%
From NHE Projections 2009-2019 (Table 11)		
	Estimated 2005 Per-Capita Prescription Drug Expenditures	$675
	Estimated 2008 Per-Capita Prescription Drug Expenditures	$769
	Percentage Growth	13.93%
Change in Percentage Growth		**-4.22%**
From Announcement of CY 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
	Annual % Increase in Avg. Per Capita Aggregate Part D Expenditures for 2011 (Attachment V, Table III-2)	2.96%
FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2012		**-1.26%**
2011 PMPM Rate Prior to FMAP and Phasedown		$317.97
FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2012		-1.26%
Projected CY 2012 PMPM Rate Prior to FMAP and Phasedown		$313.96
FMAP State Share		50.00%
Projected CY 2012 PMPM Rate Prior to Phasedown		$156.98
CY 2012 Phasedown Percentage		80.00%
Projected CY 2012 PMPM Rate		**$125.58**

Sources: Centers for Medicare & Medicaid Services, NHE Projections 2008-2018, Table 11; Centers for Medicare & Medicaid Services, NHE Projections 2009-2019, Table 11; and Announcement of CY 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table III-2.

To estimate the PMPM rate for CY 2013 (Table 2), the Department used the projected annual percentage increase in prescription drug expenditures between 2012 and 2013 from the 2009-19 NHE projections, followed by the corresponding phasedown percentage for CY 2013 after the state share was included in the calculation.

Table 2: CY 2013 PMPM Rate		
From NHE Projections 2009-2019 (Table 11)		
	Projected 2012 Per-Capita Prescription Drug Expenditures	$911
	Projected 2013 Per-Capita Prescription Drug Expenditures	$952
Percentage Growth		**4.50%**
Projected CY 2012 PMPM Rate Prior to FMAP and Phasedown		$313.96
FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013		4.50%
Projected CY 2013 PMPM Rate Prior to FMAP and Phasedown		$328.09
FMAP State Share		50.00%
Projected CY 2013 PMPM Rate Prior to Phasedown		$164.04
CY 2013 Phasedown Percentage		78.33%
Projected CY 2013 PMPM Rate		**$128.49**

Source: Centers for Medicare & Medicaid Services, NHE Projections 2009-2019, Table 11.

The Department notes the projection of PMPM rates is based on the growth in the NHE drug expenditures; however, federal law states the growth factor for 2007 and succeeding years will equal the annual percentage increase in average per-capita aggregate expenditures for covered Part D drugs in the United States for Part D-eligible individuals during the 12-month period ending in July of the previous year. Since actual expenditure data is not available for 2012 and beyond at the time of this request, the actual per-capita rate growth may differ from the Department's projection.

Caseload Calculation

To estimate caseload, the Department analyzed data from January 2006 through June 2011 and concluded a 3.75% historical trend is the most reasonably accurate forecast method for this population. This method estimates caseload by increasing the figure from the same month during the previous year by 3.75%. Because clients are able to be retroactively enrolled and disenrolled for up to 24 months, retroactivity is also considered in this forecast. Historical data shows current month enrollment accounts for approximately 95% of the final caseload figure including retroactivity. This data also shows a decay rate that spreads the remaining 5% out over the first 12 retroactive months.

The Department has recalculated its estimate for FY 2011-12 (see Table 3). Based upon the updated forecast, the Department anticipates caseload will increase in FY 2011-12 from 59,563 in July 2011 to 62,711 in June 2012. As a result, the revised expenditure estimate totals $93,512,819, which is $2,356,099 higher than what was estimated last year.

Table 3: FY 2011-12 Projected MMA Caseload and Expenditures

	CY 2010	CY 2011	CY 2012	FY 2011-12 TOTAL
July 2011	298	59,265	0	59,563
August 2011	209	59,611	0	59,820
September 2011	150	59,905	0	60,055
October 2011	90	60,233	0	60,323
November 2011	61	60,591	0	60,652
December 2011	30	60,715	0	60,745
January 2012	0	3,054	58,020	61,074
February 2012	0	2,005	59,692	61,697
March 2012	0	1,398	60,751	62,149
April 2012	0	933	61,247	62,180
May 2012	0	626	61,945	62,571
June 2012	0	439	62,272	62,711
CY Client Total	838	368,775	363,927	
CY Rate	$101.49	Varies*	$125.58	
Expenditures	**$85,049**	**$47,724,962**	**$45,702,808**	**$93,512,819**

** CY 2011 Rates: CQ1 $107.07; CQ2 $111.98; CQ3 $129.84; CQ4 $129.84.*

Based upon the same forecast, the Department anticipates FY 2012-13 caseload will increase from 61,796 in July 2012 to 65,062 in June 2013 (see Table 4). As a result, the total projected expenditure for the Medicare Modernization Act of 2003 State Contribution Payment for FY 2012-13 is $96,674,862.

Table 4: FY 2012-13 Projected MMA Caseload and Expenditures				
	CY 2011	**CY 2012**	**CY 2013**	**FY 2012-13 TOTAL**
July 2012	309	61,487	0	61,796
August 2012	217	61,846	0	62,063
September 2012	156	62,151	0	62,307
October 2012	94	62,492	0	62,586
November 2012	63	62,863	0	62,926
December 2012	32	62,992	0	63,024
January 2013	0	3,168	60,196	63,364
February 2013	0	2,080	61,931	64,011
March 2013	0	1,451	63,029	64,480
April 2013	0	968	63,544	64,512
May 2013	0	649	64,268	64,917
June 2013	0	455	64,607	65,062
CY Client Total	871	382,602	377,575	
CY Rate	Varies*	$125.58	$128.49	
Expenditures	**$113,091**	**$48,047,159**	**$48,514,612**	**$96,674,862**

** CY 2011 Rates: CQ1 $107.07; CQ2 $111.98; CQ3 $129.84; CQ4 $129.84.*

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicaid Fee-for-Service Reform
Priority Number: R-5

Dept. Approval by: John Bartholomew 10/24/11 (Date)

OSPB Approval by: 10/24/11 (Date)

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

Line Item Information	Fund	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
Total of All Line Items	Total	$3,576,353,663	$0	$3,592,616,694	($1,845,030)	($4,101,831)
	FTE	313.0	0.0	313.5	1.8	2.0
	GF	$909,607,782	$0	$992,363,869	($865,469)	($1,932,879)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$611,468,003	$0	$537,464,114	($57,047)	($118,037)
	RF	$6,849,809	$0	$3,563,458	$0	$0
	FF	$1,764,252,652	$0	$1,775,049,836	($922,514)	($2,050,915)
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	$21,290,686	$0	$21,847,209	$116,204	$133,108
	FTE	313.0	0.0	313.5	1.8	2.0
	GF	$7,675,241	$0	$7,865,443	$58,102	$66,554
	GFE	$0	$0	$0	$0	$0
	CF	$1,974,533	$0	$2,030,651	$0	$0
	RF	$448,289	$0	$448,289	$0	$0
	FF	$11,192,623	$0	$11,502,826	$58,102	$66,554
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	Total	$2,024,577	$0	$2,024,577	$8,106	$8,842
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$627,749	$0	$627,749	$4,053	$4,421
	GFE	$0	$0	$0	$0	$0
	CF	$255,164	$0	$255,164	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,141,664	$0	$1,141,664	$4,053	$4,421
(1) Executive Director's Office; (A) General Administration, Short-term Disability	Total	$32,188	$0	$32,188	$184	$212
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$12,334	$0	$12,334	$92	$106
	GFE	$0	$0	$0	$0	$0
	CF	$2,503	$0	$2,503	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$17,351	$0	$17,351	$92	$106

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
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	Total	$532,854	$0	$532,854	$3,718	$4,792
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$190,728	$0	$190,728	$1,859	$2,396
	GFE	$0	$0	$0	$0	$0
	CF	$53,148	$0	$53,148	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$288,978	$0	$288,978	$1,859	$2,396
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	Total	$427,325	$0	$427,325	$3,196	$4,326
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$151,785	$0	$151,785	$1,598	$2,163
	GFE	$0	$0	$0	$0	$0
	CF	$42,482	$0	$42,482	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$233,058	$0	$233,058	$1,598	$2,163
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	$1,586,232	$0	$1,546,560	$11,306	$1,900
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$679,994	$0	$708,357	$5,653	$950
	GFE	$0	$0	$0	$0	$0
	CF	$101,248	$0	$53,049	$0	$0
	RF	$13,461	$0	$13,461	$0	$0
	FF	$791,529	$0	$771,693	$5,653	$950
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	$6,596,052	$0	$6,410,052	($52,000)	($52,000)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,430,918	$0	$1,487,168	($26,000)	($26,000)
	GFE	$0	$0	$0	$0	$0
	CF	$721,750	$0	$497,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,443,384	$0	$4,425,384	($26,000)	($26,000)
(2) Medical Services Premiums	Total	$3,543,863,749	$0	$3,559,795,929	($1,935,744)	($4,203,011)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	($910,826)	($1,983,469)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$0	$534,529,617	($57,047)	($118,037)
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$0	$1,756,668,882	($967,871)	($2,101,505)

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

Cash or Federal Fund Name and COFRS Fund Number: CF: Breast and Cervical Cancer Prevention and Treatment Fund (15D); Hospital Provider Fee Cash Fund (24A). FF: Title XIX.

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

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

Schedule 13s from Affected Departments: None.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-5
Request Title: Medicaid Fee-for-Service Reform

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Medicaid Fee-for-Service Reform	($1,845,030)	($865,469)	1.8

Request Summary:
The Department requests a reduction of $1,845,030 total funds, $865,469 General Fund in FY 2012-13 and a reduction of $4,101,831 total funds, $1,932,879 General Fund in FY 2013-14 to implement payment reforms that will better align provider incentives with delivering quality, efficient care. This request expands on the studies funded by FY 2010-11 BRI-2/BA-13, "Coordinated Payment and Payment Reform" (COPPR), in key service areas and in conjunction with opportunities provided by the federal government. It proposes several initiatives that carry out the Department's mission and vision, as stated in the strategic plan, by improving the delivery and cost-effectiveness of health care services.

Medicaid services are largely reimbursed on a fee-for-service basis in Colorado, a system that encourages high volumes of services rather than cost-effective care. Providers have little financial incentive to manage and coordinate care for their clients, resulting in an increased likelihood of preventable episodes that need to be treated in the emergency room or inpatient hospital setting. This reimbursement system leads to greater costs for the State.

Most of the payment reforms included in this request involve an element of gainsharing, which is a payment methodology whereby providers receive a percentage of savings that result in other service categories from greater care management of their clients. Gainsharing puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the gainsharing reforms are guaranteed to be budget neutral or negative.

Physical and Behavioral Health Payment Reforms
The Department requests to implement a gainsharing payment system whereby Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are paid a percentage of any savings in expenditure incurred by clients attributable to their centers. This will result in savings to the State and better health outcomes for clients.

The Department requests to create a gainsharing incentive plan in which Behavioral Health Organizations (BHOs) are held accountable for managing expenditure on psychotropic drugs for seriously and persistently mentally ill clients.

The Department requests funding to hire a consultant to research and plan a pilot program in which participating primary care providers are paid prospectively for services provided in their offices and episodes of care for their clients.

The Department requests to establish an incentive pool to make gainsharing payments to physicians in order to provide cost savings to other Medicaid service categories. These payments would be funded solely from enhanced federal funds for physician rates provided through the Affordable Care Act (ACA). The ACA requires that, for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The Department anticipates that a gainsharing program will meet this requirement.

The Department requests the authority to pay gainsharing incentive payments to providers participating in the Accountable Care Collaborative (ACC) starting in FY 2012-13. Implementing gainsharing in this program will allow the ACC providers to share in any demonstrable aggregate savings of over 7.0% per client, which will provide a concrete incentive for them to manage care in a way that will produce savings beyond the amount already appropriated.

Long-Term Care Payment Reforms
The Department requests funding to redesign the assessment tool and care-planning system for long-term care services in order to create robust, person-centered budgets.

The Department requests funding to study the feasibility and potential impact of changing the long-term care delivery system to include palliative care as a Medicaid benefit and to consolidate services for clients living in naturally occurring retirement communities.

FTE and Operating Expenses
The Department requests 1.0 FTE at the General Professional IV level and 1.0 FTE at the Rates/Financial Analyst II level to coordinate and implement each of the initiatives listed above.

Anticipated Outcomes:
The Department anticipates that creating financial incentives for providers to reduce unnecessary emergency or specialty care will not only generate short term savings, but also slow long-term Medicaid cost growth.

Please see Appendix A for detailed explanations of anticipated outcomes for each initiative.

Assumptions for Calculations:
Please see Appendix C for detailed calculations.

Consequences if not Funded:
If this request is not funded, the Department will not be able to change its payment systems in a way that will incentivize providers to deliver quality and efficient care. The current payment system provides little incentive for fee-for-service providers to effectively manage and coordinate care for their clients. Providers should be rewarded for delivering cost-effective care by sharing in any accrued savings that result from clients attributable to their practices. Implementing these reforms will foster better client outcomes and short- and long-term efficiencies to the State.

Cash Fund Projections:
Please see Appendix B for a summary table of the cash fund projections.

Relation to Performance Measures:
The requested initiatives would allow the Department to meet its performance measures, as specified in its strategic plan, to improve health outcomes, contain health care costs, and improve the long-term care delivery system. The proposed payment reforms create incentives for providers to manage client health care more effectively and to prevent avoidable complications that result in more costly care. The Department is also focusing on its long-term care delivery system for future improvements.

Current Statutory Authority or Needed Statutory Change:
The Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per section 25.5-4-401(1)(a), C.R.S. (2011).

Appendix A: Medicaid Fee-for-Service Reform Detailed Narrative

In this request, the Department is proposing to reform payment systems to better align provider incentives with delivering quality, efficient care. The Department requested funding to investigate a series of initiatives to reform payment methodologies in FY 2010-11 BRI-2/BA-13, "Coordinated Payment and Payment Reform" (COPPR). This request expands on the results of those studies by requesting to implement payment reforms in key service areas, many in conjunction with financing opportunities provided by the federal government. It proposes several initiatives that carry out the Department's mission and vision, as stated in the strategic plan, by improving the delivery and cost-effectiveness of health care services. As these reforms tie directly to the Department's work done thus far through COPPR, the annualization of the appropriated funds from COPPR equaling $532,000 total funds, $266,000 General Fund will be incorporated into this request and used to take the next steps in understanding and implementing payment reform.

Most of the payment reforms included in this request involve an element of gainsharing, which is a payment methodology whereby providers receive a percentage of savings that result from greater care management of their clients. Gainsharing puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the gainsharing reforms are guaranteed to be budget neutral or negative. If providers do not produce savings, they will receive no incentive payments and the Department will incur no additional costs. In the more likely case that providers respond to the incentives by concentrating efforts on reducing their clients' expenditure, the Department will pay a percentage of the savings and retain the rest, resulting in an overall cost savings to the State. Each of the gainsharing initiatives will be implemented through a state plan amendment and, when necessary, a change to the Medical Services Board rules to ensure that they meet compliance with federal and state regulations.

Implementing several payment reforms simultaneously requires a tangible system for determining which providers produced savings in the target service categories. The Department will use a standardized method of attributing clients to the providers with whom they receive the majority of their care. Many clients in the fee-for-service program have access to see any provider of their choice and are not locked in to one organization or physician – the Department is not requesting to change that system in this request. To determine savings and incentive payments for providers, however, the Department would attribute those clients to whichever provider they consistently see for their care, based on the clients' claims data. For example, a client may have received treatment at several places of service during a year but most consistently received services at a particular FQHC. If the FQHC was able to reduce expenditure for that client in that year, those savings would be attributable to the FQHC and not the other providers that the client saw infrequently. This way, the Department can allocate savings to the providers that were most invested in each client's health. Further, this gives providers an additional incentive to function as medical homes for clients. Attributing clients to a particular provider encourages the provider to be responsible for the clients and are thus more likely to coordinate and oversee their care.

The first section of this request includes payment reforms to physical and behavioral health. Two of the initiatives in that section are ready to be implemented in FY 2012-13 and are expected to generate savings in that fiscal year. The second section of this request includes payment reforms to long-term care. The Department is requesting to use a portion of the existing COPPR funding to continue studying how to best

implement reforms in that area; as a result, the studies requested are essentially funded through continuation funding. Each reform in this request is different based on the type of program and how federal health care initiatives may affect it. The overarching goal of each is the same, however – to reform reimbursement systems to reward providers for improved performance, measured by both cost-savings and client clinical outcomes, and to do so in a way that is sustainable in the long run for the State.

Physical and Behavioral Health Payment Reforms

FQHC and RHC Rate Reform and Gainsharing

The Department requests a reduction of $1,594,121 total funds, $750,082 General Fund in FY 2012-13 and a reduction of $3,320,426 total funds, $1,568,186 General Fund in FY 2013-14 to implement a gainsharing payment system whereby Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are paid a percentage of any savings in expenditure incurred by clients attributable to their center. This would result in savings to the State and better health outcomes for clients.

A recent article written by Department staff and published in *Health Affairs*[1] reported results from a study on the impact of FQHCs in Colorado. The authors found that Medicaid clients whose usual source of care was an FQHC during that fiscal year were about one-third less likely to have emergency department visits, inpatient hospitalizations, or preventable hospital admissions than Medicaid clients whose usual source of care was a private, fee-for-service provider. The decreased probability of avoidable treatment among FQHC clients was statistically significant for all of the outcome variables. Currently, several FQHCs and RHCs are working with the Department in conjunction with JSI Research and Training Institute, Inc. in a data collection initiative that will focus on measuring outcomes for more intentional care management. This project will greatly aid the FQHCs and RHCs in understanding where they can continue to decrease expenditure in those service categories and how it can be accomplished.

FQHCs and RHCs are already managing care in a way that produces less cost to the State in other service categories and better health outcomes for their clients. The Department would like to further incentivize this behavior by implementing a gainsharing program, allowing the centers to share a portion of any demonstrable savings. Savings would be measured as the difference between expenditure for hospital services and prescription drugs from the current year to the prior year for clients attributable to each FQHC and RHC. A percentage of savings achieved by each FQHC and RHC would then be paid as a supplemental payment. This program would be budget neutral or negative because it pays providers only if they achieve savings. The supplemental payments would be a percentage of the total savings while the State retains the remainder. The program will begin January 1, 2013. Payments would be lagged by six months due to the required runout of claims – the first payments would be made in FY 2013-14 for savings accrued in the latter six months of FY 2012-13. After that, the payments would be made on an annual basis for the savings accrued over the previous year.

The specific outcomes that the Department would measure include the following: generic drug utilization, hospital readmissions, outpatient hospital visits, and emergency department visits. The Department assumes that the FQHCs and RHCs will be able to reduce utilization and expenditure in each of these areas by 5%, and that they would receive 50% of those savings as supplemental payments. This reduction estimate is feasible given that many of the FQHCs and RHCs are already actively engaged in conversations with the Department and other organizations, such as JSI Research and Training Institute, Inc., regarding

[1] Jennifer Rothkopf, Katie Brookler, Sandeep Wadhwa and Michael Sajovetz. "Medicaid Patients Seen At Federally Qualified Health Centers Use Hospital Services Less Than Those Seen By Private Providers." *Health Affairs*, 30, no.7 (2011): 1335-1342.

how to measure outcomes and reduce expenditure in those areas. There is evidence that the FQHCs and RHCs are able to manage care in a way that will produce savings elsewhere, and the Department is confident that they will continue to improve. In addition, the FQHCs and RHCs are likely to respond to incentive programs as the majority of their funding comes from Medicaid or Medicare. In contrast, the Department is not requesting savings for a similar gainsharing program for physicians, described below; the Department anticipates that there will be a longer lag in time for physicians to make significant reductions in expenditure in these areas, and the magnitude of savings that physicians can achieve is unclear at this time.

To estimate the savings generated from reducing expenditure in these areas, the Department attributed Medicaid clients in the FY 2009-10 claims data to FQHCs and RHCs and calculated utilization and expenditure for the outcome variables during that year. A client was attributed to a center if they had two or more visits to the center during the fiscal year, at least one full year of enrollment in Medicaid, and at least one evaluation and management procedure code billed during the fiscal year. Please see tables A.1, A.2, A.3, and A.4 for detailed calculations of the savings estimates.

The Department has been working with the FQHCs and RHCs on the possibility of reforming their reimbursement methodology to incentivize certain outcome measures. If this request is approved, the Department will continue to involve them and other stakeholders in each step of implementing the gainsharing program.

Primary Care Provider Subcapitation Pilot Program

The Department requests $112,500 total funds, $56,250 General Fund in FY 2012-13 and $112,500 total funds, $56,250 General Fund in FY 2013-14 for a consultant to research and plan a pilot program in which participating primary care providers are paid prospectively for services provided in their offices and episodes of care for their clients. The Department assumes that the consultant would need 500 hours to research the program at an estimated rate of $225 per hour, and that the Department can use a currently contracted vendor to do the research and analysis. The vendor would then be able to begin working on this program in July 2012.

PROMETHEUS Payment[2] is a model designed by the Health Care Incentives Improvement Institute (HCI3) to set rates for providers that both compensates them fairly and incentivizes them to deliver quality, efficient episodes of care. An episode refers to the entire treatment period, from diagnosis until the end of treatment. The Department would use this model to develop a rate schedule and incentive plan for primary care providers to participate in the pilot program in a future fiscal year. Through the support from the non-profit organization Colorado Health Foundation, HCI3 is conducting an implementation of the PROMETHEUS Payment Model in at least three different pilot sites across Colorado. The results of those pilots will help guide the Department in planning its pilot program. The Colorado Business Group on Health (CBGH) performed preliminary analysis on the potential for the PROMETHEUS Payment Model to impact expenditure for the Department using two years of claims data. In the resulting report provided to the Department[3], CBGH found that implementing this sort of payment methodology would produce significantly more savings to the State than the costs to run the program.

[2] www.prometheuspayment.org

[3] "A Report to HCPF on the Feasibility and Benefits of Implementing Bundled Payments." Colorado Business Group on Health, June 2011.

Currently, primary care providers are not at risk for the costs of referring clients to specialists within their office or for any laboratory work for their clients. This can result in inappropriate referrals for and utilization of these services. Once implemented, this pilot program would pay providers prospectively for the work delivered in physicians' offices, including specialty care, as well as for all laboratory work done inside and outside of the physicians' offices. If the physician provides care that shows measurable savings, the provider would receive an incentive payment, calculated in the same way as the gainsharing methodology for FQHCs and RHCs, as discussed above. The incentive would only be paid out if the provider maintains quality standards predetermined by the Department and stakeholders, ensuring that quality of care does not suffer in providers' efforts to decrease costs.

The Department does not expect to implement this program in FY 2012-13, but to begin planning in conjunction with HCI3 and to assess how the program will impact costs and outcomes. This would be accomplished through a shadow model in which the Department will analyze how providers would have been paid during that year if the program was implemented. This program is also intended to work in conjunction with the primary care changes under section 1202 of the Health Care and Education Reconciliation Act (HCER), an amendment to the Affordable Care Act (ACA), as discussed below. Specifically, the Department would use the increase in payments to primary care providers through section 1202 of the HCER as a baseline to then establish how the episodic payments would be made in the primary care subcapitation pilot program once it is implemented.

Grant funding was awarded by the Colorado Health Foundation to HCI3, and there is a possibility that the Department will be able to use some of this funding for administration costs once the program begins; there is no grant funding, however, for the technical costs of designing the program prior to implementation. The Department's funding request is to plan and design the pilot program. If the shadow model is successful, the Department would request to implement the program through the standard budget process upon completion of the shadow model and assessment period.

Psychotropic Utilization Reduction Gainsharing

To align Behavioral Health Organization (BHO) objectives with more efficient outcomes, the Department is requesting a reduction of $319,123 total funds, $149,494 General Fund in FY 2012-13 and a reduction of $860,085 total funds, $404,033 General Fund in FY 2013-14 to create an incentive plan in which BHOs are held accountable for managing expenditure on psychotropic drugs for their seriously and persistently mentally ill clients.

BHOs manage the mental health benefits for Medicaid clients, but they are not contractually responsible to cover any pharmacy expenditures. The Department pays for all pharmaceuticals through fee-for-service. The Department can incentivize better management of mental health psychotropic drugs by implementing a gainsharing program, which would reward BHOs for having cost-effective prescription practices.

The Department is requesting to implement this by calculating a projected baseline of expenditure on psychotropic drugs for each BHO and a target savings amount below that baseline that the BHOs have to reach. After a set period of time, actual fee-for-service expenditure on psychotropic drugs by BHO would be compared to the projected baseline amount and the target savings amount. The BHOs that meet quality performance measures established by the Department, with input from the BHOs and stakeholders, would then be eligible to receive a percentage of any additional savings they achieved in the form of supplemental payments. The program will focus on the pharmacy expenditure for seriously and persistently mentally ill

clients as those clients have the most contact with the BHOs and are prescribed mainly within the BHO networks.

By implementing this rate reform, BHOs would have a vested interest to prescribe less expensive drugs when possible and to ensure that prescription drugs are the most appropriate treatment method. The Department would also retain some of the savings in pharmacy expenditure, ensuring that this program is budget neutral or negative. If it is determined with stakeholder input that the BHOs can expand the scope of this program to include all of their members, the Department may request for that change through the standard budget process.

The Department would amend BHO contracts to allow the BHOs to manage pharmaceuticals for their clients over the initial period of January 1, 2013 through June 30, 2013. In order to determine if savings have been achieved, the Department assumes that it will require 6 months after the period is closed before any gainsharing payment can be made. This lag is required in order to: allow for all claims to be processed; allow for the collection of drug rebates; and, allow for the gainsharing payment to be calculated and reviewed. As a result, the Department estimates that the first gainsharing payment, if achieved, would not be made until January or February of 2014 (in FY 2013-14). The Department will continue to calculate the savings and make the payments every six months. In order to properly calculate the earned incentive payments, the Department requests $22,500 total funds, $11,250 General Fund to increase the contract funding for actuarial certification of the BHO rates each calendar year.

Based on preliminary discussions with the BHOs, the Department will set the target savings percentage at 3%. All savings up to the 3% target would accrue to the Department. Savings beyond the 3% target would be split between the BHOs and the Department, with the BHOs retaining 60% of the savings and the state retaining 40%. The Department assumes that the BHOs would receive over 50% of the additional savings to account for the fact that they already had to achieve a significant amount of savings to reach the 3% target. They can then use the payments to reinvest in outreach efforts to reduce pharmacy expenditure, which would continue to bend the cost curve and produce higher incentive payments for the BHOs.

To be conservative, the Department is only requesting a decrease of funds in Medical Services Premiums equal to achieving the 3% target. Because utilization of these drugs is not currently managed, the Department believes this savings percentage is attainable in FY 2012-13. The Department estimates that the reduction to Medical Services Premiums related to hitting the 3% savings target will be $341,623 total funds, $160,744 General Fund in FY 2012-13 and $882,585 total funds, $415,283 General Fund in FY 2013-14. See table B.1 for calculations.

In order to properly account for the potential payment of incentives, the Department requests that a footnote be added to the Long Bill beginning in FY 2013-14 that allows for a transfer of up to $478,273 total funds from the Medical Services Premiums Long Bill group to the Medicaid Mental Health Community Programs Long Bill group. The amount of the transfer is calculated based on a total savings assumption of 10% for the first six months of the program; the Department believes this is a sufficient upper limit for the savings potential for the first year of the program. If 10% savings is achieved, the Department estimates that it would achieve an additional $797,121 total funds savings in FY 2012-13 and an additional $1,581,091 total funds savings in FY 2013-14. See table B.3 for calculations.

The Department is requesting transfer authority as opposed to spending authority because it is not clear that the BHOs can achieve savings above the 3% target. If the Department was appropriated additional spending authority in the Medicaid Mental Health Community Programs Long Bill group, there would need

to be a corresponding decrease to the Medical Services Premiums Long Bill group. If, however, the BHOs did not achieve the additional savings, the Department would be at risk of an overexpenditure. In the future, the Department would use the normal budget process to account for any savings achieved; once the program is well established, the Department may seek to convert the transfer authority to spending authority.

Physician Rate Reform and Gainsharing (Sec. 1202 of the Health Care and Education Reconciliation Act)

The Department is requesting to use enhanced federal funds for physician rates provided through section 1202 of the Health Care and Education Reconciliation Act (HCER), an amendment to the Affordable Care Act (ACA), to establish an incentive pool for physicians in order to provide cost savings to other Medicaid service categories. For this reform, along with the ACC gainsharing incentive payment reform described below, the Department is requesting for authority to change reimbursement methodologies without corresponding changes to the Department's appropriation.

Section 1202 of the HCER states that for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate will apply to certain primary care services, including evaluation and management and immunizations, performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

Subject to approval by the Centers for Medicare and Medicaid Services (CMS), rather than increasing rates for those specific codes and practitioners specified in the HCER, the Department will make supplemental payments to qualifying physicians based on predetermined quality measures calculated periodically. In aggregate, the total amount of the supplemental payments will be based on the amount the Department would have paid for those services at the higher Medicaid rates; in this way, the Department will ensure that the program is both budget neutral and in compliance with the federal law requiring payment at not less than 100% of the Medicare rate.

The specific quality measures will be developed in conjunction with stakeholders, but will focus on reducing hospital utilization and expenditure. Physicians who are able to perform better on these quality measures relative to other physicians will receive higher incentive payments. The Department believes that there is the potential for significant savings from implementing this reform – higher incentives will be paid out to physicians who demonstrate that they reduced their clients' utilization of hospital services. It will also give physicians more responsibility for managing care for their clients, which will produce better health outcomes for clients.

The Department is not requesting a decrease in its appropriation to reflect the potential savings of this reform. It is unknown whether physicians can make meaningful impacts on expenditure for their clients in the first year of the program; physicians may need time to gather information on the quality measures to affect client behavior, creating a lag in savings. The Department also does not know by how much the physicians have been able to decrease expenditure in these areas in the past, in contrast to the evidence showing the impact that FQHCs and RHCs have had in the past, as described above. If approved, the Department would track and analyze the impact of this reimbursement change throughout the timeframe of the program to reach a more informed decision on whether it can produce savings and the magnitude of those savings.

The Department is designing this program to be sustainable after the enhanced FMAP expires at the end of 2014. In order to do so, the Department must show that the incentive payments are directly tied to reductions in other areas. As part of calculating supplemental payments, the Department will assess whether the gainsharing methodology has saved the State money beyond the cost of maintaining the funding available in the incentive pool. If the incentive program is shown to demonstratively reduce costs in other areas, the Department would use the standard budget process to request the continuation of the program; this would only occur if the Department can show that the program is at least budget neutral.

Since the increase in physician rates is federally mandated, the Department is not requesting for a change in appropriation in this request but for the authority to use the increase as an incentive pool. The anticipated increase to physician payments will be accounted for in the Department's November 2011 Request for Medical Services Premiums (R1). Based on preliminary calculations, the Department estimates that the incentive pool will equal $4,950,838 in FY 2012-13 and $12,872,971 in FY 2013-14.

Instituting this program would decrease the growth in expenditure on other service categories through the same gainsharing mechanism as the FQHC/RHC rate reform. It would foster improved client health through more intentional care management at the physician level, much as the FQHC/RHC payment reform focuses these efforts at the center level. Implementing these two programs together would capture a large portion of the physical health delivery system.

Accountable Care Collaborative Gainsharing Incentive Payments

The Department is requesting the authority to pay gainsharing incentive payments to providers participating in the Accountable Care Collaborative (ACC)[4] starting in FY 2012-13.

The ACC is expected to decrease aggregate expenditure per enrolled client by 7%, and the Department's appropriation includes that reduction. Currently there is no incentive for the providers in the ACC to reduce expenditure per client beyond that percentage. Implementing gainsharing into this program would allow the Regional Care Collaboration Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs) to share in any demonstrable aggregate savings of over 7% per client. This creates a concrete incentive for providers to manage their clients' care in the most cost-effective way.

The Department is not including any expected savings into this request but the authority to pay a percentage of the savings to the ACC providers. If aggregate per enrollee expenditure is not reduced by more than 7%, than no payments will be made and the Department would only achieve those savings that it was already appropriated. If aggregate per enrollee expenditure is reduced by more than 7%, the Department would retain a portion of those savings and pay the rest as supplemental payments. Implementing gainsharing in the ACC is budget neutral or negative. The Statewide Data and Analytics Contractor (SDAC) currently working with the Department to track and analyze ACC client data is already tasked with calculating the cost savings per client by RCCO and can send that data to the Department quarterly. This information can then be used to determine any supplemental payments owed to the RCCOs.

The specific components of the gainsharing program would be designed in conjunction with stakeholders for an estimated implementation date of January 1, 2013. In particular, the Department would work with the RCCOs and PCMPs to develop a method for determining how the payments will be split between those

[4] The Accountable Care Collaborative was originally requested in FY 2010-11 S-6/BA-5, "Accountable Care Collaborative."

two entities. The Department would involve the ACC providers and other interested stakeholders in each step to ensure that the program is successful.

Long-Term Care Payment Reforms

Person-Centered Payments in Long-Term Care

The Department requests $220,000 total funds, $110,000 General Fund in FY 2012-13 and $220,000 total funds, $110,000 General Fund in FY 2013-14 to redesign the assessment tool and care-planning system for long-term care services in order to create robust person-centered budgets for clients in long-term care programs. A person-centered budget is a set amount allocated for a client that is determined by the assessment of the client's needs, which will ultimately lead to significant cost savings for the State and improved health outcomes for clients in long-term care programs.

The Department contracts with single entry point (SEP) agencies to provide information about long-term care services and to assess individuals' needs for services. The SEP agencies perform level-of-care determinations for eligibility for Medicaid waiver and nursing facility services, develop care plans based on those assessments, and provide case management services for individuals receiving Medicaid waiver services. Data from the clients' assessments and their assignments into programs are compiled and stored in the Benefits Utilization System (BUS), which also maintains records of case management services provided to clients receiving long-term care.

The SEPs and the BUS are crucial components of the long-term care delivery system. Jointly, they ensure that clients receive timely information on services, proper assessments of their needs, and case management over time. The current system is not effective or efficient in meeting clients' needs, largely due to its fragmentation. The SEP agencies do not coordinate with other providers managing long-term care services services for their clients. The current assessment instrument (known as the ULTC 100.2) requires time-consuming, costly manual data entry and does not yield consistent care plans for clients as it relies on subjective and inconsistent decision making by the case managers. Information from the BUS is difficult to access and is not linked to the MMIS, inhibiting case managers and Department staff from gaining a cohesive understanding of a client's needs and utilization pattern and preventing the Department from making data-informed quality incentive payments based on this information. Without robust data on clients, there is no way to reform the payment structure of long-term care services to be more centered on clients and to reduce cost inefficiencies.

The Department proposes to redesign the current client assessment instrument, the plan of care process, case management, and payment system through a multi-year initiative. In FY 2012-13 and FY 2013-14, the Department would work with stakeholders to develop a new assessment instrument that would identify an individual's functional abilities, assess an individual's need for services, translate those needs into a written plan of care for the individual using standardized care-planning algorithms, and upload the data into a client case file. The Department would also begin building a new information system that can upload authorized service levels into the MMIS to tie the assessments and care plans to the payments made for the clients and to allow for greater data analysis of their utilization and expenditure trends.

Once the Department has adequate tools to assess clients for long-term care services, the Department can develop budgets for clients based on their individual needs. This will allow case managers and clients to manage expenditure under a set amount, ensuring that the services provided and amounts paid are chosen appropriately and are comparable to the amounts paid for clients with similar severities of conditions. It

will also encourage greater cooperation between the client, his/her case manager, and the client's providers. The Department anticipates that this reform will result in increased care coordination and decreased costs in the long run.

The Department requests funding for approximately 1,100 consulting hours to research the Department's needs and determine a concrete plan for replacing the BUS and the current assessment instrument. It is anticipated that the Department will use this funding to contract with different vendors for specific issues throughout the year. As a result, the exact start dates and task orders for the studies are uncertain. Table C details the Department's estimate on how many hours each will be needed to study the BUS and the assessment instrument. The Department does not expect to have solved all problems associated with implementation in FY 2012-13 but to continue working with its vendors in FY 2013-14, which will ensure that the components are implemented successfully and are as effective as possible.

In future budget cycles, the Department may request to change the reimbursement structure for long-term care services once the new assessment tool and BUS are in place. The Department expects that this payment reform would ensure that payments are allocated to the most appropriate services for clients, decreasing the incentive to provide services that are not effective or beneficial to clients and reducing overall Department spending on long-term care services.

Study Future Long-Term Care Goals

The Department is requesting $125,000 total funds, $62,500 General Fund in FY 2012-13 and $125,000 total funds, $62,500 General Fund in FY 2013-14 to study the feasibility and potential impact of changing the long-term care delivery system in the following areas:

- Include Palliative Care as a Medicaid Benefit: There are many Medicaid enrollees whose health and well-being would be improved with enhanced palliative care services instead of other unneeded, unwanted, and costly medical procedures. Although palliative care is often associated with "end of life" care, it is more broadly associated with pain relief and other health and emotional support for individuals with a wide range of serious chronic illnesses, including cancer, congestive heart failure, kidney failure, chronic obstructive pulmonary disease, AIDS, and Alzheimer's disease.

  The Department proposes to convene a group of medical professionals, consumers, and their families to evaluate the costs and benefits of an enhanced focus on palliative care services. The Department will evaluate data on Medicaid enrollees with specific chronic illnesses and do both quantitative and qualitative research on specific service interventions, using evidence-based research from other states on the impact of targeted services on specific chronic illnesses. The advisory group will work with the Department to analyze the data and make recommendations for demonstration programs of enhanced palliative care.

- Consolidate Services for Clients Living in Naturally Occurring Retirement Communities: The Department proposes to explore the development of both naturally occurring retirement communities (NORCs) and naturally occurring regions (NORs) as a method to maximize efficiency and effectiveness of long-term care services delivery. NORCs were developed to address the desires of older adults who needed long-term care and wanted to continue to live at home. Health and social service planners discovered that many people needing services were living independently in housing that was in close proximity to one another and developed programs where services could be consolidated and delivered by specific providers with lower overall cost. Today NORCs in many locations throughout the U.S.

deliver cost-effective case management, health care management, education, recreation and socialization services to community members. NORCs have demonstrated significant savings by reducing the risk and incidence of heart disease and Alzheimer's disease in older adults, encouraging older adults to utilize and participate in community resources, preventing hospital readmissions, and reducing the risk of falls in older adults[5].

The Department proposes to convene an advisory group comprised of a broad group of health and social services providers, consumers and family members, as well as other state and local government and community organizations to evaluate the feasibility of developing these types of programs in Colorado. NORCs began in urban areas where individuals needing services were living close together, but there is no reason why this concept could not be applied to a suburban or rural area, resulting in a NOR. The Department will analyze the location where Medicaid enrollees receiving long-term care or other chronic care services are residing, identify common services they are receiving from state and local governments, and analyze the costs and benefits of consolidating services for those individuals. The Department will work with the advisory to develop a demonstration program, if determined feasible, that would measure both health and social outcomes.

The Department requests funding for approximately 625 consulting hours to research the Department's needs and determine a concrete plan for implementing these two initiatives. It is anticipated that the Department will use this funding to contract with different vendors for specific issues throughout the year. As a result, the exact start dates and task orders for the studies are uncertain. Table D details the Department's estimate on how many hours each will be needed to study palliative care and naturally occurring retirement communities. The Department does not expect to have solved all problems associated with implementation in FY 2012-13 but to continue working with its vendors in FY 2013-14, which will ensure that the components are implemented successfully and are as effective as possible.

FTE and Operating Expenses

The Department requests 1.0 FTE at the Rate/Financial Analyst II level to design the program and rates for these initiatives, as described in detail above. The FTE would need to establish the gainsharing methodology for each of the gainsharing reforms, attribute clients to providers, and calculate savings and incentive payments for each program. The FTE would also be responsible for procuring and maintaining contracts with the vendors for each of the requested studies. In addition, the FTE would clear all payment changes with the Centers for Medicare and Medicaid Services (CMS) through state plan amendments and ensure those changes are reflected in rule.

The Department also requests 1.0 FTE at the General Professional IV level to implement these initiatives. The FTE would be responsible for drafting and managing the required provider contracts for each of the reforms and fielding questions and concerns from providers and other stakeholders. The FTE would collaborate with Department staff and provider groups to make sure that each initiative is implemented on time and with input from all applicable parties.

As soon as the Long Bill is signed, the Department would begin the process of hiring the FTE, allowing them to begin as soon after July 1, 2012 as possible. This will give them time to be trained and ready to implement and manage the initiatives, most of which begin January 1, 2013.

[5] Bedney, Barbara Joyce and Robert Goldberg. "Health Care Cost Containment and NORC Supportive Service Programs: An Overview and Literature Review." *NORCs: An Aging in Place Initiative.* The Jewish Federations of North America, Inc., 22 April 2009. Web. 26 July 2011.

Other Long-Term Care Initiatives

The Department is also pursuing other long-term care initiatives using existing resources.

Community First Choice Option in the State Plan

In addition to the studies requested above, the Department is currently investigating the feasibility of offering the Community First Choice program as a state plan service for disabled individuals and eliminating the Consumer Directed Attendant Support Services (CDASS) program as a home and community based waiver benefit. This will continue to be a priority for research using the Department's existing resources.

Section 2401 of the Affordable Care Act (ACA) specifies that states will receive an increase to its federal financial participation rate of 6 percentage points on services provided under the Community First Choice program, effective October 1, 2011. This program is very similar in scope to the current CDASS program offered under the Elderly, Blind, and Disabled (EBD) and the Mental Illness (MI) waivers and to a small client population covered under the state plan. It is designed to allow clients to stay in their communities instead of being moved to nursing facilities and to give them independence in determining how services are delivered to them. The Department will study how the program can be added as state plan benefit available to clients who need assistance with daily living. Since it will be offered in the state plan, it will no longer need to be offered as a waiver service. Eventually, clients in the Community First Choice program will be given person-centered budgets, as described above.

If the Department determines that this program can be implemented in its state plan, the Department would submit a request through the standard budget process.

Health Homes to Better Integrate Physical and Mental Health for Clients with Chronic Conditions

The Department is also researching how it can design and implement a health home program for clients with chronic conditions. These provider teams will likely include physical health providers, such as the RCCOs; mental health providers, such as Community Mental Health Centers (CMHCs); and long-term care organizations and single entry points.

Section 2703 of the Affordable Care Act (ACA) allocates an enhanced federal match of 90% for payments made to health homes for providing the following activities to their clients: comprehensive care management, care coordination/health promotion, comprehensive transitional care, patient and family support, referrals to community and social support services, and use of Health Information Technology (HIT) to link services. The Department is already paying for some of these activities and could receive a 90% match on those payments, as well as for any enhanced payments for the health home teams to provide more of these services.

The enhanced match from this provision will only apply for eight quarters, effective on the date articulated in the state plan amendment to implement chronic health homes. However, evidence regarding health homes indicates that providing coordinated care to clients will produce better and more efficient outcomes. The Department is studying how to target these objectives by implementing a gainsharing methodology whereby health home providers are paid a percentage of savings from decreasing utilization of other services by clients attributable to those providers. Because of the temporary nature of the enhanced federal

funding, the Department is still investigating how to implement the program in a manner which is sustainable when the enhanced federal funding expires. The Department will request to implement this program once it has established an implementation plan detailing the required program and administrative costs needed and how savings will be achieved.

Timeline

The following table shows the implementation timeline for each of the components of the request:

Item Requested	Administrative Funding for FY 2012-13	Procurement Method if Consultant Costs	Estimated Date Accomplished
FTE and Operating Expenses			
Hire Rates/Financial Analyst II FTE	$71,357	-	7/1/2012
Hire General Professional IV FTE	$71,357	-	7/1/2012
Subtotal FTE and Operating Expenses	$142,714	-	-
FQHC and RHC Rate Reform and Gainsharing			
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Primary Care Provider Subcapitation Pilot Program			
Hire Consultant for Shadow Program	$112,500	Amend contract	7/1/2012
Subtotal Primary Care Provider Subcapitation Pilot Program	$112,500	-	-
BHO Psychotropic Utilization Reduction Gainsharing			
Actuary Costs	$22,500	Amend contract	7/1/2012
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Subtotal BHO Psychotropic Utilization Reduction Gainsharing	$22,500	-	-
Physician Rate Reform and Gainsharing Program			
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Accountable Care Collaborative Gainsharing Incentive Payments			
SPA, Rule Change, Amend Provider Contracts	-	-	1/1/2013
Person-Centered Payments in Long-Term Care			
Hire Consultant for BUS Redesign	$120,000	Documented quote	9/1/2012
Hire Consultant for Assessment Tool Redesign	$100,000	Documented quote	9/1/2012
Subtotal Person-Centered Payments in Long-Term Care	$220,000	-	-
Study Future Long-Term Care Goals			
Hire Consultant for Naturally Occurring Retirement Communities	$75,000	Documented quote	9/1/2012
Hire Consultant for Palliative Care	$50,000	Documented quote	9/1/2012
Subtotal Study Future Long-Term Care Goals	$125,000	-	-

Table 1.1 Summary of Request FY 2012-13						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**($1,845,030)**	**($865,469)**	**($57,047)**	**$0**	**($922,514)**	**1.8**
(1) Executive Director's Office; (A) General Administration, Personal Services	$116,204	$58,102	$0	$0	$58,102	1.8
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$8,106	$4,053	$0	$0	$4,053	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$184	$92	$0	$0	$92	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,718	$1,859	$0	$0	$1,859	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,196	$1,598	$0	$0	$1,598	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$11,306	$5,653	$0	$0	$5,653	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	($52,000)	($26,000)	$0	$0	($26,000)	0.0
(2) Medical Services Premiums	($1,935,744)	($910,826)	($57,047)	$0	($967,871)	0.0

Table 1.2 Summary of Request FY 2013-14						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**($4,101,831)**	**($1,932,879)**	**($118,037)**	**$0**	**($2,050,915)**	**2.0**
(1) Executive Director's Office; (A) General Administration, Personal Services	$133,108	$66,554	$0	$0	$66,554	2.0
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$8,842	$4,421	$0	$0	$4,421	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$212	$106	$0	$0	$106	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$4,792	$2,396	$0	$0	$2,396	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,326	$2,163	$0	$0	$2,163	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$1,900	$950	$0	$0	$950	0.0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	($52,000)	($26,000)	$0	$0	($26,000)	0.0
(2) Medical Services Premiums	($4,203,011)	($1,983,469)	($118,037)	$0	($2,101,505)	0.0

Table 2.1 Cash Fund Summary		
Cash Fund Name	**Hospital Provider Fee Cash Fund**	**Breast and Cervical Cancer Prevention and Treatment Fund**
Cash Fund Number	24A	15D
FY 2010-11 Expenditures	$426,069,052	$2,903,163
FY 2010-11 End of Year Cash Balance	$22,198,436	$6,553,278
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436	$4,135,739
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436	$3,040,811
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436	$660,592

Table 3.1
Impact by Component: Base Fund Split
FY 2012-13

	Table	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request		**($1,845,030)**	**($865,469)**	**($57,047)**	**$0**	**($922,514)**	**1.8**
FTE and Operating Expenses							
(1) Executive Director's Office; (A) General Administration, Personal Services	FTE and Operating Expenses	$116,204	$58,102	$0	$0	$58,102	1.8
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	FTE and Operating Expenses	$8,106	$4,053	$0	$0	$4,053	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	FTE and Operating Expenses	$184	$92	$0	$0	$92	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	FTE and Operating Expenses	$3,718	$1,859	$0	$0	$1,859	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	FTE and Operating Expenses	$3,196	$1,598	$0	$0	$1,598	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	FTE and Operating Expenses	$11,306	$5,653	$0	$0	$5,653	0.0
Subtotal FTE and Operating Expenses		*$142,714*	*$71,357*	*$0*	*$0*	*$71,357*	*1.8*
FQHC and RHC Rate Reform and Gainsharing							
(2) Medical Services Premiums	A	($1,594,121)	($750,082)	($46,979)	$0	($797,060)	0.0
Subtotal FQHC and RHC Rate Reform and Gainsharing		*($1,594,121)*	*($750,082)*	*($46,979)*	*$0*	*($797,060)*	*0.0*
Primary Care Provider Subcapitation Pilot Program							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	$112,500	$56,250	$0	$0	$56,250	0.0
Subtotal Primary Care Provider Subcapitation Pilot Program		*$112,500*	*$56,250*	*$0*	*$0*	*$56,250*	*0.0*
Psychotropic Utilization Reduction Gainsharing							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	B.2	$22,500	$11,250	$0	$0	$11,250	0.0
(2) Medical Services Premiums	B.1	($341,623)	($160,744)	($10,068)	$0	($170,811)	0.0
Subtotal Psychotropic Utilization Reduction Gainsharing		*($319,123)*	*($149,494)*	*($10,068)*	*$0*	*($159,561)*	*0.0*
Person-Centered Payments in Long-Term Care							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	C	$220,000	$110,000	$0	$0	$110,000	0.0
Subtotal Person-Centered Payments in Long-Term Care		*$220,000*	*$110,000*	*$0*	*$0*	*$110,000*	*0.0*
Study Future Long-Term Care Goals							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	D	$125,000	$62,500	$0	$0	$62,500	0.0
Subtotal Future Long-Term Care Goals		*$125,000*	*$62,500*	*$0*	*$0*	*$62,500*	*0.0*
COPPR Annualization							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	($532,000)	($266,000)	$0	$0	($266,000)	0.0
Subtotal COPPR Annualization		*($532,000)*	*($266,000)*	*$0*	*$0*	*($266,000)*	*0.0*

Table 3.2
Impact by Component: Base Fund Split
FY 2013-14

Summary of Request FY 2013-14	Table	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request		**($4,101,831)**	**($1,932,879)**	**($118,037)**	**$0**	**($2,050,915)**	**2.0**
FTE and Operating Expenses							
(1) Executive Director's Office; (A) General Administration, Personal Services	FTE and Operating Expenses	$133,108	$66,554	$0	$0	$66,554	2.0
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	FTE and Operating Expenses	$8,842	$4,421	$0	$0	$4,421	0.0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	FTE and Operating Expenses	$212	$106	$0	$0	$106	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	FTE and Operating Expenses	$4,792	$2,396	$0	$0	$2,396	0.0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	FTE and Operating Expenses	$4,326	$2,163	$0	$0	$2,163	0.0
(1) Executive Director's Office; (A) General Administration, Operating Expenses	FTE and Operating Expenses	$1,900	$950	$0	$0	$950	0.0
Subtotal FTE and Operating Expenses		*$153,180*	*$76,590*	*$0*	*$0*	*$76,590*	*2.0*
FQHC and RHC Rate Reform and Gainsharing							
(2) Medical Services Premiums	A	($3,320,426)	($1,568,186)	($92,027)	$0	($1,660,213)	0.0
Subtotal FQHC and RHC Rate Reform and Gainsharing		*($3,320,426)*	*($1,568,186)*	*($92,027)*	*$0*	*($1,660,213)*	*0.0*
Primary Care Provider Subcapitation Pilot Program							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	$112,500	$56,250	$0	$0	$56,250	0.0
Subtotal Primary Care Provider Subcapitation Pilot Program		*$112,500*	*$56,250*	*$0*	*$0*	*$56,250*	*0.0*
Psychotropic Utilization Reduction Gainsharing							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	B.2	$22,500	$11,250	$0	$0	$11,250	0.0
(2) Medical Services Premiums	B.1	($882,585)	($415,283)	($26,010)	$0	($441,292)	0.0
Subtotal Psychotropic Utilization Reduction Gainsharing		*($860,085)*	*($404,033)*	*($26,010)*	*$0*	*($430,042)*	*0.0*
Person-Centered Payments in Long-Term Care							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	C	$220,000	$110,000	$0	$0	$110,000	0.0
Subtotal Person-Centered Payments in Long-Term Care		*$220,000*	*$110,000*	*$0*	*$0*	*$110,000*	*0.0*
Study Future Long-Term Care Goals							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	D	$125,000	$62,500	$0	$0	$62,500	0.0
Subtotal Future Long-Term Care Goals		*$125,000*	*$62,500*	*$0*	*$0*	*$62,500*	*0.0*
COPPR Annualization							
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	See Narrative	($532,000)	($266,000)	$0	$0	($266,000)	0.0
Subtotal COPPR Annualization		*($532,000)*	*($266,000)*	*$0*	*$0*	*($266,000)*	*0.0*

Table A.1 FQHC and RHC Rate Reform and Gainsharing Generic Drug Substitution				
Row	**Item**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Actual Expenditure on Prescription Drugs in FY 2009-10	$17,127,253	$17,127,253	Actual expenditure on prescription drugs for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Prescription Drugs from Replacing Brand Names with Generics	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	($856,363)	($856,363)	Row A * Row B
D	Estimated Trend for Prescription Drugs	6.25%	6.25%	Average expenditure growth in prescription drug expenditure before rebate from FY 2007-08 and FY 2009-10
E	Estimated Total Full Year Savings	($1,027,223)	($1,091,441)	FY 2012-13: Row C * (1 + Row D)^3 FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	($428,010)	($1,091,441)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	$0	$214,005	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	**Total Estimated Savings Retained by Medicaid**	**($428,010)**	**($877,436)**	**Row G + Row H**

Table A.2
FQHC and RHC Rate Reform and Gainsharing
Emergency Department Utilization Reduction

Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Emergency Department Visits in FY 2009-10	$11,833,692	$11,833,692	Actual expenditure on emergency department visits for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Emergency Department Visits	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	($591,685)	($591,685)	Row A * Row B
D	Estimated Trend for Outpatient Hospitals	8.92%	8.92%	Average expenditure growth in outpatient hospital expenditure from FY 2006-07 and FY 2009-10
E	Estimated Total Full Year Savings	($764,526)	($832,708)	FY 2012-13: Row C * (1 + Row D)^3 FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	($318,553)	($832,708)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	$0	$159,277	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	**Total Estimated Savings Retained by Medicaid**	**($318,553)**	**($673,431)**	**Row G + Row H**

Table A.3
FQHC and RHC Rate Reform and Gainsharing
Hospital Readmissions Reduction

Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Hospital Readmissions in FY 2009-10	$7,414,388	$7,414,388	Actual expenditure on hospital readmissions for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Hospital Readmissions	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	($370,719)	($370,719)	Row A * Row B
D	Estimated Trend for Inpatient Hospitals	3.52%	3.52%	Average expenditure growth in inpatient hospital expenditure from FY 2006-07 and FY 2009-10
E	Estimated Total Full Year Savings	($411,235)	($425,701)	FY 2012-13: Row C * $(1 + \text{Row D})^3$ FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	($171,348)	($425,701)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	$0	$85,674	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	**Total Estimated Savings Retained by Medicaid**	**($171,348)**	**($340,027)**	**Row G + Row H**

Table A.4
FQHC and RHC Rate Reform and Gainsharing
Outpatient Visit Utilization Reduction

Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Outpatient Hospital Visits in FY 2009-10	$25,120,080	$25,120,080	Actual expenditure on outpatient hospital visits for clients attributable to an FQHC or RHC
B	Estimated Reduction in Expenditure on Outpatient Visits	-5.00%	-5.00%	Assumed
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in FY 2009-10 Dollars)	($1,256,004)	($1,256,004)	Row A * Row B
D	Estimated Trend for Outpatient Hospitals	8.92%	8.92%	Average expenditure growth in outpatient hospital expenditure from FY 2006-07 and FY 2009-10
E	Estimated Total Full Year Savings	($1,622,903)	($1,767,637)	FY 2012-13: Row C * (1 + Row D)^3 FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Savings Incurred by FQHCs and RHCs	($676,210)	($1,767,637)	Row E * Row F
H	Estimated Amount from Savings Paid as Supplemental Payments to FQHCs and RHCs	$0	$338,105	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 50% * -1
I	**Total Estimated Savings Retained by Medicaid**	**($676,210)**	**($1,429,532)**	**Row G + Row H**

Table B.1 Psychotropic Utilization Reduction Gainsharing Cost Savings				
Row	**Item**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Actual Expenditure on Psychotropic Drugs in CY 2010, Net of Drug Rebate	$21,910,088	$21,910,088	Actual expenditure on psychotropic drugs for SMI clients between January and December 2010
B	Estimated Reduction	-3.00%	-3.00%	Target Reduction for BHOs
C	Total Estimated Medical Services Premiums Fee-for-Service Savings (in CY 2010 Dollars)	($657,303)	($657,303)	Row A * Row B
D	Estimated Trend for Psychotropic Drugs	7.65%	7.65%	Average expenditure growth in antipsychotic drug expenditure before rebate from FY 2007-08 and FY 2009-10
E	Total Estimated Medical Services Fee-for-Service Savings	($819,896)	($882,585)	FY 2012-13: Row C * (1 + Row D)^3 FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	**Total Estimated Savings**	**($341,623)**	**($882,585)**	**Row E* Row F**

Table B.2 Psychotropic Utilization Reduction Gainsharing Administrative Costs				
Row	**Item**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Estimated Hours for Actuarial Assessment of Changes to Rate-Setting Methodology	100	100	Assumed based on scope of work
B	Estimated Cost per Hour for Actuary	$225.00	$225.00	Hourly rate of actuary currently contracted by the Department
C	**Total Actuary Costs for Psychotropic Gainsharing Initiative**	**$22,500**	**$22,500**	**Row A * Row B**

Table B.3
Psychotropic Utilization Reduction Gainsharing Incentive Payments for July to December 2012 Savings
FOR INFORMATIONAL PURPOSES ONLY

Row	Item	FY 2012-13	FY 2013-14	Description
A	Actual Expenditure on Psychotropic Drugs in CY 2010, Net of Drug Rebate	$21,910,088	$21,910,088	Actual expenditure on psychotropic drugs for SMI clients between January and December 2010
B	Estimated Reduction Beyond Target Reduction	-7.00%	-7.00%	Example showing savings beyond the estimated target reduction
C	Estimated Total Medical Services Premiums Fee-for-Service Savings (in CY 2010 Dollars)	($1,533,706)	($1,533,706)	Row A * Row B
D	Estimated Trend for Psychotropic Drugs	7.65%	7.65%	Average expenditure growth in antipsychotic drug expenditure before rebate from FY 2007-08 and FY 2009-10
E	Estimated Total Medical Services Fee-for-Service Savings	($1,913,090)	($2,059,364)	FY 2012-13: Row C * (1 + Row D)^3 FY 2013-14: Row E * (1 + Row D)
F	Savings Adjustment for Implementation Date	41.67%	100.00%	Estimated implementation date: January 1, 2013. Only 5 months of savings are assumed in FY 2012-13 to account for cash accounting.
G	Total Estimated Medical Services Fee-for-Service Savings	($797,121)	($2,059,364)	Row E * Row F
H	Estimated Net Savings Retained by Medicaid	$0	$478,273	FY 2012-13: Assumed that payments will be made in the year after savings accrue due to runout of claims FY 2013-14: Row G from Previous Year * 60% * -1
I	**Total Estimated Savings Retained by Medicaid**	**($797,121)**	**($1,581,091)**	**Row G + Row H**

Table C Person-Centered Budget Administrative Costs				
Row	**Item**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Estimated Hours to Research BUS Redesign and Implementation	600	600	Assumed based on scope of work
B	Estimated Cost per Hour for Consultant	$200.00	$200.00	Hourly rate of consulting firm currently contracted by the Department
C	Total Consulting Costs to Research BUS Redesign and Implementation	$120,000	$120,000	Row A * Row B
D	Estimated Hours to Research Assessment Tool and SEP Redesign	500	500	Assumed based on scope of work
E	Estimated Cost per Hour for Consultant	$200.00	$200.00	Hourly rate of consulting firm currently contracted by the Department
F	Total Consulting Costs to Research Assessment Tool and SEP Redesign	$100,000	$100,000	Row D * Row E
G	**Total Administrative Costs for Person-Centered Budgets**	**$220,000**	**$220,000**	**Row C + Row F**

Table D Study Future Long-Term Care Goals				
Row	**Item**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Estimated Hours to Research Palliative Care Benefit	250	250	Assumed based on scope of work
B	Estimated Cost per Hour for Consultant	$200.00	$200.00	Hourly rate of consulting firm currently contracted by the Department
C	Total Consulting Costs to Research Palliative Care Benefit	$50,000	$50,000	Row A * Row B
D	Estimated Hours to Research Naturally Occurring Retirement Communities	375	375	Assumed based on scope of work
E	Estimated Cost per Hour for Consultant	$200.00	$200.00	Hourly rate of consulting firm currently contracted by the Department
F	Total Consulting Costs to Research Naturally Occurring Retirement Communities	$75,000	$75,000	Row D * Row E
G	**Total Administrative Costs for Studying Future Long-Term Care Goals**	**$125,000**	**$125,000**	**Row C + Row F**

Grand Total of FTE and Operating Expenses				
	General Professional IV		Rate/Financial Analyst II	
	FY 2012-13	FY 2013-14	FY 2012-13	FY 2013-14
FTE				
Personal Services	$58,102	$66,554	$58,102	$66,554
Health, Life and Dental	$4,053	$4,421	$4,053	$4,421
Short Term Disability	$92	$106	$92	$106
Amortization Equalization Disbursement	$1,859	$2,396	$1,859	$2,396
Supplemental Amortization Equalization Disbursement	$1,598	$2,163	$1,598	$2,163
Operating Expenses	$5,653	$950	$5,653	$950
TOTAL	**$71,357**	**$76,590**	**$71,357**	**$76,590**

FTE and Operating Expenses

								GRAND TOTAL	
Fiscal Year(s) of Request		**FY 2012-13**	**FY 2013-14**	**FY 2012-13**	**FY 2013-14**	**FY 2012-13**	**FY 2013-14**	**FY 2012-13**	**FY 2013-14**
PERSONAL SERVICES	**Title:**	**General Professional IV**		**Rate/Financial Analyst II**					
Number of PERSONS / class title		1	1	1	1				
Number of months working in FY 2012-13 and FY 2013-14		12	12	12	12				
Number of months paid in FY 2012-13 and FY 2013-14		11	12	11	12				
Calculated FTE per classification		**0.9**	**1.0**	**0.9**	**1.0**	**0.0**	**0.0**	1.8	2.0
Annual base salary		$56,796	$59,636	$56,796	$59,636	$0	$0		
Salary		$52,063	$59,636	$52,063	$59,636	$0	$0	$104,126	$119,272
PERA FY 2012-13	**10.15%**	$5,284	$6,053	$5,284	$6,053	$0	$0	$10,568	$12,106
Health, Life, and Dental	**$368.42**	$4,053	$4,421	$4,053	$4,421	$0	$0		
Short Term Disability	**0.177%**	$92	$106	$92	$106	$0	$0		
Medicare	**1.45%**	$755	$865	$755	$865	$0	$0	$1,510	$1,730
Subtotal Personal Services		**$62,247**	**$71,081**	**$62,247**	**$71,081**	**$0**	**$0**	**$116,204**	**$133,108**
OPERATING EXPENSES									
Supplies @ $500/$500*	**$500**	$500	$500	$500	$500	$0	$0	$1,000	$1,000
Computer @ $900/$0	**$900**	$900	$0	$900	$0	$0	$0	$1,800	$0
Office Suite Software @ $330/$0	**$330**	$330	$0	$330	$0	$0	$0	$660	$0
Office Equipment @ $3,440 /$0	**$3,473**	$3,473	$0	$3,473	$0	$0	$0	$6,946	$0
Telephone Base @ $450/$450*	**$450**	$450	$450	$450	$450	$0	$0	$900	$900
Subtotal Operating Expenses		**$5,653**	**$950**	**$5,653**	**$950**	**$0**	**$0**	**$11,306**	**$1,900**
GRAND TOTAL ALL COSTS		**$67,900**	**$72,031**	**$67,900**	**$72,031**	**$0**	**$0**	**$127,510**	**$135,008**

*The $450 for Telephone Base and $500 for Supplies will carry over each year as an acceptable expense.

As detailed above, the Department would begin the hiring process for both FTE as soon as the Long Bill is signed in order for them to start immediately after the start of FY 2012-13. They would then be able to work on implementing the programs that are set to begin in January 2013, which includes the FQHC and RHC rate reform and gainsharing, BHO psychotropic utilization reduction gainsharing, and the physician rate reform and gainsharing program. The Department hopes to also implement ACC gainsharing incentive payments in January 2013, but may delay implementation depending on input from stakeholders. The study of the primary care subcapitation pilot program would be completed by an existing vendor and could begin as soon as funding is available in July 2012. The Department would also amend the contract for the actuary currently working with the Department to set the rates for the psychotropic utilization reduction gainsharing program as soon as funding is available in July 2012. The implementation dates for person-centered payments in long-term care and studies of future long-term care goals are estimates; as described in each of their sections, the Department would contract with vendors throughout the current and request years to complete these studies. These would be managed by requested and existing FTE.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicaid Budget Reductions
Priority Number: R-6

Dept. Approval by: John Bartholomew 10/26/11 Date

OSPB Approval by: 10/26/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$3,551,534,588	$0	$3,567,597,651	($29,699,322)	($31,976,323)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$900,939,403	$0	$983,420,675	($30,471,105)	($31,592,518)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,377,712	$0	$534,630,271	$15,496,446	$15,479,358
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,751,653,997	$0	$1,762,269,580	($14,724,663)	($15,863,163)
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	**Total**	$7,670,839	$0	$7,801,722	$500,000	$500,000
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,100,370	$0	$2,100,370	$125,000	$125,000
	GFE	$0	$0	$0	$0	$0
	CF	$60,537	$0	$100,654	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,509,932	$0	$5,600,698	$375,000	$375,000
(2) Medical Services Premiums	**Total**	$3,543,863,749	$0	$3,559,795,929	($30,199,322)	($32,476,323)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	($30,596,105)	($31,717,518)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$0	$534,529,617	$15,496,446	$15,479,358
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$0	$1,756,668,882	($15,099,663)	($16,238,163)

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

FY 2012-13: [b] Of this amount, ~~$379,420,151~~ $394,941,574 shall be from the Hospital Provider Fee Cash Fund Created in Section 25.5-4-402.3 (4),...,~~$2,731,400~~ $2,706,422 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I)

Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee Cash Fund (24A), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Title XIX

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

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

Schedule 13s from Affected Departments: None.

Other Information: None.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-6
Request Title: Medicaid Budget Reductions

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Medicaid Budget Reductions	($29,699,322)	($30,471,105)	0.0

Request Summary:
As part of the Department's strategic objective to contain health care costs, the Department proposes to reduce Medicaid expenditure through a series of initiatives. The proposed initiatives will also assist in meeting budget balancing goals for FY 2012-13. These initiatives provide a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies to reduce Medicaid program expenditures by $29,699,322 total funds and $30,471,105 General Fund in FY 2012-13.

Department initiatives include the following:

- *Preterm Labor Prevention*: the Department is offering coverage of alpha hydroxyprogesterone caproate injections which reduces the occurrence of preterm labor.
- *Synagis PAR Review*: The Department will be increasing review of prior authorizations for Synagis to ensure only appropriate dosages are utilized of this drug.
- *Expansion of the Physician Administered Drug Rebate Program*: the Department has expanded the list of physician administered drugs for which it collects rebates as well as performed outreach to providers to ensure sufficient information is provided for the Department to claim rebates.
- *Reimbursement Rate Alignment for Developmental Screenings*: Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. Previously, the rate paid for developmental and depression screenings was well above the rates paid by Medicare and commercial insurance plans for these screenings.
- *Physician Administered Drug Pricing and Unit Limits*: the Department has realigned the pricing and unit limits on three physician administered drugs to achieve both consistency for billing and cost savings.
- *Public Transportation Utilization*: the Department has built incentives and expectations into the non emergent medical transportation program to increase the utilization of public transportation in the Denver-metro area.
- *Home Health Therapies Cap*: the Department is limiting the number of home health visits for therapy to 48 visits per calendar year.
- *Home Health Care Cap*: the Department has limited the number of hours of skilled care a patient can receive in the home health setting to eight per day.
- *Seroquel Restrictions*: the Department has implemented policies to prevent the utilization of Seroquel for off label use.
- *Dental Efficiencies*: the Department will clarify rules regarding eligibility for orthodontics. These clarifications are

expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion.

- *Augmentative Communication Devices*: the Department has implemented an initiative to provide access to less costly durable medical equipment for disabled clients that require the aid of augmentative communication devices.
- *Durable Medical Equipment Preferred Provider:* the Department initiated a competitive procurement process to acquire a sole source diabetic testing supply provider whereby the Department can leverage purchasing power to obtain significant rebates.
- *Continuation of Nursing Facility Reduction:* the Department proposes a continuation of the 1.5% rate reduction to nursing facility reimbursement current scheduled to end July 1, 2012.
- *Ambulatory Surgical Centers:* the Department has initiated a pilot project to shift outpatient surgery utilization from the outpatient hospital setting to the less costly ambulatory surgical setting.
- *Utilization Management Vendor Funding*: the Department is requesting additional funding for to expand the scope of work of the Department's contracted utilization management vendor to perform prior authorizations for the savings initiatives in this request.
- *Pharmacy Rate Methodology Transition*: to accommodate a change in available drug pricing information, the Department is changing the reimbursement methodology for pharmaceuticals. As part of the change in reimbursement methodology, reimbursement for ingredient costs will be decreased, the dispensing fee will be increased, and net savings of $4,000,000 total funds will be achieved.
- *Hospital Provider Fee Financing*: the Department is utilizing hospital provider fee to offset lost federal funds associated with certification of public expenditure for outpatient hospital services. An annual amount of $15,700,000 cash funds will be used to offset General Fund in the Medical Services Premiums line.

Anticipated Outcomes:
If implemented, the initiatives described in this request will generate savings by reducing inefficiencies in billing processes, ensuring that services received are medically necessary, and encouraging utilization in the most cost effective/clinically effective setting.

Assumptions for Calculations:
A detailed description of each proposed initiative is contained in Appendix A. Summary totals for the request are shown in Appendix B. Detailed calculations and assumptions for individual proposals are shown in Appendix C.

Consequences if not Funded:
The proposed measures in this request are necessary in order for the Department to meet strategic goals and to achieve a balanced budget in FY 2012-13. If these measures are not approved, other reductions would be required to balance the budget.

Cash Fund Projections:
See Table 5.1 of Appendix A.

Relation to Performance Measures:
HCPF Performance Measure 4: Contain Health Care Costs: The initiatives contained in this request ensure care is both necessary and appropriate without sacrificing the integrity of clients' health.

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:
The Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per 25.5-4-401 (1) (a), C.R.S. (2010).

Appendix

Appendix A
Appendix A contains a description of each of the fourteen initiatives proposed with this request as well as assumptions used in calculating fiscal impacts.

Appendix B
Appendix B contains summary information including fund splits and cash fund projects.

Appendix C
Tables containing detailed calculations are included in Appendix C.

Proposal	**Table**
Preterm Birth Prevention	Table A
Synagis Restrictions	Table B
Enhanced Physician Administered Drug Rebate Program	Table C
Reimbursement Rate Alignment for Developmental Screenings	Table D
Physician Administered Drug Pricing and Unit Limits	Table E
Increased Public Transportation Utilization	Table F
Home Health Therapies Limits	Table G
Home Health Personal Care Limits	Table H
Seroquel Restrictions	Table I
Dental Efficiencies	Table J
Augmentative Communication Devices	Table K
Durable Medical Equipment Preferred Provider	Table L
Continuation of Class I Nursing Facility Reduction	Table M
Increased Utilization of Ambulatory Surgical Centers	Appendix A
Utilization Management Vendor Funding	Appendix A

Appendix A

The components of this request represent significant reductions in expenditure, and consequently impact stakeholders in a variety of ways. To the extent possible for each initiative, the Department has engaged stakeholders to collaboratively develop proposals. Stakeholders have provided invaluable feedback that allowed the Department to identify reductions and find efficiencies that will have the least negative consequences to Medicaid clients and providers while still achieving significant savings.

The Department is able to begin many of these initiatives prior to FY 2012-13. For those instances, the Department may submit a separate supplemental budget request to account for any additional savings.

Preterm Labor Prevention

As of August 1, 2011, the Department has begun offering coverage of alpha hydroxyprogesterone caproate injections (also known as 17P) to pregnant women who meet certain criteria for being at risk of preterm birth.

Studies show that, on average, every five and a half individuals treated with 17P results in the prevention of one preterm birth.[1] Premature babies are at increased risk for newborn health complications such as respiratory system underdevelopment resulting in breathing problems. Most premature babies require care in a newborn intensive care unit (NICU), which has specialized medical staff and equipment that can deal with the multiple problems faced by premature infants. The higher level of newborn care represents a significant cost to the state; MMIS data shows that on average there is an additional expense of $6,138 per preterm birth and $9,274 per preterm birth when the baby's birth weight is low.

FY 2009-10 claims data shows 2,280 Medicaid newborns had a low birth weight diagnosis. National Vital Statistics show that 66% of low birth weight births are also premature births. This results in approximately 1,505 births that are both preterm and low birth weight. FY 2009-10 claims data also shows 655 newborns with a preterm labor diagnosis but no diagnosis of low birth weight. An additional qualifying criterion for use of 17P is a previous live preterm birth. Information from the Department of Public Health and Environment indicates that 62% of women that have a preterm birth, have had a previous live birth. Information on previous preterm live births was not available. Although the exact number cannot be calculated, given this information, the Department estimates approximately 1,000 clients will be eligible for this drug. Based on the statistics above, the Department estimates that approximately 70% are at risk of preterm labor and a low birth weight birth. The remaining 30% are at risk for preterm birth only.

Due to a six month delay between implementation of the program and demonstrated clinical effectiveness, the Department estimates an increase in FY 2011-12 expenditure equal to $131,615 total funds, $65,807 General Fund. The Department estimates a net reduction of expenditure equal to $902,736 total funds, $451,368 General Fund in FY 2012-13 and $1,000,608 total funds, $500,304 General Fund in FY 2013-14.

See tables A.1 through A.3 in Appendix C for detailed calculations.

Synagis PAR Restrictions

Synagis is a commonly prescribed prophylactic for high risk children; the pharmaceutical reduces the likelihood of hospitalization from respiratory syncytial virus (RSV) infection.

[1] 2003 New England Journal of Medicine, multicenter, randomized, placebo-controlled trial conducted by the National Institute of Child Health and Human Development.

The Department is in the process of implementing a more restrictive prior authorization process for Synagis; implementation is expected to be complete by November 1, 2011. By authorizing each dose individually, the Department will have greater control in limiting patients to the American Academy of Pediatrics (AAP) recommended number of doses per season. The Department will set up controls to ensure that a weight appropriate dose is authorized, that the client receives all authorized doses, that only the appropriate number of doses are given, and that the doses are given at the appropriate interval (28-30 days apart).

Based on the nature of the proposal, clinical data would be necessary to predict the fiscal impact with precision. Unfortunately, specific clinical data such as client weight is not available to the Department at this time. However, several studies have been done related to the pharmaceutical PAR process which allows the Department to estimate the fiscal impact of this proposal. Bernard Bloom and Jake Jacobs studied the effect of the prior authorization process of Cimetidine in the West Virginia Medicaid program. They found that utilization of the drug decreased by 84%. Walter Smalley and colleagues examined the effects of a prior authorization policy for nongeneric non-steroidal anti-inflammatory drugs in the Tennessee Medicaid program. Their results indicated a 53% decline in utilization resulting from the prior authorization process[2].

It is important to note that there are several differences between the policies implemented in West Virginia and Tennessee. First, there currently exists a prior authorization process for Synagis; it is not reviewed or restricted to the levels proposed by this initiative. As a result, the reduction in utilization from physicians being unwilling to traverse the prior authorization process will not be experienced by Colorado. Second, Synagis is in a different drug class than either of the two studies. The Department does not anticipate substitution effects with Synagis such as those that likely drove much of the reduction in utilization in the studies. To account for these differences, the Department estimates 10% of the utilization reduction seen in the Tennessee program, or 5.3% as available savings from this initiative. Should savings prove to exceed this amount, the Department will request a change in funding through the normal budgetary process.

The Department estimates $211,253 total funds, $103,217 General Fund savings in FY 2011-12; $419,772 total funds, $205,100 General Fund savings in FY 2012-13; and $486,552 total funds, $237,729 General Fund savings in FY 2013-14 from the implementation of this policy.

See table B.1 in Appendix C for detailed calculations.

Physician Administered Drug Enhanced Rebate Program

Many pharmaceuticals covered under the Medicaid program are eligible for manufacturer rebates. Physician administered drugs (also known as J-Code drugs) are also eligible for rebates. While the Department has historically collected rebates on some physician administered drugs, there was opportunity to expand the physician administered drug rebate program. Physician administered drugs are processed as a medical claim and not a pharmacy claim. This had resulted in insufficient information being supplied on these claims for the Department to claim rebates from the manufacturers. Department policy staff has been working with the provider community to clarify expectations regarding the submission of claims for physician administered drugs. Further, the Department has expanded the list of rebateable physician administered drugs by comparing the Department's rebateable drug list with other national lists to ensure all opportunities for rebate collection are identified. Because many of the physician administered drugs on the expanded drug rebate list are multisource generics for which the Department is unable to pursue

[2] Soumerai, Stephen B. "Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid", Health Affairs, V.23 , January/February 2004

collection of rebates, the Department assumes that the percentage of collectable rebates for drugs recently added to the expanded list will be 50% lower than was achieved for drugs on the list prior to the expansion. The Department began implementation of this initiative September 2011. The Department is investigating the possibility of collecting rebates on claims paid prior to September 2011, but is unclear that this will be allowable under federal law; the Department has not scored savings for historical claims as a result. However, collection of rebates on these claims may yet be possible. The Department continues to investigate the possibility and will account for any additional savings achieved through the regular budget process.

The Department estimates a $1,738,620 total funds, $869,310 General Fund savings in FY 2011-12 from this initiative. This amount annualizes to $2,418,276 total funds, $1,209,138 General Fund in FY 2012-13 and $2,803,032 total funds, $1,401,516 General Fund in FY 2013-14.

See table C.1 in Appendix C for detailed calculations.

Reimbursement Rate Alignment for Developmental Screenings

Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings. Previously, developmental and depression screenings were both billed with procedure code 96110 and the rate was set at $36.10. This was well above the rates paid by Medicare and commercial insurance plans for these screenings.

The Department reduced the rate for developmental screenings to $17.00 and continues to reimburse it using code 96110. The decision to reduce the rate to $17.00 was reached in collaboration with the Colorado Chapter of the American Academy of Pediatrics (CO AAP), which compiled a document indicating that commercial rates for this type of screening range from $16.00 to $20.00. This range is still well above the Medicare rate of $8.05 for this code, but the CO AAP maintained that Medicare rates do not accurately represent the pediatric population and urged the Department to set the rate to a commercial benchmark. The Department is also limiting reimbursement to three developmental screenings per year for children 0 to 24 months old and two developmental screenings per year for children 25 to 29 months old based on guidance from the CO AAP. Developmental screenings will not be a benefit available to children over the age of four. Exceptions to this age limit will be made if the provider shows medical justification; the Department anticipates that there will be very few exceptions and therefore did not include them in its analysis as it would not significantly change the results.

The Department has opened procedure code 99420 for adolescent depression screenings and reduced its reimbursement rate to $10.08, which is equivalent to the rate for depression screenings in the Medicare Physician Fee Schedule. Further, the Department is limiting this benefit to clients 11 to 20 years old to reflect the adolescent age group within the EPSDT population that is consistent with national guidelines for depression screening. Any claims submitted for clients outside of this range will be denied. The Department will allow for an exception for children under the age of 11 in the case of a justified need. As with developmental screenings, the Department anticipates that there will be very few exceptions and therefore did not include them in its analysis.

The Department estimates that changing the reimbursement levels and age limits for these rates will generate savings of $1,620,574 total funds, $791,810 General Fund in FY 2011-12 and $2,092,701 total funds, $1,022,490 General Fund in FY 2012-13, and $2,431,758 total funds, $1,188,154 General Fund in FY 2013-14

See tables D.1, D.2, and D.3 in Appendix C for detailed calculations.

Physician Administered Drug Pricing and Unit Restrictions
The Department has identified three physician administered drugs for which the pricing and unit limits are inconsistent with policy. The Department raised reimbursement to be equal with Medicare rates while also changing the unit limits for haloperidol decanoate (J1631) and fluphenazine decanoate (J2680) that ensures compensation is adequate; this provided consistency in billing, but ultimately results in savings for the Department. Reducing reimbursement of risperidone (J2794) brought reimbursement in line with the actual cost of the drug which is consistent with Department policy. All three drugs are used in the treatment of schizophrenia.

Claims data indicated that providers were frequently billing unit amounts that were inconsistent with standard dosages. Many claims appeared to be billing 1 unit = 1mg. The correct unit size is 1 unit = 50mg for J1631 and 1 unit = 25mg for J2680. For J2794, lowering the reimbursement to the same level as the Medicare rate generated savings for the Department as reimbursement for the drug significantly exceeded the Medicare rate. The Department has adjusted the Medicaid fee schedule to match the Medicare rate for these three office injected drugs and to change the unit limit to prevent billing incorrect units.

This change is estimated to result in $359,305 total funds, $175,555 General Fund savings in FY 2011-12; $416,472 total funds, $203,488 General Fund savings in FY 2012-13; and $482,738 total funds, $235,865 General Fund savings in FY 2013-14.

See tables E.1, E.2, E.3, and E.4 in Appendix C for detailed calculations.

Increased Utilization of Public Transportation
Effective January 2012, the Department will be implementing a public transportation utilization incentive program in the Denver-metro area to increase the utilization of public transportation under the Department's non-emergent medical transportation program.

Through a survey and comparison of national best practices, the Department identified that public transportation is being underutilized relative to other states within the state's non-emergent medical transportation (NEMT) program. Public transportation represents a significantly cheaper alternative to private vehicles, but an equally effective way for the Department to provide transportation access to Medicaid clients. Other states have experienced levels of public transportation utilization nearing 30% whereas utilization in the Denver-Metro region of Colorado is historically between 9% and 10%.

For the Denver-metro counties, the Department utilizes a contractor for the coordination of NEMT trips. This administrative contract will be reprocured early in FY 2011-12. With the contract procurement, the Department will build in incentives in the form of additional compensation for achieving specific targets (see attached tables for additional detail) to ensure the contractor is encouraging clients to utilize public transportation when they are physically able and it will not result in undue hardship for the client. Over the first eighteen month period of the contract, the Department anticipates utilization of public transportation in the NEMT program for this region to increase from 9.5% to 17.5%. The Department incorporated this assumption into the NEMT contract; under this assumption the base amount of the contract is fixed at a lower rate than in FY 2010-11 which ensures the Department will capture savings from this initiative whether the contractor achieves the public transportation utilization target or not.

In addition to the savings generated by increasing public transportation utilization, there will be a one-time cash accounting savings as the Department transitions from a prospective reimbursement methodology to a retrospective reimbursement methodology.

The combined savings generated by increasing utilization of public transportation and the onetime cash accounting savings results in total fund savings of $615,598 and $300,780 General Fund savings in FY 2011-12. This annualizes to $209,574 total fund, $102,398 General Fund savings in FY 2012-13 and a like amount in FY 2013-14.

See table F.1 in Appendix C for detailed calculations.

Home Health Efficiencies

The following initiatives proposed by the Department are aimed at ensuring appropriate utilization of home health services in the Medicaid program. Exemptions to limitation on services will be made for clients under the age of twenty as applicable and required by federal law.

Unit Cap of 48 Units on Home Health Therapies

The Department is limiting home health therapy to 48 visits per year. This policy would be consistent with the Department's current outpatient therapy limits.

Physical therapy, occupational therapy and speech therapy are services available to Medicaid recipients during the acute period of home health care (up to 60 days of care). For home health purposes, therapies should be rehabilitative and restorative in nature. In most cases, visits past the 48th visit are for maintenance, which is not covered as a home health benefit. The Department is placing a 48 visit cap per client per calendar year for all three home health therapies which will still allow a client to receive needed rehabilitative and restorative care while avoiding treatment that can no longer be considered restorative, but is instead maintenance. While the Department will allow exceptions when authorized for a medical need, it is unlikely that visits past the 48th would be restorative or rehabilitative in nature and would be approved.

This proposal may have a significant effect on those clients who would have received more than 48 units. In CY 2010, for clients that utilized services in excess of 48 unit cap, utilization would have to be reduced by approximately 36% with the unit limitation. While this reduction is large, the Department believes that any potential negative effects to clients will be mitigated through appropriate use of certified nursing aide services, and the aforementioned medical exemption process.

While some substitution may occur between home health therapy services and outpatient therapy services, the Department previously limited the number of outpatient therapy visits that can be utilized by a client (requested in FY 2011-12 BA-9: "Medicaid Reductions"). This acts to constrain, but does not eliminate completely, the substitution effect. As with the home health setting, if the therapies are no longer restorative as one would anticipate past the 48 visit point, it is unlikely the client would qualify for therapy in the outpatient setting. The Department therefore assumes no substitution effect to outpatient therapy as part of its calculations.

This initiative is estimated to save $60,601 total funds and $29,609 General Fund in FY 2011-12. This amount annualizes to $382,453 total fund, $186,866 General Fund in FY 2012-13, and $402,407 total funds, $196,615 General Fund in FY 2013-14

See table G.1 in Appendix C for detailed calculations.

Limit Home Health Care to Eight Hours per Day

Home Health rules currently state that home health visits must be completed on an intermittent basis, but the rules do not define what is considered an intermittent basis. Medicare defines intermittent as less than 8 hours a day and less than 21 days a month. For this initiative, the Department is issuing a clarifying rule consistent with Medicare. However, as many Medicaid recipients need daily care, the Department believes the 21 day per month limitation cannot be safely applied; only the 8 hour per day limitation is being incorporated. Exemptions will be allowed when deemed medically necessary and are prior authorized.

For those clients that currently utilize more than 8 hours per day of home health services, the average number of hours utilized is 10.5. For this subset of home health 'high utilizers, the restriction results in an approximate 19.8% reduction in hours of service received. However, when accounting for all home health utilizers, the reduction in hours resulting from the cap is far less, approximately 4.1%. Meeting the eight hour limit without negatively impacting those clients whose utilization exceeds the cap will require home health agencies to be more efficient with time spent attending a client's needs. In cases where meeting the needs of the client within the hour limitations is not possible, documentation of medical necessity will need to be provided and reviewed.

The Department estimates FY 2011-12 savings equal to $652,941 total funds, $319,026 General Fund, FY 2012-13 savings of $4,117,163 total funds, $2,011,640 General Fund and FY 2013-14 savings of $4,326,979 total funds, $2,114,155 General Fund.

See table H.1 in Appendix C for detailed calculations.

Seroquel Restrictions

Seroquel is a pharmaceutical that is prescribed to treat schizophrenia and mood disorders such as bipolar disorder. In low doses, this drug is sometimes used as a sleep aid or anxiety reducer. The Department believes this off-label use of an antipsychotic agent exposes clients to unnecessary risk of adverse reactions while driving additional expenditure for the state. Effective January 2012, the Department is restricting use of Seroquel to treatment of psychotic disorders though the Department's pharmacy prior authorization process. As a result of this policy change, the Department anticipates a shift in utilization away from Seroquel to cheaper and more appropriate medications for the treatment of sleep disorders and anxiety. In comparing the cost of Seroquel to generic Zolpiden, the Department estimates costs for off-label use of Seroquel in excess of four times what would be paid for a generic sedative.

Seroquel can be used in low doses to titrate to higher doses for use as an antipsychotic. The Department identified claims where a low dose of Seroquel was prescribed for lengths of time greater than one month. As titration should be complete within a month, this indicated that approximately 78% of low dosage Seroquel was likely to be off label use. To avoid an overestimation of savings, the Department conservatively assumes that 30% of the low dosage utilization is appropriate usage.

The Department estimates the impact of this policy change to equal $694,210 total fund, $339,190 General Fund in FY 2011-12. This amount annualizes to $1,931,172 total funds, $943,568 General Fund in FY 2012-13 and $2,238,420 total fund, $1,093,689 General Fund in FY 2013-14.

See Table I.1 in Appendix C for detailed calculations.

Dental Efficiencies
Effective January 2012, the Department will be clarifying several policies regarding reimbursement for orthodontic services. Orthodontic services are covered by Medicaid when a client has a qualifying medical need. State rules do not clearly define the criteria under which a client is eligible. This proposal includes clarification of the definition of a 'severe handicapping malocclusion', which ensures procedures are reimbursed only when the procedure was medically necessary.

Under current policy, an entire procedure is paid in full up front. Under multiple circumstances, this results in overpayment by the Department. For example, if a client becomes ineligible for Medicaid or initiates but fails to complete treatment, the state incurs avoidable costs. The Department will be transitioning to a new payment methodology where payments are made in three equal installments. This will reduce expenditure for partially performed procedures.

To reduce spurious claims, the Department will restrict reimbursement for diagnostic casts, x-rays and other preparatory diagnostics associated with orthodontic procedures through the PAR process. The procedures will only be reimbursed when associated with a preapproved orthodontic procedure.

Because the Department has limited access to clinical data, it is difficult to predict the level of savings which can be achieved with precision. However, in comparing Colorado's expenditure on dental services to other states, the Department identified that states which have relatively stricter limitations on access to orthodontic procedures have significantly lower expenditure. For example, Rhode Island has a per member per month dental expenditure of approximately $12.76 (after adjustments for administrative expenses) whereas Colorado has a per member per month of $31.22 for clients under the age of 21. This represents a 59% difference in per member per month costs. While there are differences between programs other than the relative restrictiveness of medical necessity criteria, the indication is that more restrictive policies can achieve significant savings. Comparison of expenditure to North Carolina showed a similar relationship: North Carolina's orthodontic expenditure comprises approximately 8% of their total Medicaid dental expenditure. Colorado's orthodontic expenditure is 12% of total Medicaid dental expenditure. Dr. Mark Casey of the North Carolina Department of Health and Human Services surmised that one driving factor for Colorado's higher ratio of orthodontic expenditure is the orthodontics approval criteria. If Colorado were to achieve the same ratio of orthodontic expenditure to total dental expenditure as North Carolina through clarification of qualification criteria and other efficiencies enacted as part of this initiative, orthodontic expenditure would be reduced by approximately 32%. To account for programmatic differences between states, the Department assumes one third of this reduction, or 10% of total orthopedic expenditure, as attainable savings.

This initiative is estimated to save $603,812 total funds, $295,022 General Fund in FY 2011-12; $1,641,594 total funds, $802,081 General Fund in FY 2012-13; and $1,859,598 total fund, $908,597 General Fund in FY 2013-14.

See Table J.1 in Appendix C for detailed calculations.

Augmentative and Alternative Communication Devices
Augmentative and alternative communication devices (AACD) aid individuals with impairments that hinder their ability to produce or comprehend verbal or visual communication. As a Medicaid benefit, clients are able to obtain these devices. On average, the Department provides approximately ten AACDs each month at an average cost of $6,500 each. With the rapid progression of technology, alternatives to the traditional AACD have become available. A tablet computer with a specialized application can achieve

nearly the same functionality as the traditional AACD, and essentially serves as a step-down alternative to the traditional AACD. Further, tablet computers with the necessary applications cost approximately $800. Unfortunately, tablet computers are not suitable for all clients that would use the traditional AACD. Some of the clients' disabilities limit their dexterity to the point of being unable to use a tablet computer. For these clients, the traditional AACD is still necessary. Based on information from a Colorado complex rehab durable medical equipment provider, the Department estimates that 80% of clients that would opt to obtain the traditional AACD are physically capable of utilizing a tablet computer instead.

Both current policy and systems capacity allow for reimbursement for tablet computers as part of the Department's durable medical equipment benefit. However, client and DME supplier outreach will be necessary to ensure access. Due to the low volume of clients with conditions that qualify for AACDs, the Department believes this outreach can be accomplished with existing resources.

The Department recognizes that some clients that qualify for an AACD based on their impairment do not opt to obtain one, but would likely opt for a tablet computer. Consequently, the Department assumes that utilization of AACDs, when tablet computers are easily accessible to clients with qualifying disabilities, will increase by 200%. Despite this increase in utilization, the large price difference between the traditional AACD and tablet computers still results in net savings.

The Department estimates savings of $184,500 total funds, $90,146 General Fund in FY 2011-12. This amount annualizes to $492,000 total funds, $240,391 General Fund in FY 2012-13 and a like amount in FY 2013-14.

See Table K.1 in Appendix C for detailed calculations.

Durable Medical Equipment Preferred Provider

As a large purchaser of diabetic testing supplies, the Department is able to leverage purchasing power to obtain discount pricing. The Department has been approached by vendors offering provision of diabetic test strips at a rate (net of rebate) lower than current costs. Further, some vendors offer free glucose meters, client education and outreach. The Department anticipates that it will be able to achieve better pricing through a competitive bid process.

Preliminary research indicates that net payment could be reduced by as much as $4.50 per box. This savings is in addition to savings the Department achieved from previously reducing reimbursement for diabetic test strips as part of FY 2011-12 BRI-5 "Medicaid Program Reductions". While reimbursement to providers would necessarily increase as their direct acquisition cost would increase, the Department can ensure, through the competitive bid process, that the manufacturer rebate will be sufficient to reduce net expenditure below current levels. As additional criteria for a sole source provider for these supplies, the Department will require a prospective rebate agreement which will be reconciled retroactively. This reduces the gap between expenditure and collection of rebates and any cash flow issues that could potentially arise as a result. Providers that have approached the Department have indicated willingness to adhere to such a policy. If the criteria described cannot be met by any provider that bids through the competitive bid process, the initiative will not be implemented.

Current annual utilization of glucose meters is estimated at 16,782 units and approximately $45 per unit. With the manufacturer supplying these units for free, the Department can achieve significant savings.

Lastly, the Department would require the preferred provider to offer free client education and outreach. Helping clients understand how to properly manage their condition results in long run savings. When clients are able to manage their diabetes well, conditions such as diabetic ketoacidosis, high blood pressure, tissue degeneration, and a litany of secondary conditions can be avoided. The Department would account for any savings achieved from the additional client education through the normal budget process.

Implementation is scheduled for July 1, 2012. The net effect of leveraging the Department's purchasing power to obtain steep rebates, changing reimbursement on testing strips, and free glucose meters is estimated to result in $1,150,732 total funds, $562,246 General Fund savings in FY 2012-13. This annualizes to $1,422,312 total funds, $694,940 General Fund in FY 2013-14.

See Table L.1 in Appendix C for detailed calculations.

Continuation of Class I Nursing Facility Rate Reduction

Nursing facility reimbursement has two components. The first component, funded by a combination of General Fund and federal funds, covers expenditure for direct and indirect health care, raw food, administrative and general services, and fair rental value. The second component is funded by the Nursing Facility Provider Fee and federal funds and consists of supplemental payments to facilities for performance, acuity adjustments, and growth beyond the General Fund cap[3].

As part of the FY 2011-12 budget balancing package, across the board reductions to nearly all provider types were implemented. As part of this measure, SB 11-215 "2011 Nursing Facility Rate Reduction" was passed which reduced the General Fund portion of FY 2011-12 nursing facility per diem rates by 1.5%. This reduction did not represent an additional cut to nursing facility reimbursement relative to FY 2010-11 rates, but rather a continuation of the 1.5% reduction effective March 1, 2010 as imposed by HB 10-1324 "Nursing Facility Per Diem Rates". Unlike the reductions to other provider types, the reduction to nursing facility reimbursement as outlined in SB 11-215 was limited to FY 2011-12. Under the Department's proposal, the reduction will continue indefinitely. As the reimbursement methodology for this provider type is outlined in statute, legislation will be required to implement this proposal.

The Department proposes a continuation of the 1.5% rate reduction to the General Fund portion of Class I nursing facility reimbursement. This proposal will generate an estimated $9,024,677 total funds, $4,512,338 General Fund savings in FY 2012-13 and $9,320,345 total funds, $4,660,172 General Fund in FY 2013-14.

See Table M.1 in Appendix C for detailed calculations.

Increased Utilization of Ambulatory Surgical Centers

Clients in need of outpatient surgery are able to access services in a variety of settings. Depending on the invasiveness of the procedure, a client can have a surgery performed in an outpatient hospital setting, in an ambulatory surgical center (ASC), or even in a physician's office. Medicaid reimbursement methodologies are different from setting to setting. For example, outpatient hospital services are reimbursed using a cost based methodology while ASCs are reimbursed on a fixed fee schedule. The differences in reimbursement methodologies result in disparity in reimbursement for identical procedures performed in different settings. A procedure performed in an ASC is typically less expensive than the same procedure performed in the outpatient hospital setting. Because equivalent clinical outcomes can be achieved in either setting, there is

[3] SB 09-263 established a three percent annual growth cap on the General Fund portion of the statewide average nursing facility per diem rate net of patient payment.

an opportunity for efficiency gains when utilization of outpatient surgery services is shifted from the outpatient hospital setting to the ASC setting.

Over the last year, the Department has engaged the ambulatory surgical center provider community to determine if opportunities for greater efficiencies, such as those described above, can be achieved. As a result of this collaboration, the Department is currently running a limited scope trial to determine if utilization can be shifted from the outpatient setting to the ASC setting when ASCs are actively engaged in offering and promoting access of their facilities to surgeons that participate in Medicaid. Following completion of the trial (mid FY 2011-12), the Department will have the data necessary to structure incentives within the ASC reimbursement methodology to incentivize this migration between settings while capturing the efficiency of acquiring services from the least costly setting.

As the trial is not yet complete, the Department cannot yet estimate the exact fiscal impact from of this proposal, comparison of costs between settings and examination of a broad grouping of procedure codes indicates that savings of $500,000 total funds, $244,299 General Fund is attainable in FY 2011-12. This annualizes to $1,000,000 total funds, $488,599 General Fund in FY 2012-13 and a like amount in FY 2013-14.

Pharmacy Rate Methodology Transition

Until recently, many states have utilized average wholesale price (AWP), a pricing statistic provided primarily by First Data Bank, as the primary component of their pharmaceutical reimbursement methodology. Following a lawsuit wherein the flaws of average wholesale price setting were exposed, First Data Bank ceased to publish average wholesale pricing data. This occurred September 26, 2011. States that utilized this information in their pricing methodology, including Colorado, were forced to establish new pricing methodologies.

The Department has implemented a new pricing methodology that relies on a combination of state maximum allowable cost (SMAC) and wholesale acquisition cost (WAC). Although the Department is currently in transition and using a temporary SMAC list, implementation is expected to be complete by spring of 2012. The reimbursement for each drug will be changing (in some cases drastically) under the implementation of the final reimbursement methodology. To ensure drug pricing is fair and directly connected to actual provider costs, a rate rebalance is required.

The rate rebalance presents an opportunity as the Department will be able to realign reimbursement to reflect actual provider costs. The Department believes this is most effectively accomplished by reducing reimbursement to pharmacies for the material component of the pharmaceuticals and simultaneously increasing dispensing fees. This ensures that both the time and material components are reimbursed at a level that most accurately reflects costs to pharmacies. Further, the Department is able to complete the rebalance in a manner that generates savings. Under the proposed methodology, the Department is committed to reducing aggregate pharmaceutical expenditure by $4,000,000 total funds, $1,954,394 General Fund in FY 2012-13 through the rates rebalance process.

As many states have been forced to find an alternative to AWP pricing, several have completed dispensing fee studies. Alabama's rate rebalance resulted in significant reductions to drug costs and an increase of their dispensing fee to $10.18. Oregon also saw significant reductions to drug costs, but opted to stratify their dispensing fee. Until the final SMAC data set is available, the Department cannot explicitly state how much reimbursement for the raw material cost of pharmaceuticals will be reduced, or the exact level of the dispensing fee. The Department is engaging a private contractor to perform an analysis about the adequacy

Appendix B

Table 1.1
Summary of Estimate
FY 2011-12

Summary of FY 2011-12 Impact	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Estimated Impact	**($7,859,799)**	**($19,618,256)**	**$15,625,858**	**$0**	**($3,867,401)**
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	$250,000	$62,500	$0	$0	$187,500
(2) Medical Services Premiums	($8,109,799)	($19,680,756)	$15,625,858	$0	($4,054,901)

Table 1.2
Summary of Request
FY 2012-13

Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($29,699,322)**	**($30,471,105)**	**$15,496,446**	**$0**	**($14,724,663)**
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	$500,000	$125,000	$0	$0	$375,000
(2) Medical Services Premiums	($30,199,322)	($30,596,105)	$15,496,446	$0	($15,099,663)

Table 1.3
Summary of Request
FY 2013-14

Summary of Request FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**($31,976,323)**	**($31,592,518)**	**$15,479,358**	**$0**	**($15,863,163)**
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	$500,000	$125,000	$0	$0	$375,000
(2) Medical Services Premiums	($32,476,323)	($31,717,518)	$15,479,358	$0	($16,238,163)

Appendix B

Table 2.1
Impact by Component: Base Fund Split
FY 2011-12

FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Impact	**($7,859,799)**	**($19,618,256)**	**$15,625,858**	**$0**	**($3,867,401)**	
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	**$250,000**	**$62,500**	**$0**	**$0**	**$187,500**	**Narrative**
(2) Medical Services Premiums	**($8,109,799)**	**($19,680,756)**	**$15,625,858**	**$0**	**($4,054,901)**	
Preterm Labor Prevention	$131,615	$65,807	$0	$0	$65,808	Table A
Synagis Prior Authorization Review	($211,253)	($103,217)	($2,409)	$0	($105,627)	Table B
Expansion of Physician Administered Drug Rebate Program	($1,738,620)	($869,310)	$0	$0	($869,310)	Table C
Reimbursement Rate Alignment for Developmental Screenings	($1,620,574)	($791,810)	($18,477)	$0	($810,287)	Table D
Physician Administered Drug Pricing and Unit Limits	($359,305)	($175,555)	($4,097)	$0	($179,653)	Table E
Public Transportation Utilization	($615,598)	($300,780)	($7,019)	$0	($307,799)	Table F
Home Health Therapies Cap	($60,601)	($29,609)	($691)	$0	($30,301)	Table G
Home Health Care Cap	($652,941)	($319,026)	($7,444)	$0	($326,471)	Table H
Seroquel Restrictions	($694,210)	($339,190)	($7,915)	$0	($347,105)	Table I
Dental Efficiency	($603,812)	($295,022)	($6,884)	$0	($301,906)	Table J
Augmentative Communication Devices	($184,500)	($90,146)	($2,104)	$0	($92,250)	Table K
DME Preferred Provider	$0	$0	$0	$0	$0	Table L
Continuation of Nursing Facility Reduction	$0	$0	$0	$0	$0	Table M
Ambulatory Surgical Centers	($500,000)	($244,299)	($5,701)	$0	($250,000)	Narrative
Pharmacy Rate Methodology Transition	($1,000,000)	($488,599)	($11,401)	$0	($500,000)	Narrative
Hospital Provider Fee Financing	$0	($15,700,000)	$15,700,000	$0	$0	Narrative

Appendix B

Table 2.2
Impact by Component: Base Fund Split
FY 2012-13

FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**($29,699,322)**	**($30,471,105)**	**$15,496,446**	**$0**	**($14,724,663)**	
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	**$500,000**	**$125,000**	**$0**	**$0**	**$375,000**	**Narrative**
(2) Medical Services Premiums	**($30,199,322)**	**($30,596,105)**	**$15,496,446**	**$0**	**($15,099,663)**	
Preterm Labor Prevention	($902,736)	($451,368)	$0	$0	($451,368)	Table A
Synagis Prior Authorization Review	($419,772)	($205,100)	($4,786)	$0	($209,886)	Table B
Expansion of Physician Administered Drug Rebate Program	($2,418,276)	($1,209,138)	$0	$0	($1,209,138)	Table C
Reimbursement Rate Alignment for Developmental Screenings	($2,092,701)	($1,022,490)	($23,860)	$0	($1,046,351)	Table D
Physician Administered Drug Pricing and Unit Limits	($416,472)	($203,488)	($4,748)	$0	($208,236)	Table E
Public Transportation Utilization	($209,574)	($102,398)	($2,389)	$0	($104,787)	Table F
Home Health Therapies Cap	($382,453)	($186,866)	($4,360)	$0	($191,227)	Table G
Home Health Care Cap	($4,117,163)	($2,011,640)	($46,941)	$0	($2,058,582)	Table H
Seroquel Restrictions	($1,931,172)	($943,568)	($22,018)	$0	($965,586)	Table I
Dental Efficiency	($1,641,594)	($802,081)	($18,716)	$0	($820,797)	Table J
Augmentative Communication Devices	($492,000)	($240,391)	($5,609)	$0	($246,000)	Table K
DME Preferred Provider	($1,150,732)	($562,246)	($13,120)	$0	($575,366)	Table L
Continuation of Nursing Facility Reduction	($9,024,677)	($4,512,338)	$0	$0	($4,512,339)	Table M
Ambulatory Surgical Centers	($1,000,000)	($488,599)	($11,401)	$0	($500,000)	Narrative
Pharmacy Rate Methodology Transition	($4,000,000)	($1,954,394)	($45,606)		($2,000,000)	Narrative
Hospital Provider Fee Financing	$0	($15,700,000)	$15,700,000	$0	$0	Narrative

Appendix B

Table 2.3
Impact by Component: Base Fund Split
FY 2013-14

FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**($31,976,323)**	**($31,592,518)**	**$15,479,358**	**$0**	**($15,863,163)**	
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	**$500,000**	**$125,000**	**$0**	**$0**	**$375,000**	**Narrative**
(2) Medical Services Premiums	**($32,476,323)**	**($31,717,518)**	**$15,479,358**	**$0**	**($16,238,163)**	
(2) Medical Services Premiums						
Preterm Labor Prevention	($1,000,608)	($500,304)	$0	$0	($500,304)	Table A
Synagis Prior Authorization Review	($486,552)	($237,729)	($5,547)	$0	($243,276)	Table B
Expansion of Physician Administered Drug Rebate Program	($2,803,032)	($1,401,516)	$0	$0	($1,401,516)	Table C
Reimbursement Rate Alignment for Developmental Screenings	($2,431,758)	($1,188,154)	($27,725)	$0	($1,215,879)	Table D
Physician Administered Drug Pricing and Unit Limits	($482,738)	($235,865)	($5,504)	$0	($241,369)	Table E
Public Transportation Utilization	($209,574)	($102,398)	($2,389)	$0	($104,787)	Table F
Home Health Therapies Cap	($402,407)	($196,615)	($4,588)	$0	($201,204)	Table G
Home Health Care Cap	($4,326,979)	($2,114,155)	($49,334)	$0	($2,163,490)	Table H
Seroquel Restrictions	($2,238,420)	($1,093,689)	($25,521)	$0	($1,119,210)	Table I
Dental Efficiency	($1,859,598)	($908,597)	($21,202)	$0	($929,799)	Table J
Augmentative Communication Devices	($492,000)	($240,391)	($5,609)	$0	($246,000)	Table K
DME Preferred Provider	($1,422,312)	($694,940)	($16,216)	$0	($711,156)	Table L
Continuation of Nursing Facility Reduction	($9,320,345)	($4,660,172)	$0	$0	($4,660,173)	Table M
Ambulatory Surgical Centers	($1,000,000)	($488,599)	($11,401)	$0	($500,000)	Narrative
Pharmacy Rate Methodology Transition	($4,000,000)	($1,954,394)	($45,606)	$0	($2,000,000)	Narrative
Hospital Provider Fee Financing	$0	($15,700,000)	$15,700,000	$0	$0	Narrative

Appendix B

Table 3.1
Cash Fund Splits
FY 2011-12

FY 2011-12	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Reappropriated Funds	Federal Funds
Total Impact	**($7,859,799)**	**($19,618,256)**	**$15,634,956**	**($9,098)**	**$0**	**($3,867,401)**
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	$250,000	$62,500	$0	$0	$0	$187,500
(2) Medical Services Premiums	($8,109,799)	($19,680,756)	$15,634,956	($9,098)	$0	($4,054,901)

Table 3.2
Cash Fund Splits
FY 2012-13

FY 2012-13	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Reappropriated Funds	Federal Funds
Total Request	**($29,699,322)**	**($30,471,105)**	**$15,521,424**	**($24,978)**	**$0**	**($14,724,663)**
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	$500,000	$125,000	$0	$0	$0	$375,000
(2) Medical Services Premiums	($30,199,322)	($30,596,105)	$15,521,424	($24,978)	$0	($15,099,663)

Table 3.3
Cash Fund Splits
FY 2013-14

FY 2013-14	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Reappropriated Funds	Federal Funds
Total Request	**($31,976,323)**	**($31,592,518)**	**$15,506,433**	**($27,075)**	**$0**	**($15,863,163)**
(1) EDO (E) Utilization and Quality Review Contracts, Professional Services Contracts	$500,000	$125,000	$0	$0	$0	$375,000
(2) Medical Services Premiums	($31,976,323)	($31,592,518)	$15,506,433	($27,075)	$0	($15,863,163)

Appendix B

Table 4.2: New Letternote Totals for FY 2012-13

Long Bill Group	Line Item	Fund	Appropriation Type	COFRS Number	FY 2011-12 Base Request	Requested Total	Incremental Change
(2) Medical Services Premiums	Medical Services Premiums	Hospital Provider Fee Cash Fund	Cash Fund	24A	$354,420,151	$369,941,575	$15,521,424
(2) Medical Services Premiums	Medical Services Premiums	Breast and Cervical Cancer Prevention and Treatment Fund	Cash Fund	15D	$2,731,400	$2,706,422	($24,978)

Appendix B

Table 5.1 Cash Fund Projections

Cash Fund Name	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund
Cash Fund Number	24A	15D
FY 2010-11 Expenditures	$426,069,052	$2,903,163
FY 2010-11 End of Year Cash Balance	$22,198,436	$6,553,278
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436	$4,135,739
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436	$3,040,811
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436	$660,592

Appendix C

Table A.1
Savings Summary from Preterm Birth Prevention Initiative

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Clients at Risk of Low Birth Weight or Preterm Birth	$54,846	($778,236)	($828,576)	Table A.2
B	Clients at Risk of Preterm Birth Only	$76,769	($124,500)	($172,032)	Table A.3
C	**Total Savings**	**$131,615**	**($902,736)**	**($1,000,608)**	**Row A + Row B**

Table A.2
Savings for Clients at Risk of Both Preterm Birth and Low Birth Weight

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Monthly Potentially Eligible Clients at Risk of Preterm Birth and Low Birth Weight	58	64	71	Estimate based on survey of FY 2009-10 MMIS data by diagnostic code inflated annually by the percentage increase in Medicaid births from FY 2008-09 to FY 2009-10 (10.73%)
B	Cost of 17P treatment per Client	$725.55	$725.55	$725.55	21 doses at $14.55 administration fee per dose and $20.00 per dose for the medication
C	Estimated Monthly Cost	$42,082	$46,435	$51,514	Row A * Row B
D	Applicable Months	11	12	12	Assumes August 1, 2011 implementation date
E	Estimated Total Costs	$462,902	$557,220	$618,168	Row C * Row D
F	Average Monthly Avoided Preterm Births	11	12	13	Row A / 5.5 (See Narrative)
G	Applicable Months	4	12	12	Assumes August 1, 2011 implementation date and six months of utilization before clinical results are seen. Also adjusted for cash based accounting.
H	Savings Per Preterm Birth	($9,274)	($9,274)	($9,274)	Based on FY 2009-10 MMIS data
I	Gross Savings	($408,056)	($1,335,456)	($1,446,744)	Row F * Row G
J	**Estimated Savings**	**$54,846**	**($778,236)**	**($828,576)**	**Row G + Row K**

Table A.3
Savings for Clients at Risk of Preterm Labor

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Monthly Potentially Eligible Clients at Risk of Preterm Labor	25	28	31	Estimate based on survey of FY 2009-10 MMIS data by diagnostic code inflated annually by the percentage increase in Medicaid births from FY 2009-10 to FY 2010-11 (10.73%)
B	Cost of 17P treatment per Client	$725.55	$725.55	$725.55	21 doses at $14.55 administration fee per dose and $20.00 per dose for the medication
C	Estimated Monthly Cost	$18,139	$20,315	$22,492	Row A * Row B
D	Applicable Months	11	12	12	Assumes August 1, 2011 implementation date
E	Estimated Total Costs	$199,529	$243,780	$269,904	Row C * Row D
F	Average Monthly Avoided Preterm Labor	5	5	6	Row A / 5.5 (See Narrative)
G	Applicable Months	4	12	12	Assumes August 1, 2011 implementation date and six months of utilization before clinical results are seen. Also adjusted for cash based accounting.
H	Savings Per Preterm Labor	($6,138)	($6,138)	($6,138)	Based on FY 2009-10 MMIS data
I	Gross Savings	($122,760)	($368,280)	($441,936)	Row F * Row G
J	**Estimated Savings**	**$76,769**	**($124,500)**	**($172,032)**	**Row G + Row K**

Table B.1
Synagis PAR Review

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Synagis Expenditure	$6,833,049	$7,920,187	$9,180,289	FY 2010-11 MMIS data inflated annually by the percentage growth in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
B	Estimated Percentage Where Lower Dose Would Have Been Equally Effective	5.30%	5.30%	5.30%	See Narrative
C	Avoidable Expenditure	$362,152	$419,770	$486,555	Row A * Row B
D	Average Monthly Savings	$30,179	$34,981	$40,546	Row C / 12
E	Applicable Months	7	12	12	Assumes November 2011 implementation and adjustments for cash based accounting
F	**Estimated Savings**	**($211,253)**	**($419,772)**	**($486,552)**	**Row D * Row E * -1**

Appendix C

Table C.1
Enhanced Physician Administered Drug Rebate Program

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	FY 2009-10 Expenditure on J-Codes Not Receiving Rebates	$10,992,329	$12,741,209	$14,768,335	Based on FY 2009-10 MMIS claims data inflated annually by the average percentage of pharmacy expenditure growth from FY 2009-10 to FY 2010-11 (15.91%)
B	Estimated Percentage of Collectable Rebates	18.98%	18.98%	18.98%	50% of the FY 2009-10 rebate percentage for those J-Codes the Department collected rebates. (See Narrative)
C	Estimated Collectable Rebates	$2,086,344	$2,418,281	$2,803,030	Row A * Row B
D	Average Monthly Collectable Rebates	$173,862	$201,523	$233,586	Row C / 12
E	Applicable Months	10	12	12	Assumes September 2011 implementation and adjustments for cash based accounting
G	**Estimated Savings**	**($1,738,620)**	**($2,418,276)**	**($2,803,032)**	**Row D * Row E * -1**

Appendix C

Table D.1
Summary of Savings from Reimbursement Rate Alignment for Developmental Screenings Initiative

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Opening Depression Screening Rate and Setting Age Limits	($191,302)	($248,679)	($290,561)	Table D.2
B	Changing Developmental Screening Rate and Setting Age Limits	($1,429,272)	($1,844,022)	($2,141,197)	Table D.3
C	**Total Savings**	**($1,620,574)**	**($2,092,701)**	**($2,431,758)**	**Row A + Row B**

Table D.2
Opening Depression Screening Rate (Code 99420) and Setting Age Limits

Row	Item	FY 2011-12[(1)]	FY 2012-13	FY 2013-14	Description
A	Forecasted Utilization[(2)]	5,569	7,248	8,476	Forecasted using linear regression of historical monthly utilization of code 99420 for clients over age four.
B	Current Rate	$35.83	$35.83	$35.83	Department rate, effective July 1, 2011
C	Estimated Expenditure Under Current Rate	$199,537	$259,696	$303,695	Row A * Row B
D	Forecasted Utilization Under Proposed Age Limits	817	1,093	1,303	Forecasted using linear regression of historical monthly utilization of code 99420 for clients ages eleven to twenty
E	Proposed Rate	$10.08	$10.08	$10.08	Rate based on 100% of Medicare
F	Estimated Expenditure Under Proposed Rate	$8,235	$11,017	$13,134	Row D * Row E
G	**Estimated Savings**	**($191,302)**	**($248,679)**	**($290,561)**	**Row F - Row C**

Table D.3
Changing Developmental Screening Rate (Code 96110) and Setting Age Limits

Row	Item	FY 2011-12[(1)]	FY 2012-13	FY 2013-14	Description
A	Forecasted Utilization[(2)]	75,904	97,930	113,712	Forecasted using linear regression of historical monthly utilization of code 96110 for clients up to four years old
B	Current Rate	$35.83	$35.83	$35.83	MMIS rate after 0.75% cut effective July 1, 2011
C	Estimated Expenditure Under Current Rate	$2,719,640	$3,508,832	$4,074,301	Row A * Row B
D	Proposed Rate	$17.00	$17.00	$17.00	Rate based on commercial insurance rates
E	Estimated Expenditure Under Proposed Rate	$1,290,368	$1,664,810	$1,933,104	Row A * Row D
F	**Estimated Savings**	**($1,429,272)**	**($1,844,022)**	**($2,141,197)**	**Row E - Row C**

(1) Proposed rate changes will be effective August 1, 2011.

(2) Currently, providers bill code 96110 for both developmental and depression screenings; to estimate the impact of changing the rates separately for the two screenings, the Department assumes that depression screenings were given to clients over the age of four and developmental screenings were given to clients four years old and under. In addition, this analysis takes into account the proposed age limits of zero to four years old for developmental screenings and eleven to twenty years old for depression screenings.

Table E.1
Summary of Savings from Physician Administered Drug Pricing Adjustments and Unit Limitations

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Savings from Pricing and Unit Adjustments to J1631	($18,551)	($21,503)	($24,929)	Table E.2
B	Savings from Pricing and Unit Adjustments to J2680	($3,710)	($4,302)	($4,985)	Table E.3
C	Savings from Pricing Adjustment to J2794	($337,044)	($390,667)	($452,824)	Table E.4
D	**Total Savings**	**($359,305)**	**($416,472)**	**($482,738)**	**Row A + Row B + Row C**

Table E.2
Physician Administered Drug Pricing and Unit Limit Adjustments (J1631)

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Current Reimbursement Per Unit	$1.34	$1.34	$1.34	CY 2010 MMIS Data
B	Total Billed Units	26,300	30,484	35,334	CY 2010 MMIS Data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
C	Total Reimbursement	$35,242	$40,849	$47,348	Row A * Row B
D	Medicare per Unit Reimbursement	$15.44	$15.44	$15.44	Medicare Fee Schedule
E	Adjusted CY 2010 Reimbursed Units Under Unit Limitations	1,081	1,253	1,452	Unit restriction applied to CY 2010 MMIS data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
F	Estimated Reimbursement at Medicare Rate for Adjusted Units	$16,691	$19,346	$22,419	Row D * Row E
G	**Estimated Savings**	**($18,551)**	**($21,503)**	**($24,929)**	**Row F - Row C**

Table E.3
Physician Administered Drug Pricing and Unit Limit Adjustments (J2680)

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Current Reimbursement Per Unit	$0.85	$0.85	$0.85	CY 2010 MMIS Data
B	Total Billed Units	22,963	26,616	30,851	CY 2010 MMIS Data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
C	Total Reimbursement	$19,519	$22,624	$26,223	Row A * Row B
D	Medicare per Unit Reimbursement	$10.88	$10.88	$10.88	Medicare Fee Schedule
E	Adjusted CY 2010 Reimbursed Units Under Unit Limitations	1,453	1,684	1,952	Unit restriction applied to CY 2010 MMIS data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
F	Estimated Reimbursement at Medicare Rate for Adjusted Units	$15,809	$18,322	$21,238	Row D * Row E
G	**Estimated Savings**	**($3,710)**	**($4,302)**	**($4,985)**	**Row F - Row C**

Table E.4
Physician Administered Drug Pricing and Unit Limit Adjustments (J2794)

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Current Reimbursement Per Unit	$6.37	$6.37	$6.37	CY 2010 MMIS Data
B	Total Billed Units	278,549	322,866	374,234	CY 2010 MMIS Data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
C	Total Reimbursement	$1,774,357	$2,056,656	$2,383,871	Row A * Row B
D	Medicare per Unit Reimbursement	$5.16	$5.16	$5.16	Medicare Fee Schedule
E	Adjusted CY 2010 Reimbursed Units Under Unit Limitations	278,549	322,866	374,234	Unit restriction applied to CY 2010 MMIS data inflated annually by the aggregate percentage change in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
F	Estimated Reimbursement at Medicare Rate for Adjusted Units	$1,437,313	$1,665,989	$1,931,047	Row D * Row E
G	**Estimated Savings**	**($337,044)**	**($390,667)**	**($452,824)**	**Row F - Row C**

Appendix C

Table F.1
Increased Utilization of Public Transportation

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14[2]	Description
A	Estimated Monthly Expenditure Under Current Policy on Base Contract	$535,740	$535,740	$535,740	Based on current contracted service costs and forecasted expenditure for Weld County
B	Estimated Monthly Expenditure Under Incentive Program on Base Contract[1]	$508,276	$508,276	$508,276	Based on maximum allowable contractor bids as stated in the current request for NEMT proposals
C	Difference	($27,465)	($27,465)	($27,465)	Row A - Row B
D	Applicable Months	5	12	12	Assumes January 1, 2012 implementation date and adjustments for cash based accounting
E	Maximum Contractor Incentive Payment	$30,000	$120,000	$120,000	Maximum of $10,000 monthly contingent up the contractor successfully hitting public transportation utilization targets (paid quarterly).
F	One-time Cash Savings from Transition to Retrospective Payment System	($508,276)	$0	$0	See Narrative
G	**Estimated Savings**	**($615,598)**	**($209,574)**	**($209,574)**	**(Row C * Row D) + Row E + Row F**

(1) While the Department has estimated the monthly contract amount, contractors have yet to bid. This amount may vary.
(2) Under the fixed price contract, savings will be the same in FY 2013-14 as in FY 2012-13

Table G.1
Unit Cap of 48 Units on Home Health Therapies

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Monthly Reimbursed Units Over the Proposed Cap of 48	328	345	363	CY 2010 MMIS data inflated annually by the percentage growth in home health expenditure from FY 2009-10 to FY 2010-11 (5.09%)
B	Estimated Percentage of Units That Will Qualify for Exemption	10%	10%	10%	See Narrative
C	Average Monthly Avoidable Units	295	311	327	Row A * (1- Row B)
D	Applicable Months	2	12	12	Assumes Implementation April 1, 2012 and adjustments for cash based accounting
E	Estimated Total Units Over the 48 Unit Cap	656	4,140	4,356	Row A * Row C
F	Average Cost per Unit of Home Health Therapy	$92.38	$92.38	$92.38	CY 2010 MMIS Data
G	**Estimated Savings**	**($60,601)**	**($382,453)**	**($402,407)**	**Row B * Row D * -1**

Table H.1
Limit Home Health Care to 8 Hours per Day

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Estimated Monthly Units Reimbursed for Clients Exceeding the 8 Hour Limit	73,192	76,917	80,832	CY 2010 MMIS data inflated annually by the percentage growth in home health expenditure from FY 2009-10 to FY 2010-11 (5.09%)
B	Percentage of Units Over the 8 Hour Cap	21.94%	21.94%	21.94%	Based on CY 2010 MMIS data
C	Estimated Monthly Units Over the 8 Hour Cap	16,058	16,876	17,735	Row A * Row B
D	Estimated Percentage of Units Over the 8 Hour Cap That Would Qualify for an Exemption	10%	10%	10%	See Narrative
E	Estimated Average Monthly Avoidable Units	14,452	15,188	15,962	Row C * (1 - Row D)
F	Applicable Months	2	12	12	Assumes April 1, 2012 implementation and adjustments for cash-based accounting
G	Total Avoidable Units over 8 Hour Cap	28,904	182,256	191,544	Row E * Row F
H	Average Cost per Unit	$22.59	$22.59	$22.59	Based on CY 2010 MMIS data
I	**Estimated Savings**	**($652,941)**	**($4,117,163)**	**($4,326,979)**	**Row G * Row H * -1**

Appendix C

Table I.1
Seroquel Restrictions

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Expenditure on Low Dose Units of Seroquel	$4,760,281	$5,517,642	$6,395,499	FY 2010-11 MMIS Data inflated annually by the percentage growth in pharmacy expenditure from FY 2009-10 to FY 2010-11 (15.91%)
B	Percentage of Low Dose Units Likely to be Off Label Use	70%	70%	70%	See Narrative
C	Estimated Off Label Use Seroquel Expenditure	$3,332,197	$3,862,349	$4,476,849	Row A * Row B
D	Estimated Increase in Expenditure for Substitutes of Off Label Use Seroquel	$1,666,099	$1,931,175	$2,238,425	Row C * (50%) - Based on the ratio of the average cost of Seroquel substitutes to Seroquel
E	Estimated Net Savings	($1,666,099)	($1,931,175)	($2,238,425)	Row D - Row C
F	Average Monthly Savings	($138,842)	($160,931)	($186,535)	Row E / 12
G	Applicable Months	5	12	12	Assumes January 2012 implementation and adjustments for cash based accounting
H	**Estimated Savings**	**($694,210)**	**($1,931,172)**	**($2,238,420)**	**Row F * Row G**

Appendix C

Table J.1
Dental Efficiencies

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Estimated Average Monthly Expenditure on Orthodontics	$1,207,623	$1,367,995	$1,549,665	FY 2010-11 MMIS Data inflated annually by the percentage growth in dental expenditure from FY 2009-10 to FY 2010-11 (13.28%)
B	Estimated Percentage of Reduced Expenditure Under New Definition	10%	10%	10%	See Narrative
C	Monthly Savings	($120,762)	($136,800)	($154,967)	Row A * Row B * -1
D	Number of Applicable Months in Fiscal Year	5	12	12	Assumes implementation of January 2012 and cash based accounting adjustments
E	**Estimated Savings**	**($603,812)**	**($1,641,594)**	**($1,859,598)**	**Row C * Row D**

Appendix C

Table K.1
Augmentative Communication Device (ACD) Options

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Monthly ACD Units Purchased	11	12	13	Based on FY 2010-11 data with an annual trend equal to the percentage change in durable medical equipment expenditure from FY 2009-10 to FY 2010-11 (8.02%)
B	Cost per Unit	$6,500.00	$6,500.00	$6,500.00	Based on average invoice pricing
C	Current Average Monthly Expenditure	$71,500	$78,000	$84,500	Row A * Row B
D	Monthly Number of Clients that Would Opt for the ACD Step-down Options Instead of an ACD	9	10	10	Assumes only an 80% conversion as not all clients would be able to use the ACD step-down unit due to dexterity deficiencies (See Narrative)
E	Monthly Number of Clients that elect to obtain ACD Step-down Option That Would NOT have Otherwise Obtained an ACD Despite Qualifying	18	20	20	Assumes 200% more utilization by those that are eligible for a ACD but elect not to obtain one than those that are eligible and would have chosen an ACD
F	Total Monthly ACD Step-down Option Purchases	27	30	30	Row D + Row E
G	Average Cost of the ACD Step-down Option with Required Communication Applications	$800.00	$800.00	$800.00	Estimate based on average retail value of ACD step-down device
H	Monthly Expenditure on ACD Step-down Option	$21,600	$24,000	$24,000	Row F * Row G
I	Monthly Expenditure on ACDs when ACD Step-down Option is Available	$13,000	$13,000	$19,500	(Row A - Row D) * Row B
J	Total Monthly Expenditure when ACD Step-down Option is Available	$34,600	$37,000	$43,500	Row H + Row I
K	Difference Between Monthly Expenditure	($36,900)	($41,000)	($41,000)	Row J - Row C
L	Applicable Months	5	12	12	Assumes January 2012 implementation and adjustments for cash based accounting
M	**Estimated Savings**	**($184,500)**	**($492,000)**	**($492,000)**	**Row K * Row L**

Table L.1
Sole Source DME Provider

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Description
A	Average Units of Test Strips Purchased per Month	6,459	7,317	8,289	FY 2009-10 MMIS data inflated annually by the percentage growth in DME expenditure from FY 2009-10 to FY 2010-11 (13.28%)
B	Price Per Unit Under Current Policy	$18.00	$18.00	$18.00	Fee Schedule
C	Price Per Unit Under Sole Source	$13.50	$13.50	$13.50	Based on estimates provided by DME suppliers
D	Difference in Price Per Unit	($4.50)	($4.50)	($4.50)	Row C - Row B
E	Monthly Savings on Test Strips	($29,066)	($32,927)	($37,301)	Row A * Row D
F	Average Monthly Units of Meters	1,406	1,593	1,805	FY 2009-10 MMIS data inflated annually by the percentage growth in DME expenditure from FY 2009-10 to FY 2010-11 (13.28%)
G	Average Cost per Unit	$45.00	$45.00	$45.00	Average based on FY 2009-10 MMIS data
H	Average Monthly Saving from Meters	($63,270)	($71,685)	($81,225)	Row F * Row G * -1 (all meters provided free of charge)
J	Applicable Months	-	11	12	Assumes July 2012 implementation and adjustments for cash based accounting
K	**Estimated Savings**	**$0**	**($1,150,732)**	**($1,422,312)**	**(Row E + Row H) * Row J**

Appendix C

Table M.1
Continuation of FY 2011-12 1.5% Nursing Facility Reduction

Row	Item	FY 2011-12	FY 2012-13	FY 2013-14	Notes
A	Estimated FY 2012-13 Per Diem for Core Components[(1)]	$185.69	$191.26	$197.00	FY 2011-12 estimate inflated by the maximum allowable growth under current legislation (3%)
B	Rate Under Continuation of 1.5% Reduction		$188.39	$194.05	Row A * (1 - 0.015)
C	Difference		($2.87)	($2.95)	Row B - Row A
D	Estimated Covered Days of Service[(1)]	3,238,178	3,400,087	3,417,087	FY 2011-12 estimate inflated by 0.5%
E	Estimated Percentage of Covered Days Reported in the Same Fiscal Year In		92.46%	92.46%	See Narrative
F	Current Year's Dates of Service Reported in Current Fiscal Year		3,143,720	3,159,439	Row D * Row E
G	Savings For Current Year's Dates of Service		($9,024,677)	($9,320,345)	Row C * Row G
H	Savings for Prior Year's Dates of Service		$0	($735,951)	Row C * (Row D - Row F) using prior year's figures
G	**Estimated Savings**		**($9,024,677)**	**($9,320,345)**	**Row G + Row H**

(1) As reported in the Department's February 15, 2011 Medical Services Premiums Supplemental Request.

of the current dispensing fee; however, preliminary analysis by the Department based on the results from other states suggests a dispensing fee of $8.00 to $10.00 may be recommended. For reference, with approximately 3,783,212 prescriptions filled in FY 2010-11, an increase of the dispensing fee to $9.00 would generate an increase of $18,916,060 reimbursement in dispensing fees; to achieve a net reduction of $4,000,000 total funds, the Department would implement a $22,916,060 reduction in material component reimbursement.

It is important to recognize that, while these figures are large, reimbursement under AWP pricing blurred the distinction between material acquisition costs and service provision costs. While providers were reimbursed at a level that approximated their acquisition costs plus costs of providing service at the aggregate level, these two components could not be cleanly separated from one another. The significant increase to the dispensing fee and decrease to material reimbursement under SMAC/WAC pricing signifies the magnitude of distortion between relative costs for the two components under the AWP pricing methodology, not a change in aggregate level of reimbursement to pharmacies.

Utilization Management Vendor Funding

As a result of the proposed initiatives, the Department anticipates that there will be an increase in required prior authorizations and medical reviews. The Department requests $250,000 total funds, $62,500 General Fund in FY 2011-12 annualizing to $500,000 total funds, $125,000 General Fund in FY 2012-13 to increase its current utilization review program. This funding will add the capacity to perform 12,500 additional prior authorizations and reviews at approximately $40 per prior authorization. The actual cost per review will depend on the specific requirements developed on the Department's utilization review contractor. These reviews will be related to the Seroquel reviews, Synagis reviews, dental efficiencies, and home health limitations. It is unknown at this time how many new prior authorizations will be performed. However, if funding for utilization reviews is not adequate, the Department may not achieve the savings proposed in this request.

Hospital Provider Fee Financing

Through Upper Payment Limit (UPL) financing, the Department is able to increase Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund. This is accomplished by certifying the uncompensated costs from these entities as public expenditure. The matching federal funds are then accounted for as General Fund offset in the current year. With the implementation of the Health Care Affordability Act of 2009 (HB 09-1293), the Department is no longer able to certify public expenditure for outpatient hospitals as the hospital provider fee program brings Medicaid payment to hospitals up to the UPL.

Section 25.5-4-402.3(4)(b)(VII), C.R.S. (2011) states that the Hospital Provider Fee Cash Fund may be utilized to offset the loss of any federal matching funds due to a decrease in certification of public expenditure for outpatient hospital services. Therefore, for this request the Department would utilize funding from the Hospital Provider Fee cash fund to offset the increase to General Fund in the Medical Services Premiums line incurred due to a loss of certification of public expenditure. Each year, a total of $15,700,000 would be reserved from the Hospital Provider Fee cash fund for this purpose. To account for this transfer, the Department's appropriation for FY 2012-13, and each subsequent fiscal year, should be adjusted to increase cash funds expenditure by $15,700,000 from the Hospital Provider Fee cash fund, and General Fund should be decreased by a corresponding $15,700,000.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Cost Sharing for Medicaid and CHP+
Priority Number: R-7
Dept. Approval by: John Bartholomew 10/20/11 Date
OSPB Approval by: 10/24/11 Date

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

Line Item Information	Fund	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
Total of All Line Items	Total	$3,795,958,940	$0	$3,785,740,072	($3,407,194)	($6,049,804)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$936,403,660	$0	$1,014,333,063	($1,438,020)	($2,547,449)
	GFE	$284,621,517	$0	$284,621,517	$0	$0
	CF	$655,100,840	$0	$576,931,818	$91,841	$70,906
	RF	$6,488,387	$0	$3,202,036	$0	$0
	FF	$1,913,344,536	$0	$1,906,651,638	($2,061,015)	($3,573,261)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	$6,596,052	$0	$6,410,052	$30,000	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,430,918	$0	$1,487,168	$15,000	$0
	GFE	$0	$0	$0	$0	$0
	CF	$721,750	$0	$497,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,443,384	$0	$4,425,384	$15,000	$0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	Total	$32,412,990	$0	$31,767,217	$523,964	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,581,901	$0	$6,459,471	$130,991	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,479,670	$0	$1,698,513	$0	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$24,251,091	$0	$23,508,905	$392,973	$0
(2) Medical Services Premiums[a]	Total	$3,543,863,749	$0	$3,559,795,929	($2,171,793)	($4,003,554)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	($1,060,682)	($1,955,296)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$0	$534,529,617	($25,214)	($46,480)
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$0	$1,756,668,882	($1,085,897)	($2,001,778)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs[b]	Total	$213,086,149	$0	$187,766,874	($1,789,365)	($2,046,250)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	($523,329)	($592,153)
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$0	$40,206,188	$117,055	$117,386
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$0	$122,048,467	($1,383,091)	($1,571,483)

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

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**
(a) FY 2012-13; b of this amount, ~~$379,420,151~~ $379,397,984 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $67,978,040 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S., $43,157,867 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S., $23,401,464 shall be from recoveries and recoupments, $7,722,438 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program, $6,638,222 shall be from the Medicaid Buy-In Cash Fund created in Section 25.5-6-1405 (3) (b), C.R.S., $0 shall be from the Supplemental Old Age Pension Health and Medical Care Fund created in Section 25.5-2-101 (2), C.R.S., ~~$2,731,400~~ $2,728,354 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I), C.R.S., $878,625 shall be from the Colorado Autism Treatment Fund created in Section 25.5-6-805 (1), C.R.S., $200,335 shall be from the Coordinated Care for People with Disabilities Fund created in Section 25.5-6-111 (4), C.R.S., and $170,575 shall be from the the Home Health Telemedicine Cash Fund created in Section 25.5-5-321 (1) (c), C.R.S.
(b)FY 2012-13: of this amount, ~~$27,555,780~~ $27,894,248 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,188,707~~ $11,967,294 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Children's Basic Health Plan Trust Fund (11G); FF: Title XIX, Title XXI.

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments:

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-7
Request Title: Cost Sharing for Medicaid and CHP+

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Cost Sharing for Medicaid and CHP+	**($3,407,194)**	**($1,438,020)**	0.0
Cost Sharing for Medicaid	($1,617,829)	($914,691)	0.0
Cost Sharing for CHP+	($1,789,365)	($523,329)	0.0

Request Summary:
The Department requests $3,407,194 total funds, $1,438,020 General Fund in FY 2012-13 and $6,049,804 total funds, $2,547,449 General Fund in FY 2013-14 from increased cost sharing for Medicaid and Child Health Plan *Plus* (CHP+) clients by increasing co-payment and enrollment fees. The estimated reduction of $264,453 total funds, $138,601 General Fund in FY 2011-12 is reported for informational purpose only.

The Department currently charges nominal co-payment amounts to clients for various services including inpatient hospital, outpatient hospital, practitioner, and psychiatric services in Medicaid and CHP+. In addition to co-payments, the Department currently charges enrollment fees for clients with family income above 150% of the Federal Poverty Level (FPL) in CHP+. The Department currently does not require any cost sharing for CHP+ clients at or below 100% FPL.

Medicaid Cost Sharing
As part of this proposal, the Department requests to increase the current Medicaid nominal co-payment amounts to the maximum amounts allowable under federal regulations. All Medicaid clients, excluding those clients exempt (see Appendix A), would be required to pay the co-payment amounts at the point of service or sale.

Further, the Department requests to charge co-payment amounts on additional Medicaid services including: Non-Emergency Medical Transportation, Outpatient Substance Abuse, Physical, Occupational and Speech Therapy, Home Health and Private Duty Nursing. The Department would charge the maximum co-payments permitted under federal regulations. By expanding the list of services requiring co-payments, the Department would realize savings and encourage clients to be more responsible for their health, by avoiding unnecessary care.

Finally, the Department requests to increase co-payments above the nominal amount on emergency department services that are determined to be non-emergent to the maximum amount permitted under federal regulation. Based on the federal regulations for cost sharing, the Department anticipates that it must demonstrate that clients needing non-emergent care have alternative locations to receive care. To ensure compliance the Department would hire a contractor to review rural hospitals and determine alternative care locations.

The Department estimates these initiatives would result in savings of $1,617,829 total funds, $914,691 General Fund in FY 2012-13 and savings of $4,003,554 total funds, $1,955,296 General Fund in FY 2013-14.

Child Health Plan *Plus* Cost Sharing
The Department requests to increase cost sharing in CHP+ through two separate initiatives. First, the Department would triple CHP+ annual enrollment fees for families with children above 205% FPL beginning in January 2012. The Department currently requires these families to pay an enrollment fee of $25 for one child or $35 for 2 or more children; these enrollment fees would be increased to $75 and $105, respectively. Second, the Department would increase CHP+ co-payment amounts for families above 100% FPL based on income tiers beginning in July 2012.

The Department has actively engaged stakeholders to determine what level of increases to CHP+ cost sharing would result in the lowest attrition of clients and maintain affordability for families while still increasing clients' responsibility in their personal and family health care while realizing savings to the State.

The Department estimates that these initiatives will result in savings of $264,453 total funds, $138,601 General Fund in FY 2011-12, savings of $1,789,365 total funds, $523,329 General Fund in FY 2012-13 and savings of $2,046,250 total funds, $592,153 General Fund in FY 2013-14.

Anticipated Outcomes:
The Department anticipates that increasing co-payment amounts would reduce unnecessary emergency or specialty care and would not only generate savings, but also slow long-term Medicaid and CHP+ cost growth. Shifting some of the cost of health care to clients could encourage a more involved decision-making process when clients decide whether or not they need to visit a physician or hospital.

These increases, in addition to higher CHP+ enrollment fees for clients in higher income brackets would ease some financial burden from the Department while moderately increasing costs for families that are most able to absorb them.

Assumptions for Calculations:
Summary totals are contained in Appendix C. Please see Appendix D for detailed Medicaid calculations and assumptions, and Appendix E for detailed CHP+ calculations and assumptions.

Consequences if not Funded:
If this request is not funded, the Department would not be able to realize the proposed savings. Further, the Department would lose an opportunity to mitigate long-term cost growth by requiring clients to be more financially involved in their health care decisions.

Cash Fund Projections:
See Appendix F, Table H.1.

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. The initiatives propose to increase co-payment amounts and enrollment fees to increase clients' responsibility for their health care and to reduce costs to the Department.

Current Statutory Authority or Needed Statutory Change:
Cost sharing for Medicaid clients is authorized in sections 1916 and 1916A of the Social Security Act. For detailed information on federal Medicaid regulations, please see Appendix A.

Section 25.5-4-209 (1)(b), C.R.S. (2011) requires clients to pay a portion of any medical benefit as outlined in state rules.

Sections 25.5-8-107 (1)(b) and (c), C.R.S. (2011) authorize the Department to implement a cost sharing structure for the Children's Basic Health Plan that includes an annual enrollment fee based on a sliding fee scale and co-payments. Families with incomes below 151% FPL and pregnant women are exempt from paying enrollment fees.

Appendix A: Medicaid Cost Sharing Detailed Narrative

This appendix describes the Department's proposed steps for using client cost sharing as a cost saving strategy. Cost sharing is carefully regulated by the Centers for Medicare and Medicaid Services (CMS) to prevent barriers to access for Medicaid clients. This appendix describes these federal regulations, the Department's current cost sharing strategies, and proposals for additional cost sharing.

Federal Regulations Restricting the Use of Cost Sharing

Prior to 2005, state Medicaid programs had very limited options for cost sharing. The authority for cost sharing, contained in section 1916 of the Social Security Act [42 U.S.C. 1396o], allows the state to impose cost sharing as long as the co-payment amounts are not above nominal amounts specified in federal regulation. Maximum nominal amounts are determined annually by the Secretary of the United States Department of Health and Human Services (the Secretary). Under this authority, providers may not deny services to a client who does not pay the co-payment if the client is at or below 100% of the Federal Poverty Level (FPL).

Co-payment amounts are based on the amount the Department reimburses for services and inflated yearly by the percentage increase in the medical component of the Consumer Price Index - All Urban Consumers (CPI-U). While the absolute maximum co-payment amount (other than the exemption for non-emergent outpatient visits) is currently $3.80, services with a reimbursement rate less than $50.01 cannot have a co-payment amount set at that maximum. The maximum for each reimbursement bracket is set by the secretary.

Table 1 below illustrates current co-payment maximums.

Table 1
Maximum Allowable Co-Payment Charges[1]

Reimbursement Amount for Service	Maximum Co-payment Amount
$10 or less	$0.65
$10.01 to $25	$1.25
$25.01 to $50	$2.55
$50.01 or more	$3.80

Federal regulations at 42 CFR § 447.55 permit the Department to charge a standard, or fixed, co-payment amount for any service. This standard co-payment may be determined by applying the maximum amounts in Table 1 to the Department's average or typical payment for that service. Federal regulations describe the following example to illustrate this authority: "…if the agency's typical payment for prescribed drugs is $4 to $5 per prescription, the agency might set a standard co-payment of $0.65 per prescription." The Department uses this authority to charge standard co-payments for most services.

Alternative cost sharing regulations under Section 1916A of the Social Security Act were created as part of the Deficit Reduction Act of 2005 (DRA), and were further clarified in the Tax Relief and Health Care Act

[1] The Department is not permitted to charge the maximum amount in all cases. This limitation is discussed in further detail in later sections.

of 2006. These regulations give states more flexibility to impose cost sharing. This flexibility applies largely to clients who are above 100% FPL, and therefore has limited practical application for Colorado's Medicaid program. The flexibility also comes with a greater burden to demonstrate that cost sharing does not exceed 5% of a family's income. For these reasons, the Department does not currently impose cost sharing under the 1916A authority.

Both sets of regulations include protections for certain populations and services, exempting them from co-payments. According to federal regulation, the following populations and services are exempt from paying co-payments:

- Children under 18 years of age;
- Services to pregnant women;
- Services furnished to individuals who are inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded or other medical institution that requires them to spend down their assets to be there;
- Emergency Services and family planning services;
- Services to an individual receiving hospice care; and,
- Native Americans.

In addition, Department regulation at 10 CCR 2505-10, Section 8.754.5 restricts cost sharing for;

- Children under the age of 19; and,
- Services provided under a Community Mental Health Services program and Managed Care programs.

Clients who are not exempt from cost sharing are asked to pay the co-payment amount at the service or purchase point. The Department imposes co-payments on clients by reducing the amount of payment to the provider; it is the providers' responsibility to collect co-payments from clients. If a client cannot pay the co-payment amount at the time of the service, the provider must still provide the service without collecting the co-payment.

Current Cost Sharing Strategies

The Department currently charges nominal standard co-payment amounts on twelve services offered through the Medicaid program. The Department's current cost sharing rates are shown below in Table 2 in the "Increase Nominal Co-payment Amounts" section of the narrative. Under certain conditions, states are permitted to charge amounts above the nominal amount. In particular, states are allowed to charge a co-payment of twice the nominal amount for emergency services determined non-emergent under section 1916(a)(3) of the Social Security Act [42 U.S.C. 1396o] as long as clients have alternative sources of non-emergent outpatient care without an imposed co-payment amount. This higher co-payment, however, requires a waiver from the Secretary.

The Department is not permitted to charge co-payments on emergency services. To ensure the Department is not imposing co-payment amounts on emergency services, providers are required to indicate on the claim form if the services were provided due to an emergency. For emergency services, the Department reimburses the provider the full amount for the service without deducting the co-payment amount.

The Department is requesting authority to implement the following initiatives to increase cost sharing between Medicaid clients and the Department and reduce expenditure in FY 2012-13.

Increase Nominal Co-Payment Amounts

For this initiative the Department would increase current standard nominal co-payment amounts to the maximum allowable amount as set in 42 CFR § 447.52 and 447.56. See Table 2 below for a list of current services requiring co-payment with current and proposed co-payment amounts.

Table 2
Current and Proposed Co-Payment Rates by Service

Service	Current Co-Payment	New Co-Payment
Inpatient Hospital Services	$10 per covered day or 50% of the averaged allowable daily rate, whichever is less.	$12 per covered day or 50% of the averaged allowable daily rate.
Outpatient Hospital Services	$3.00 per visit	$3.80
Practitioner Services (MD, DO, NP, PA)	$2.00 per visit	$2.55
Optometrist Visit	$2.00 per visit	$2.55
Podiatrist Visit	$2.00 per visit	$2.55
Psychiatric Services	$.50 per unit of service (1 unit = 15 minutes)	$0.65
Community Mental Health Center Services	$2.00 per visit	$2.55
Rural Health Clinic/ FQHC Services	$2.00 per date of service	$2.55
Durable Medical Equipment	$1.00 per unit or period of service, depending on the item.	$1.30
Laboratory	$1.00 per date of service	$1.30
Radiology (X-ray) Services	$1.00 per date of service. (Dental x-rays do not have a co-pay.)	$1.30
Prescription Services (each prescription or refill)	Generic drugs - $1.00 Brand name drugs - $3.00	Generic: $1.30 Brand name: $3.80

In many cases, the Department is proposing to raise co-payments to less than the maximum permitted (as shown in Table 1). As discussed above, the maximum allowable co-payment amount, under section 1916(a)(3) [42 U.S.C. 1396o] of the Social Security Act, is based on the reimbursement amount the Department pays for each service.

In order to increase co-payment amounts, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. State plan amendments require approval from the Centers for Medicare and Medicaid Services (CMS). The Department anticipates that it will submit a SPA to CMS by June 1, 2012, and approval could be expected by August 31, 2012. The Department would then promulgate rules in order for the new co-payment amounts to be effective October 1, 2012.

The Department estimates that increasing the co-payments on these services would reduce fee-for-service expenditure by $2,125,138 total funds and $1,037,897 General Fund in FY 2012-13, annualizing to $2,915,917 total funds and $1,424,134 General Fund in FY 2013-14. The Department's calculations are located in appendix D, Table A.1.

Add Co-Payments to Additional Services

For this initiative the Department would add nominal co-payment amounts to non-emergency medical transportation, outpatient substance abuse, physical, occupational and speech therapy, home health and private duty nursing services. See Table 3 below for proposed additional services and co-payment amounts.

Table 3 -Proposed Co-Payment Rates for New Services

Service	New Co-Payment
Non-Emergency Medical Transportation	$1.30
Outpatient Substance Abuse	$1.30
Physical, Occupational and Speech Therapy	$2.55
Home Health	$2.55
Private Duty Nursing	$2.55

Because each of the services the Department is proposing to add a co-payment amount to have varying reimbursement amounts, the Department has calculated the co-payment amount based on the current average billed amount. Once the average was determined, the Department selected the closest co-payment amount (from Table 1) to the average. The Department believes that selecting co-payment amounts consistent with other co-payments charged by the Department would reduce provider administrative costs and prevent confusion associated with charging new co-payments. See Table B.1 in Appendix D for further derivation of new co-payment amounts.

In order to implement new co-payment amounts, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. The Department anticipates that it will submit the amendment to CMS by June 1, 2012, and obtain approval by August 31, 2012. In addition, the Department would be required to make system changes to the Medicaid Management Information System (MMIS) in order to add seven new parameters in the system to reflect each new service type. The Department estimates this process would take approximately nine months to complete as the changes impact multiple claim types and pricing logic. The Department anticipates it would take two months to complete the Advanced Planning Document approval, one month for contract execution and approximately six months to complete the system changes. Given this timeline, the Department would set the effective date of the SPA to match system change timelines and anticipates system changes and the new co-payments to be implemented by April 1, 2013. The Department would require $523,964 total funds, $130,991 General Fund in FY 2012-13 to make the appropriate changes.

The Department estimates this initiative would cost $523,964 total funds**,** $130,991 General Fund in FY 2012-13 and reduce expenditure by $895,529 total funds, $437,367 General Fund in FY 2013-14. See appendix D, Table C.1 for the calculation of this initiatives costs and savings for FY 2012-13 and FY 2013-14.

Increase Co-Payment for Non-Emergent Use of the Emergency Room

For this initiative the Department would implement higher co-payments amounts for clients who use the emergency room for non-emergent conditions. Under federal law, there are multiple ways the Department can implement a higher co-payment for these services. It is not clear, however, what CMS will permit the Department to impose. The remainder of this section details both the Department's preferred option and the alternative method.

Imposing Higher Co-Payment Rates through a Waiver

The Department's preferred option to impose a higher co-payment for clients who use the emergency room for non-emergent conditions is to charge these clients a co-payment of twice the nominal amount, or $7.30 per episode. This option is based on specific authority in section 1916(a)(3) of the Social Security Act which allows states to implement cost sharing up to twice the nominal amount established for non-emergent outpatient services received at a hospital emergency room. This option requires a waiver granted by the Secretary; the Secretary has specific authority for this type of waiver in section 1916(a)(3). The State must also demonstrate to the satisfaction of the Secretary that individuals have access to alternative sources of non-emergency outpatient services.

Under this option, the Department would apply for a waiver in order to impose co-payments above the nominal amounts for non-emergency use of the emergency room. This would enable the Department to charge $7.30 for non-emergent services for eligible populations (see restricted populations above).

The Department does not know what restrictions and requirements CMS will include as a condition of approving the waiver, or how likely it is that CMS will approve the waiver. CMS has informed the Department that no state currently has a waiver under this provision, although one state was previously granted waiver authority. At minimum, however, the Department must guarantee that clients have access to alternative sources of non-emergency outpatient services. In order to remain complaint with federal regulations requiring access to non-emergency services, the Department would hire a contractor to survey rural areas and determine alternate care sites for clients unwilling to pay the co-payment amounts. The Department estimates that the contractor would cost $30,000 total funds, $15,000 General Fund in FY 2012-13, based on similar Department initiatives. If the Department determines particular areas where a hospital is the only source of care, the Department would exempt those hospitals from the requirement to charge the higher co-payment.

To allow sufficient time for the application of a waiver, as well as time for the contractor to determine any exempt hospitals, the Department assumes that in order to implement this initiative using this first option the program could be implemented by April 1, 2013. This assumption is based on the Department's past experience in submitting demonstration waivers; CMS does not have a specified timeline to approve or deny the Department's waiver request. The Department's experience has been that changes in federal policies and guidelines often require that the Department significantly change components of the initial waiver application, and engage in extended discussions regarding the particulars outlined in the application. The Department does not require additional administrative resources to complete the waiver application, and therefore estimates submitting a waiver application by July 1, 2012; if the approval process and required rule changes require approximately nine months to complete, the Department could implement this initiative by April 1, 2013. However, this is not known. The Department assumes current methodology to determine whether an outpatient service is considered an emergency or not would be sufficient to meet waiver requirements.

The Department anticipates savings of $16,655 total funds and $7,785 General Fund in FY 2012-13 and $192,050 total funds, $93,795 General Fund in FY 2013-14 from the implementation of this initiative. Please see appendix D, Tables D.1 for the calculation of costs and savings associated with this proposal.

Alternative Method of Imposing Higher Cost-Sharing
The second option the Department has identified is to apply guidance under Section 1916A of the Social Security Act [42 U.S.C. 1396o-1] which would allow the Department to implement cost sharing for non-emergency use of the emergency room through a state plan amendment. Under this allowance the Department is allowed to charge a co-payment amount to exempt populations with the following requirements:

- The Department could not charge more than the maximum nominal co-payment amount (currently $3.65) for populations at or under 100% of the Federal Poverty Level (FPL);
- The Department could charge double the nominal amount for populations between 100-150% FPL;
- The Department would have to ensure the co-payment amounts charges to each family does not exceed 5% of family's monthly income; and,
- The Department would have to ensure that clients who are exempt from all co-payments except this one (for example, children) have access to alternative facilities to receive care without paying the co-payment amount.

The Department currently does not have the mechanism in place to determine the maximum amount a client could be required to pay in co-payment each month. To enable the system to indentify a client's income level and transmit it to the claims system, the Department would require $235,440 in FY 2012-13 to implement necessary changes in the Colorado Benefits Management System (CBMS). This preliminary estimate was provided by the Governor's Office of Information Technology, and assumes 2,180 hours of work at $108 per hour.

In addition to CBMS changes, the Department would require changes to the MMIS to meet the requirements of Section 1916A of the Social Security Act [42 U.S.C. 1396o-1]. The claims system would be required to appropriately transmit the correct co-payment to providers when the service is provided, and to calculate the maximum monthly co-payment amount a family could be charged to ensure that co-payments were not charged above the maximum amount. Providers would continue to be required to indicate if the service provided was due to an emergency; once a claim is indicated as an emergency a co-payment would not be applied. For non-emergent services the Department would need to add logic to the MMIS to match the claim with the proper co-payment amount for each client based on the FPL information transmitted from CBMS. The MMIS would also require programming to track client co-payment charges to ensure compliance with federal law requiring that co-payment amounts remain below 5 percent of a family's monthly income. The MMIS would transfer information to the provider the web portal to indicate whether a client is required to pay the co-payment amount or not. This logic is currently in the system and calculation to ensure the 5 percent threshold is not crossed would occur within the MMIS. In order to transmit this necessary information from CBMS and track co-payment amounts, the Department preliminarily estimates 2,410 hours of work at $126 per hour for an estimated $303,660 for MMIS changes. If CMS does not approve the Department's preferred methodology for imposing cost sharing, the Department would request funding for these changes through the normal budget process. The Department assumes it would be able to receive a 75% enhanced match on MMIS related system changes.

The Department assumes that, if necessary, it may request supplemental funding during the FY 2012-13 budget cycle. Assuming the funding is approved and the Department receives supplemental funding to

implement this initiative in March 2013, the Department estimates that a state plan amendment (SPA) and rule changes would be complete by July 1, 2013. However, due to system constraints from federally mandated updates to the MMIS, the Department estimates the earliest this initiative would be able to be implemented is October 2013. The Department would set the effective date of the SPA to October 2013 to be consistent with the system changes.

Under this option, the Department anticipates costs of $539,100 total funds, $193,635 General Fund in FY 2012-13 and savings of $996,194 total funds, $486,532 General Fund in FY 2013-14 from the implementation of this initiative. Please note, however, that these totals are for informational purposes only; because the Department would pursue a waiver as described in the prior section, the Department is not requesting these amounts. Please see appendix D, Table G.1, for the calculation of costs and savings associated with this proposal.

Appendix B: Child Health Plan *Plus* Cost Sharing Detailed Narrative

The Department is requesting to implement two measures to increase cost-sharing for clients of the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+). Federal regulation at 42 C.F.R. § 457.53 authorizes the Department to vary premiums, deductibles, coinsurance, co-payments or any other cost sharing in CHP+ based on family income in a manner that does not favor children from families with higher incomes over children from families with lower incomes. Families with incomes above 150% of the Federal Poverty Level (FPL) are currently required to pay an annual enrollment fee before their eligible children can enroll in CHP+. Under this policy, families with one child pay $25 while families with two or more children pay $35. Co-payments are also charged on a sliding fee scale for children with family incomes above 100% FPL. CHP+ imposes no cost-sharing on children in families with incomes at or below 100% FPL or pregnant women. Since the program's inception, this cost sharing schedule has not been altered other than to add income categories as the program has expanded eligibility. As a result, Colorado has one of the lowest cost-sharing structures in the nation for a Children's Health Insurance Program.

During the 2011 Legislative Session, the General Assembly passed SB 11-213 "Concerning Enrollee Cost-Sharing for Children Enrolled in the Children's Basic Health Plan." This legislation would have increased cost sharing in CHP+ by implementing monthly premiums for families with incomes between 206% and 250% FPL. Each of these families would be required to pay a monthly premium of $20 for the first child and $10 for each additional child up to a maximum of $50 per month. The intent of this legislation was to foster a greater sense of personal responsibility in the health care decisions of CHP+ families, while generating savings to the State. The 1,000% increase in costs to the families affected by the new premiums, however, was estimated to have a significant negative impact on enrollment in CHP+. The Department and Joint Budget Committee Staff estimated that approximately 20% of affected children would drop CHP+ coverage if SB 11-213 was implemented. Because the cost of private insurance is relatively high, it is unlikely that children dropping out of CHP+ would become privately insured. Thus, this legislation would inevitably lead to higher uninsurance and worse health outcomes among children in Colorado. It is also likely that the children dropping CHP+ coverage would include a disproportionally large number of healthy children whose lower health care costs would not make the increased premiums worthwhile, and relatively sicker children with higher utilization and costs would remain in CHP+. This adverse selection would have led to increased per capita costs in CHP+ as the number of healthy relative to unhealthy children declines, resulting in a higher cost risk pool and increased per member per month rates for health care.

After considering the potential negative outcomes described above, Governor John Hickenlooper vetoed SB 11-213 and committed his staff and the Department to developing an approach to increase cost sharing while minimizing any negative impact on CHP+ families. The Department believes that the measures it is proposing, which include a wider range of more reasonable cost increases, will be more effective in fostering a sense of responsibility in the health care decisions of all of its clients while minimizing negative impacts to families and generating savings to the State.

The Department is recommending the following measures:

- Triple the current annual enrollment fees to $75 for families with one child and $105 for families with two or more children above 205% FPL; and,
- Increase co-payments for families above 100% FPL on a sliding fee scale.

By distributing the increased costs to clients between enrollment fees and co-payments, the Department believes that each family will be better able to cope with these additional costs. Additionally, the Department's request would not add cost sharing for families at or below 100% FPL. Per federal regulations at 42 C.F.R. §457.560 (a), total cost sharing may not exceed 5% of a family's total income for the length of a child's eligibility period in CHP+. The Department does not believe many families would reach this maximum due to its proposal as these moderate increases are applied on a sliding fee scale. Any family that reaches this 5% maximum, and demonstrates that it has done so receives a co-payment waiver and does not incur any additional costs for the remainder of the enrollment period. Per Colorado's CHIP State Plan, families are required to record and track their own cost sharing amounts and notify the Department if this maximum is reached.

Tripling Annual Enrollment Fees

The Department proposes tripling the annual enrollment fees for families with children above 205% FPL to $75 for families with one child and $105 for families with two or more children. Due to the Maintenance of Effort under the Affordable Care Act (ACA), the Department is only allowed to increase enrollment fees for groups that became eligible after March 23, 2010 (the date of enactment of the ACA), which includes only children with income from 206% to 250% FPL. In addition, the Department believes that these families at the higher end of eligible family incomes would be best able to absorb these increased costs. At the same time, the Department assumes that a number of families will choose to no longer enroll in CHP+ as a result of this increase. Given the magnitude of the new enrollment fees and the experiences of other states that have increased their enrollment fees or premiums, the Department estimates a 3% attrition rate, though this is indeterminate at this time. This would result in 118, 294 and 322 children losing health insurance coverage in FY 2011-12, FY 2012-13 and 2013-14, respectively. This decrease in enrollment would result in lower costs to CHP+. Please see Table G.1 in Appendix E for the caseload reduction and savings associated with this attrition rate.

Utilizing historical caseload data, the Department has estimated the distribution of families by size to estimate savings from the increased annual enrollment fees. Based on the number of children required to pay an enrollment fee and this distribution of family size, the Department estimates that these increased enrollment fees would result in $140,705, $343,630 and $377,070 additional revenues to the CHP+ Trust Fund (the Trust) in FY 2011-12, FY 2012-13 and FY 2013-14, respectively. This does not include the decrease in collections resulting from the attrition rate described above. The Trust funds medical and dental expenses for clients up to 205% FPL. Clients from 206% to 250% FPL are funded through the Hospital Provider fee implemented in HB 09-1293. Due to the current insolvency of the Trust, General Fund is required to backfill CHP+ medical and dental expenses for its designated populations. Thus, any increased revenues to the Trust result in equivalent General Fund savings. Since enrollment fees are not eligible to receive federal matching funds, the increased revenue generated by the higher annual enrollment fees results in reduced federal funds. Because the medical and dental premiums expenses for CHP+ populations remain the same for this calculation, additional funds from the Hospital Provider fee are required to replace the reduced federal funds. Please see Table G.2 in Appendix E for calculations of the impact of the increased enrollment fees.

To implement these increased annual enrollment fees, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. The Department would submit the SPA in November 2011 to be approved in January 2012. Therefore the Department anticipates the new annual enrollment fee would be effective January 1, 2012.

Increasing Co-payments

Co-payments for CHP+ clients are collected by providers at the point of service. Currently, CHP+ charges co-payments for various services on a sliding fee schedule for families above 100% FPL. As the Department does not collect these co-payments, the Department's actuary estimates co-payment collections using CHP+ service utilization. The actuary assumes that co-payments are collected by providers and become part of their compensation for the services they provide to CHP+ clients. This allows the actuary to incorporate these co-payments into lower capitation rates, which result in savings to the Department. At the point of service, however, providers may waive these co-payments if families are unable to pay them. Since the Department is unable to determine whether or not a client actually pays the co-payment amount, the full impact of the cost sharing proposal on providers and clients is difficult to determine.

The Department proposes maintaining the same co-payment amounts for families at or below 100% FPL and raising co-payments for families with higher incomes. The Department's proposed co-payment schedule maintains the same co-payment for services provided in an office setting, including routine office visits, while increasing other services such as emergency care, specialists, and prescription drugs co-payments. In addition, the Department would impose new co-payments on hospital services, including inpatient, outpatient and hospital physician services, for which cost sharing has historically not been required. The Department believes this structure provides the correct incentives for CHP+ children to continue to utilize routine office visits to maintain overall health through preventive care, and requiring higher cost sharing for more costly inpatient or emergency care. In its calculations, the Department assumes that these additional co-payments would not change the utilization patterns of CHP+. Please Table 4 below for a complete list of the Department's current and proposed co-payments.

Table 4 - Current CHP+ Co-payments vs. the Department's Proposed CHP+ Co-payments

	101-150% FPL		151 - 200% FPL		201% - 250% FPL	
Service	**Current Co-pays**	**Proposed Co-pays**	**Current Co-pays**	**Proposed Co-pays**	**Current Co-pays**	**Proposed Co-pays**
Emergency Care and Urgent/After Hours Care	$3	$3	$15	$20	$20	$50
Emergency Transport/Ambulance Services	$0	$2	$0	$15	$0	$25
Hospital/Other Facility Services						
Inpatient (Includes treatment for Mental Illness Care, Intractable Pain and Autism Coverage in an inpatient setting)	$0	$2	$0	$20	$0	$50
Physician	$0	$2	$0	$5	$0	$10
Outpatient/ Ambulatory	$0	$2	$0	$5	$0	$25
Routine Medical Office Visit (Includes treatment for Mental Illness Care, Vision, Audiology, Intractable Pain and Autism Coverage in an office setting)	$2	$2	$5	$5	$10	$10
Laboratory and X-Ray	$0	$0	$0	$5	$0	$10
Prescription Drugs						
Generic	$1	$1	$3	$3	$5	$5
Brand Name	$1	$1	$5	$10	$10	$15

The following service categories would not have co-payments: Preventive, Routine, and Family Planning Services; Maternity Care; Durable Medical Equipment (DME); Transplants; Home Health Care; Hospice Care; Kidney Dialysis; Skilled Nursing Facility Care; Dietary Counseling /Nutritional Services; Therapies: Chemotherapy and Radiation.

The Department has used the children's caseload estimates from its November 1, 2011, R-3 "Children's Basic Health Plan Medical Dental Premiums Costs" in its calculations. By applying the current and the proposed co-payment amounts for each service to the utilization data provided by the CHP+ actuary, the Department estimates the average total annual co-payment amount per child for each income category. Due to the complexity of the utilization data, the Department has only included the weighted average total annual co-payment amount in this request (Appendix E, Table G.3). As described above, beginning in January 2012, the Department believes that 118 children will leave CHP+. Since the new copayments will not be implemented until July 2012, the Department estimates a $6,728 decrease in copayment collections in FY 2011-12 due to the reduced caseload. The Department estimates that the new co-payments would result in $1,081,554 and $1,237,966 total fund savings in FY 2012-13 and FY 2013-14, respectively. Due to the differing fund sources for CHP+ populations, the Department estimates that $184,861 of the FY 2012-13 savings and $220,737 of FY 2013-14 savings will be General Fund. Please see Table G.3 in Appendix E for details on the calculations of these savings.

To implement these increased co-payments, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. The Department would submit the SPA in April 2012, to be approved in June 2012. Therefore the Department anticipates the new cost-sharing measures would be effective July 1, 2012.

The Department assumes that any cost to implement changes to the Colorado Benefits Management System to increase the annual enrollment fees could be absorbed within existing resources. Since the CHP+ co-payments are accounted for in the rates paid to health plans, the Department assumes that it will incorporate changes to the co-payment structure into its rate setting process for the FY 2012-13 rates, and thus there will be no additional administrative costs for this initiative.

Overall, the Department estimates net savings of $264,453 total funds from the increased enrollment fees in FY 2011-12 and savings from both of the initiatives of $1,789,365 total funds in FY 2012-13 and savings of $2,046,250 total funds in FY 2013-14. Of these savings, $138,601, $523,329 and $592,153 would be net General Fund savings in FY 2011-12, FY 2012-13 and FY 2013-14, respectively. Please see Table G.4 for the cumulative effect of these cost sharing measures, including an overview of the Department's assumptions for its calculations for this request. Tables 5, 6 and 7 below summarize the effect of the Department's proposal on the estimated average annual cost sharing per child.

Table 5 - Overall Cost Sharing in Colorado Under Current Structure		
Average Estimated Cost Sharing Per Child Per Year (using actual utilization, includes fees and co-pays)	101-150% FPL	$10
	151-200% FPL	$56
	201-250% FPL	$82

Table 6 - Overall Cost Sharing in Colorado Under Department Proposal		
Average Estimated Cost Sharing Per Child Per Year (using actual utilization, includes fees and co-pays)	101-150% FPL	$12
	151-200% FPL	$79
	201-250% FPL	$192

Table 7 - Change in Overall Cost Sharing in Colorado from Current Structure to Department Proposal		
Average Estimated Cost Sharing Per Child Per Year (using actual utilization, includes fees and co-pays)	101-150% FPL	20%
	151-200% FPL	41%
	201-250% FPL	134%

As these tables illustrate, the Department's proposal has a moderate yet increasing effect on cost sharing per child as family income increases. While SB 11-213 achieved savings by increasing the enrollment fees for only one income category by 1,000%, the Department's cost sharing initiatives spread the increases over most CHP+ clients and achieve greater total fund savings than SB 11-213. However, since SB 11-213 only increased enrollment fees (premiums) which are deposited directly into the CHP+ Trust Fund, most of the total fund savings would have been General Fund as less General Fund would be required to backfill the insolvent CHP+ Trust Fund. A large portion of the savings from the Department's proposal is generated by the increased co-payments. As a result, these savings include funding sources other than General Fund, depending on the client's income level. Thus the Department proposal generates less General Fund savings than SB 11-213. Please see Table 8 below for this comparison.

Table 8 - Comparison of SB 11-213 and Department Proposal- FY 2012-13		
	SB 11-213	**Department Proposal**
Total Change To Client Cost Sharing Plan (Fees + Co-payments)	$1,277,441	$1,609,382
Total General Fund Savings	($1,210,626)	($592,153)

Appendix C
Summary of Calculations

Summary of Estimate FY 2011-12					
Summary of Estimate FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Total Estimate	**($264,453)**	**($138,601)**	**$136,133**	**$0**	**($261,985)**
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	($264,453)	($138,601)	$136,133	$0	($261,985)

Summary of Request FY 2012-13					
Summary of Request FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Total Request	**($3,407,194)**	**($1,438,020)**	**$91,841**	**$0**	**($2,061,015)**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$30,000	$15,000	$0	$0	$15,000
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	$523,964	$130,991	$0	$0	$392,973
(2) Medical Services Premiums	($2,171,793)	($1,060,682)	($25,214)	$0	($1,085,897)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	($1,789,365)	($523,329)	$117,055	$0	($1,383,091)

Summary of Request FY 2013-14					
Summary of Request FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Total Request	**($6,049,804)**	**($2,547,449)**	**$70,906**	**$0**	**($3,573,261)**
(2) Medical Services Premiums	($4,003,554)	($1,955,296)	($46,480)	$0	($2,001,778)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	($2,046,250)	($592,153)	$117,386	$0	($1,571,483)

Appendix C
Summary of Calculations

FY 2011-12 Impact by Component						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Estimate	**($264,453)**	**($138,601)**	**$136,133**	**$0**	**($261,985)**	
Increased Cost Sharing in CHP+	($264,453)	($138,601)	$136,133	$0	($261,985)	

FY 2012-13 Impact by Component						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Request	**($3,407,194)**	**($1,438,020)**	**$91,841**	**$0**	**($2,061,015)**	
Increase Nominal Co-Payment Amounts	($2,125,138)	($1,037,897)	($24,672)	$0	($1,062,569)	Table A.1
Add Co-Payments to Additional Services	$523,964	$130,991	$0	$0	$392,973	Table C.2
Increase Co-Payment for Non-Emergent Use of the Emergency Room	($16,655)	($7,785)	($542)	$0	($8,328)	Table D.2
Increased Cost Sharing in CHP+	($1,789,365)	($523,329)	$117,055	$0	($1,383,091)	Table G.4

FY 2013-14 Impact by Component						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Request	**($6,049,804)**	**($2,547,449)**	**$70,906**	**$0**	**($3,573,261)**	
Increase Nominal Co-Payment Amounts	($2,915,975)	($1,424,134)	($33,853)	$0	($1,457,988)	Table A.1
Add Co-Payments to Additional Services	($895,529)	($437,367)	($10,397)	$0	($447,765)	Table C.3
Increase Co-Payment for Non-Emergent Use of the Emergency Room	($192,050)	($93,795)	($2,230)	$0	($96,025)	Table D.3
Increased Cost Sharing in CHP+	($2,046,250)	($592,153)	$117,386	$0	($1,571,483)	Table G.4

Table A.1 - Estimated Nominal Co-Payment Savings

Row	Service	Current Co-Payments Charged	Number of Units	Proposed Increase to Co-Payment	Estimated FY 2010-11 Savings	Estimated FY 2012-13 Savings	Estimated FY 2013-14 Savings
	Column	A	B	C	D	E	F
	Formula/Source	MMIS Data	MMIS Data	Narrative	Col B * Col C	Col D * (1 + Row A)^2 * (Row B / 12)	Col D * (1 + Row A)^3 * (Row B / 12)
A	Estimated Trend [(1)]					2.91%	2.91%
B	Effective Months					9	12
C	Inpatient Hospital Services	($324,192)	26,627	$2.00	($53,254)	($42,299)	($58,040)
D	Outpatient Hospital Services	($805,565)	387,232	$0.80	($309,786)	($246,058)	($337,625)
E	Practitioner Services	($704,386)	1,207,793	$0.55	($664,286)	($527,633)	($723,982)
F	Optometrist Visit	($25,263)	12,632	$0.55	($6,947)	($5,518)	($7,572)
G	Podiatrist Visit	($6,548)	3,274	$0.55	($1,801)	($1,430)	($1,963)
H	Psychiatric Services	($138)	69	$0.15	($10)	($8)	($11)
I	Community Mental Health Center Services	($11,575)	5,788	$0.55	($3,183)	($2,528)	($3,469)
J	Rural Health Clinic/ FQHC Services	($2,807)	1,404	$0.55	($772)	($613)	($841)
K	Durable Medical Equipment	($222,273)	222,273	$0.30	($66,682)	($52,964)	($72,674)
L	Laboratory	($362)	358	$0.30	($107)	($85)	($117)
M	Radiology (X-ray) Services	($4,902)	4,103	$0.30	($1,231)	($978)	($1,342)
N	Prescription Services - Brand Name Drugs	($1,361,450)	453,817	$0.30	($136,145)	($108,138)	($148,380)
O	Prescription Services - Generic Drugs	($1,789,165)	1,789,165	$0.80	($1,431,332)	($1,136,886)	($1,559,959)
P	**Total Estimated Cost Savings**	**($5,258,626)**	**4,114,533**	**-**	**($2,675,536)**	**($2,125,138)**	**($2,915,975)**

[(1)] Estimated trend is based on the growth rate of Acute Care total expenditure for FY 2009-10

Table A.2 - Summary of Additional Co-Payment Amounts for FY 2012-13					
Summary of Request FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$0	$0	$0	$0	$0
Savings	($2,125,138)	($1,037,897)	($24,672)	$0	($1,062,569)
Total	**($2,125,138)**	**($1,037,897)**	**($24,672)**	**$0**	**($1,062,569)**

Table A.3 - Summary of Additional Co-Payment Amounts for FY 2013-14					
Summary of Request FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$0	$0	$0	$0	$0
Savings	($2,915,975)	($1,424,134)	($33,853)	$0	($1,457,988)
Total	**($2,915,975)**	**($1,424,134)**	**($33,853)**	**$0**	**($1,457,988)**

Table B.1 - Proposed Additional Nominal Co-Payment Amounts				
Service	**Number of Paid Units in FY 2010-11**	**Maximum Co-Payment Amount**	**Estimated FY 2010-11 Co-Payment**	**Maximum Co-Payment Amount**
Column	A	B	C	D
Formula/Source	MMIS data	Table 1	Column A * Column B	See Narrative
Non-Emergency Medical Transportation				
$10 or less	12,596	$0.65	$8,187	
$10.01 to $25	10,379	$1.25	$12,974	
$25.01 to $50	5,898	$2.45	$14,450	
$50.01 or more	1,203	$3.65	$4,391	
Sub-Total NEMT	30,076		$40,002	
Average Co-payment Amount per Paid Unit (Column C / Column A)			$1.33	$1.30
Outpatient Substance Abuse				
$10.01 to $25	16,219	$1.25	$20,274	
$25.01 to $50	8,386	$2.45	$20,546	
$50.01 or more	1,158	$3.65	$4,227	
Sub-Total Outpatient Substance Abuse	25,763		$45,047	
Average Co-payment Amount per Paid Unit (Column C / Column A)			$1.75	$1.30
Physical, Occupational and Speech Therapy				
$10 or less	5,368	$0.65	$3,489	
$10.01 to $25	49,836	$1.25	$62,295	
$25.01 to $50	7,549	$2.45	$18,495	
$50.01 or more	34,370	$3.65	$125,451	
Sub-Total Therapies	97,123		$209,730	
Average Co-payment Amount per Paid Unit (Column C / Column A)			$2.16	$2.55
Home Health				
$10 or less	5,275	$0.65	$3,429	
$25.01 to $50	117,773	$2.45	$288,544	
$50.01 or more	110,853	$3.65	$404,613	
Sub-Total Home Health	233,901		$696,586	
Average Co-payment Amount per Paid Unit (Column C / Column A)			$2.98	$2.55
Private Duty Nursing				
$10.01 to $25	12	$1.25	$15	
$25.01 to $50	5,733	$2.45	$14,046	
Sub-Total Private Duty Nursing	5,745		$14,061	
Average Co-payment Amount per Paid Unit (Column C / Column A)			$2.45	$2.55

Table C.1 - Estimated Savings from Additional Co-Payments			
Row	**Item**	**FY 2012-13**	**FY 2013-14**
	Column	A	B
	Formula/Source	(Paid Units) * (1 + Row A)^2 * (Co-Payment Amount) * Row B / 12	(Paid Units) * (1 + Row A)^3 * (Co-Payment Amount) * Row B / 12
A	Estimated Trend	2.91%	2.91%
B	Effective Months	0	11
	Non-Emergency Medical Transportation		
C	FY 2010-11 Number of Paid Units	30,076	30,076
D	Co-Payment Amount	$1.30	$1.30
E	Estimated NEMT Savings	$0	($39,061)
	Outpatient Substance Abuse		
F	FY 2010-11 Number of Paid Units	25,763	25,763
G	Co-Payment Amount	$1.30	$1.25
H	Estimated Outpatient Substance Abuse Savings	$0	($32,173)
	Physical, Occupational and Speech Therapy		
I	FY 2010-11 Number of Paid Units	97,123	97123
J	Co-Payment Amount	$2.55	2.45
K	Estimated Therapy Savings	$0	($237,724)
	Home Health		
L	FY 2010-11 Number of Paid Units	233,901	233901
M	Co-Payment Amount	$2.55	2.45
N	Estimated Home Health Savings	$0	($572,509)
	Private Duty Nursing		
O	FY 2010-11 Number of Paid Units	5,745	5745
P	Co-Payment Amount	$2.55	2.45
Q	Estimated Private Duty Nursing Savings	$0	($14,062)
R	**Total Estimated Savings**	**$0**	**($895,529)**

Table C.2 - Summary of Additional Co-Payment Amounts for FY 2012-13					
Summary of Request FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$523,964	$130,991	$0	$0	$392,973
Savings	$0	$0	$0	$0	$0
Total	**$523,964**	**$130,991**	**$0**	**$0**	**$392,973**

Table C.3 - Summary of Additional Co-Payment Amounts for FY 2013-14					
Summary of Request FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$0	$0	$0	$0	$0
Savings	($895,529)	($437,367)	($10,397)	$0	($447,765)
Total	**($895,529)**	**($437,367)**	**($10,397)**	**$0**	**($447,765)**

Appendix D
Medicaid Cost Sharing Calculations

Table D.1 - Estimated Savings from Increased Non-Emergent Co-Payments under 1916 Waiver							
Row	**Service**	**Current Co-Payment Savings**	**Number of Units**	**Proposed Increase to Co-Payment**	**Estimated FY 2010-11 Savings**	**Estimated FY 2012-13 Savings**	**Estimated FY 2013-14 Savings**
	Column	A	B	C	D	E	F
	Formula/Source	MMIS Data	MMIS Data	Narrative	Column C * Column D	Column D * $(1 + \text{Row A})^2$ * Row B / 12	Column D * $(1+ \text{Row A})^3$ * Row B / 12
A	Estimated Trend [(1)]					2.91%	2.91%
B	Effective Months					3	12
C	Non-Emergent Hospital Services	($144,834)	48,278	$3.65	($176,215)	($46,655)	($192,050)
D	**Total Estimated Cost Savings**	**($144,834)**	**48,278**	**$3.65**	**($176,215)**	**($46,655)**	**($192,050)**

[(1)] Estimated trend is based on the growth rate of Acute Care total expenditure for FY 2009-10

Table D.2 - Summary of Increased Non-Emergent Co-Payments under 1916 Waiver FY 2012-13					
Summary of Request FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$30,000	$15,000	$0	$0	$15,000
Savings	($46,655)	($22,785)	($542)	$0	($23,328)
Total	**($16,655)**	**($7,785)**	**($542)**	**$0**	**($8,328)**

Table D.3 - Summary of Increased Non-Emergent Co-Payments under 1916 Waiver FY 2013-14					
Summary of Request FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$0	$0	$0	$0	$0
Savings	($192,050)	($93,795)	($2,230)	$0	($96,025)
Total	**($192,050)**	**($93,795)**	**($2,230)**	**$0**	**($96,025)**

Table E.1 - Estimated Savings from Increased Non-Emergent Co-Payments under 1916A							
Row	**Service**	**Current Co-Payment Savings**	**Number of Units[2]**	**Proposed Increase to Co-Payment**	**Estimated FY 2010-11 Savings**	**Estimated FY 2012-13 Savings**	**Estimated FY 2013-14 Savings**
	Column	A	B	C	D	E	F
	Formula/Source	MMIS Data	MMIS Data	Narrative	Column B * Column C	Column D * (1+ Row A)^2 * Row B / 12	Column D * (1+ Row A)^3 * Row B / 12
A	Estimated Trend [1]					2.91%	2.91%
B	Effective Months					-	11
C	Outpatient Hospital Services for < 100% FPL	($268,522)	129,077	$0.65	($83,900)	$0	($81,450)
D	Outpatient Hospital Services for 100% -150% FPL	($268,522)	129,077	$3.65	($471,132)	$0	($457,372)
E	Outpatient Hospital for > 150% FPL	($268,522)	129,077	$3.65	($471,132)	$0	($457,372)
F	**Total Estimated Cost Savings**	**($805,565)**	**387,232**	**$7.95**	**($1,026,165)**	**$0**	**($996,194)**

[1] Estimated trend is based on the growth rate of Acute Care total expenditure for FY 2009-10

[2] The MMIS claims system does not currently hold information on clients' FPL bracket. In order to calculate savings associated with this initiative the Department assumed a proportional distribution of clients between these brackets.

Table E.2 - Summary of Increased Non-Emergent Co-Payments under 1916A FY 2012-13					
Summary of Request FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
CBMS Costs	$235,440	$117,720	$0	$0	$117,720
MMIS Costs	$303,660	$75,915	$0	$0	$227,745
Savings	$0	$0	$0	$0	$0
Total	**$539,100**	**$193,635**	**$0**	**$0**	**$345,465**

Table E.3 - Summary of Increased Non-Emergent Co-Payments under 1916A FY 2013-14					
Summary of Request FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Administrative Cost	$0	$0	$0	$0	$0
Savings	($996,194)	($486,532)	($11,565)	$0	($498,097)
Total	**($996,194)**	**($486,532)**	**($11,565)**	**$0**	**($498,097)**

Table F.1 - Cost Sharing Administrative Costs				
Row	**Item**	**FY 2012-13**	**FY 2013-14**	**Comments**
A	MMIS System Changes for additional co-payments	$523,964	$0	1,800 hours at $126/hr
B	Rural Hospital Contractor	$30,000	$0	Based on similar Departmental projects
C	Total Administrative Costs	$553,964	$0	Row A + Row B

Appendix E
CHP+ Cost Sharing Calculations

Table G.1 - Savings from Caseload Attrition

	Current Cost Sharing Structure			Department's Proposal			Difference			Notes
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	
Estimated Caseload	7,891	9,785	10,737	7,891	9,785	10,737		0	0	
Change In Caseload due to Attrition	0	0	0	(118)	(294)	(322)	(118)	(294)	(322)	Assumes that 3% of children with family income between 206-250% FPL will choose to no longer enroll in CHP+ due to the high monthly premium. Please see narrative
Net Caseload	7,891	9,785	10,737	7,773	9,491	10,415	(118)	(294)	(322)	
Medical Per Capita	$2,129.17	$2,231.79	$2,326.98	$2,129.17	$2,231.79	$2,326.98	$0.00	$0	$0	
Dental Per Capita	$168.97	$175.73	$183.22	$168.97	$175.73	$183.22	$0.00	$0	$0	
Total Medical and Dental Costs	$18,134,623	$23,557,583	$26,952,017	$17,863,442	$22,849,772	$26,143,733	($271,181)	($707,811)	($808,284)	
General Fund	($140,705)	($171,815)	($188,535)	($138,601)	($166,653)	($182,881)	$2,104	$5,162	$5,654	
Cash Funds (CHP+ Trust Fund)	$140,705	$171,815	$188,535	$138,601	$166,653	$182,881	($2,104)	($5,162)	($5,654)	
Cash Funds (Hospital Fee)	$6,438,576	$8,356,834	$9,555,754	$6,342,295	$8,105,745	$9,269,179	($96,281)	($251,089)	($286,575)	
Federal Share	$11,696,047	$15,200,749	$17,396,263	$11,521,147	$14,744,027	$16,874,554	($174,900)	($456,722)	($521,709)	

Table G.2 - Savings from Increased Enrollment Fees

	Current Cost Sharing Structure			Department's Proposal			Difference			Notes
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	
Estimated Caseload in 206-250% FPL (After Attrition)	7,773	9,491	10,415	7,773	9,491	10,415		0	0	
Medical Per Capita	2,129	2,232	2,327	$2,129.17	$2,231.79	$2,326.98	$0.00	$0	$0	Assumes no non-compliance as the annual fee is a condition of eligibility.
Dental Per Capita	169	176	183	$168.97	$175.73	$183.22	$0.00	$0	$0	
Total Medical and Dental Costs	$17,863,442	$22,849,772	$26,143,733	$17,863,442	$22,849,772	$26,143,733	$0	$0	$0	
General Fund	($140,705)	($171,815)	($188,535)	($281,410)	($515,445)	($565,605)	($140,705)	($343,630)	($377,070)	
Cash Funds (CHP+ Trust Fund)	$140,705	$171,815	$188,535	$281,410	$515,445	$565,605	$140,705	$343,630	$377,070	
Cash Funds (Hospital Fee)	$6,343,663	$8,109,100	$9,272,854	$6,435,121	$8,332,459	$9,517,950	$91,458	$223,359	$245,096	
Federal Share	$11,519,779	$14,740,672	$16,870,879	$11,428,321	$14,517,313	$16,625,783	($91,458)	($223,359)	($245,096)	

Table G.3 - Savings from Increased Copayments

	Current Cost Sharing Structure			Department's Proposal			Difference			Notes
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	
Estimated Caseload	54,023	55,343	60,874	53,905	55,049	60,552	(118)	(294)	(322)	Assumes no change in utilization due to increased copays. Includes decreased caseload due to 3% attrition for children between 205% and 250% FPL.
Weighted Average Annual Copay per Child	$24.70	$26.28	$27.14	$24.63	$46.06	$47.73	($0.07)	$19.79	$20.59	
Total Co-payment Collections (Decreased Capitation Rates)	$1,334,388	$1,454,208	$1,652,225	$1,327,660	$2,535,762	$2,890,191	$6,728	($1,081,554)	($1,237,966)	
Cash Funds (CHP+ Trust Fund/General Fund)	($309,567)	($313,709)	($364,017)	($309,567)	($498,570)	($584,754)	$0	($184,861)	($220,737)	
Cash Funds (Hospital Fee)	($157,469)	($195,264)	($214,262)	($155,114)	($388,947)	($426,813)	$2,355	($193,683)	($212,551)	
Federal Share	($867,352)	($945,235)	($1,073,946)	($862,979)	($1,648,245)	($1,878,624)	$4,373	($703,010)	($804,678)	

Table G.4 - Costs/(Savings) From All CHP+ Cost Sharing Initiatives			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Caseload Affected by Cost Sharing	53,905	55,049	60,552
Caseload Decrease due to Attrition (3%)	(118)	(294)	(322)
Increased Copayment Costs/(Savings)	$6,728	($1,081,554)	($1,237,966)
Additional Annual Fee Collections	$138,601	$338,468	$371,416
Total Fund Savings	**($264,453)**	**($1,789,365)**	**($2,046,250)**
Total CHP+ Trust Fund Increase	$138,601	$338,468	$371,416
Total Hospital Provider Fee Savings	($2,468)	($221,413)	($254,030)
Total Federal Funds Savings	($261,985)	($1,383,091)	($1,571,483)
Total General Fund Savings	**($138,601)**	**($523,329)**	**($592,153)**
Total Change To Client Cost Sharing Plan (Fees + Copayments)	**$145,329**	**$1,420,022**	**$1,609,382**

Table H.1 - Cash Fund Projections			
Cash Fund Name	**Children's Basic Health Plan Trust Fund**	**Hospital Provider Fee Cash Fund**	**Breast and Cervical Cancer Prevention and Treatment Fund**
Cash Fund Number	11G	24A	15D
FY 2010-11 Expenditures	$43,062,875	$426,069,052	$2,903,163
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436	$6,553,278
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436	$4,135,739
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436	$3,040,811
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436	$660,592

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Federally Mandated CHIPRA Quality Measures
Priority Number: R-8

Dept. Approval by: John Bartholomew JB 10/14/11 Date

OSPB Approval by: 10/18/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$4,894,410	$0	$4,898,322	$236,671	$236,671
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$272,494	$0	$272,494	$82,835	$82,835
	GFE	$0	$0	$0	$0	$0
	CF	$1,948,454	$0	$1,949,823	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,673,462	$0	$2,676,005	$153,836	$153,836
(4) Indigent Care Program; Children's Basic Health Plan Administration	Total	$4,894,410	$0	$4,898,322	$236,671	$236,671
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$272,494	$0	$272,494	$82,835	$82,835
	GFE	$0	$0	$0	$0	$0
	CF	$1,948,454	$0	$1,949,823	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,673,462	$0	$2,676,005	$153,836	$153,836

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2012-13 Funding Request
November 1, 2011

Department Priority: R-8
Request Title: Federally Mandated CHIPRA Quality Measures

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
(4) Indigent Care Program; Children's Basic Health Plan Administration	$236,671	$82,835	0.0

Request Summary:
The Department of Health Care Policy and Financing is requesting $236,671 total funds in FY 2012-13 to implement a federally mandated provision from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This funding is requested for the purposes of amending its current External Quality Review contract to comply with an additional federally mandated managed care quality review measure for the Children's Basic Health Plan. As the Department will be required to report this quality review measure annually, this request is for on-going funding.

Section 402 (a)(2) of CHIPRA amends select Medicaid law (42 U.S.C. 1397hh (a), (e)) which outlines information states are required to report annually for CHIP programs like Colorado's Children's Basic Health Plan. This section requires states to report results from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for CHIP. Currently, states may voluntarily collect and report this data either annually or biannually for CHIP and Medicaid. Medicaid programs are not required to report a CAHPS survey but may do so voluntarily (including Colorado, as described below).

Beginning in December 31, 2013, however, all CHIP programs are required to submit CAHPS measurement data annually. To comply with this regulation, CHIP programs like the Children's Basic Health Plan must begin collecting CAHPS data in January of 2013.

Since the Department possesses neither the expertise nor the resources to conduct this survey, the Department would like to expand its contract with its External Quality Review Organization so that it may implement plan-specific CAHPS surveys meeting the federal requirements outlined in CHIPRA. This includes the survey administration, analysis and reporting for each of the five managed care organization plans and the State's Managed Care Network. In order to do this, the Department is requesting $236,671 total funds annually, of which $82,835 is General Fund, and the remainder is federal funds beginning in FY 2012-13.

Assumptions for Calculations:
Based on the Department's discussions with the current EQRO, the Department assumes that the cost of compliance with the enhanced external quality review provision beginning in FY 2012-13 will be $236,671 for the implementation and reporting of six plan-specific CAHPS surveys. This includes $200,917 for data collection and $35,754 for analysis and reports of survey results. The EQRO will conduct a total of 20,940 surveys, an average of 3,490 per plan. The cost

for each of the six plans is approximately $39,445.17. The Department believes this is a reasonable cost for the administration, analysis and reporting involved with these surveys.

Since the Children's Basic Health Plan Trust Fund is currently insolvent, the Department is requesting General Fund for the state share of this requested increase. The Department's request for all General Fund needed for the Children's Basic Health Plan is included in the November 1, 2011 FY 2012-13 R-3.

Consequences if not Funded:
This request is for funding to implement federally mandated changes. If this request is not funded, federal financial participation in the Children's Basic Health Plan will be at risk. The FY 2012-13 base request includes $128,959,010 federal funds for the Children's Basic Health Plan.

Current Statutory Authority or Needed Statutory Change:
The Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) and amended by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

Section 2108 (e)(4) of Social Security Act (42 U.S.C. 1397hh (e)(4)) as amended by P.L. 111-3, Sec. 402 (a)(2) requires that CHIP programs report a CAHPS survey on an annual basis.

25.5-8-105 C.R.S. creates the Children's Basic Health Plan Trust Fund. 25.5-8-111 C.R.S. (1)(a)(I) allows the Department to enter into personal services contracts for the administration of the Children's Basic Health Plan.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CHP+ Eligibility for Children of State Employees

Priority Number: R-9

Dept. Approval by: John Bartholomew 10/14/11 Date

OSPB Approval by: 10/14/11 Date

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

Line Item Information	Fund	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
Total of All Line Items	Total	$213,086,149	$0	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$0	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$0	$122,048,467	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$213,086,149	$0	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$0	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$0	$122,048,467	$0	$0

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

Cash or Federal Fund Name and COFRS Fund Number: None.

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

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

Schedule 13s from Affected Departments: None.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2012-13 Funding Request
November 1, 2011

Department Priority: R-9
Request Title: CHP+ Eligibility for Children of State Employees

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Statewide Savings	$0	$0	0.0

Request Summary:
The Department is proposing to reduce State expenditures by allowing State employees to enroll their eligible children into the Children's Basic Health Plan, marketed as Child Health Plan *Plus* (CHP+). Appropriations for State Health, Life and Dental benefits are set through statewide Common Policies, so the Department is not requesting specific adjustments to these appropriations at this time. However, because the state funds portion of CHP+ per capita costs are lower than the State contribution for employee dependent premiums, there will be savings to the state for every child that enrolls in CHP+ instead of the state's health and dental plans. Savings to every department will ultimately be achieved from future adjustments to Common Policy through the normal budgetary process.

Prior to the passage of the Affordable Care Act, section 2110(b) of the Social Security Act (the Act) excluded children of state employees from being eligible for the Children's Health Insurance Program (CHIP). Over time, it has become clear that in some states, children of State employees who are within the income eligibility level of their State's CHIP program do not have access to affordable and comprehensive coverage options. Section 10203(b)(2)(D) of the Affordable Care Act permits States to extend CHIP eligibility to children of State employees who are otherwise eligible under the State child health plan to the extent that one of two conditions is met. These conditions are described in a new section 2110(b)(6) of the Act (added by the Affordable Care Act and amended by Public Law 111-309) and are referred to as the hardship and the maintenance of agency contribution conditions.

The Department believes that Colorado may extend coverage to children of state employees under CHP+ through the maintenance of agency contribution condition. Please see Appendix A for more detail. The State must demonstrate that it has been consistently contributing to the cost of employee dependent coverage, with increases for inflation, since 1997. According to the Department of Personnel and Administration, the 1997 contribution per employee for child health coverage would be $2,188.36 in 2010 dollars. The State actually contributed $3,372.48 per employee for child coverage in 2010, which is $1,184.12 greater than the 1997 contribution adjusted for inflation.

The Department believes that this request would result in savings to the state. While the State contributes to the health insurance premiums of its employees and covered dependents using state funds, CHP+ receives a 65% federal match on its expenditures. Additionally, CHP+ child per capita costs are projected to be lower than the annualized premiums contributions paid by the State for employees' dependents. In FY 2012-13, the Department estimates the average State

contribution for employee dependents to be $3,700, while the CHP+ medical and dental per capita is estimated to be $2,407.31.

Due to the movement from dependents' enrollment in the state's health and dental plans to enrollment in CHP+, implementation of this policy will result in higher costs to the Department with lower Common Policy costs to other departments. Savings will ultimately be achieved from future adjustments to Common Policy through the normal budgetary process.

Modifications to the Colorado Benefits Management System will be necessary to implement this policy change. Preliminary cost estimates for design, development and testing are approximately $16,000 in FY 2011-12 in order to implement this policy change by July 1, 2012.

Thus, the Department is proposing to take advantage of the opportunity presented by the Affordable Care Act to reduce the number of uninsured and underinsured children in Colorado by allowing income- and age-eligible children of State employees to enroll in CHP+ while realizing savings to the State.

Please see Appendix A for a detailed description of the background for this request.

Anticipated Outcomes:
The Department anticipates that a substantial number of state employees would enroll their children in CHP+ as a result of this request. This would lead to savings to the State as the number of health care premiums contributions for children of employees would decrease as these moved to CHP+.

The Department believes that this change would also benefit families that choose to enroll their children in CHP+ through lower costs to the family for health insurance. While the State provides a healthy subsidy to families who enroll in the state health insurance plans, the cost-sharing in CHP+ is lower than the employee contribution toward the current state health plans. This would allow low-income families to have access to a more affordable, comprehensive health insurance plan for their children.

Consequences if not Funded:
If this request is not approved, the State will forego the opportunity to save state funds, including General Fund, while providing affordable and comprehensive health care options for its employees.

Impact to Other State Government Agency:
All state agencies with employees who decide to enroll their children in CHP+ will realize savings to their Health, Life and Dental appropriations through the normal the Common Policy process.

Current Statutory Authority or Needed Statutory Change:
The Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) and amended by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Section 2110(b)(6) of Social Security Act (42 U.S.C. 1397jj (b)(6)), as amended by Section 10203(b)(2)(D) of the Affordable Care Act (P.L. 111-148) allows eligible children of state employees to enroll in CHP+ as long as the hardship condition or the maintenance of agency contribution condition is met
This request necessitates statutory change as 25.5-8-109 (1) C.R.S. requires that a child not have been insured by a comparable health plan through an employer, with the employer contributing at least 50% of the premium cost in the three months prior to application for CHP+. Children who have lost coverage due to a change in, or loss of, employment are exempt for this three month rule. The current statute would force eligible children of state employees to go uninsured for three months (or purchase costly small-group insurance) before applying for CHP+, effectively discouraging movement into the program. An additional exception for children of state employees from this three month waiting period in state statute would be required to implement the proposed change and achieve savings to the State.

Appendix A: Assumptions and Calculations for R-9

Maintenance of Agency Contribution

This condition is met when the public agency expenditures for health coverage for employees that have dependent coverage is not less than the amount of such expenditures in the 1997 State fiscal year, increased by the percentage increase of the medical care expenditure category of the Consumer Price Index (CPI-M) for All-Urban Consumers (all items: U.S. City Average). To meet this condition, States may aggregate employee contributions by the public agency. Only the expenditures for health coverage for employees who elect dependent coverage need be considered.

In 1997, Colorado contributed $2,902.08 towards the health insurance coverage of an employee with two or more dependents. From 1997 to 2010, the CPI-M was 66%[1], which equates to a state contribution of $4,817.27 in 2010. In 2010, the State contributed $7,655.52 for employees plus one or more child. This is an increase of 164%, well above the 1997 inflation-adjusted figure. Considering only the children's portion of the state contribution, the State contributed $1,321.68 per employee in 1997. Using the same CPI-M as above, this amount would be $2,188.36 in 2010. In that year, the State contributed $3,372.48 per employee for child coverage, which is a 155% increase and greater than the 1997 amount adjusted for inflation.

The Child Health Plan Plus (CHP+) clearly meets the maintenance of agency contribution criteria and may begin to provide CHP+ coverage to the income- and age-eligible children of state employees. The Department believes that allowing the children of state employees to enroll in CHP+ would result in savings to the state. While the State contributes to the health insurance premiums of its employees and covered dependents using only state funds, CHP+ receives a 65% federal match on its expenditures. Additionally, CHP+ child per capita costs are projected to be lower than the annualized premiums contributions paid by the State for employees' dependents. Please see Table 1 below for these costs.

Table 1: CHP+ Per Capitas vs State Contribution per Child (Estimates)

	FY 2011-12	FY 2012-13	FY 2013-14
CHP+ Medical	$2,099.03	$2,231.58	$2,326.76
CHP+ Dental	$168.97	$175.73	$183.22
Total CHP+	**$2,268.00**	**$2,407.31**	**$2,509.98**
Employee Only State Contribution	$4,706.64	$4,706.64	$4,706.64
Employee + Child State Contribution	$8,410.08	$8,410.08	$8,410.08
State contribution for Child (in addition to employee only coverage)	**$3,703.44**	**$3,703.44**	**$3,703.44**
Employee + Spouse State Contribution	$7,949.04	$7,949.04	$7,949.04
Employee Plus Family State Contribution	$11,650.56	$11,650.56	$11,650.56
State contribution per Child (in addition to employee + spouse coverage)	**$3,701.52**	**$3,701.52**	**$3,701.52**

[1] From the US Bureau of Labor Statistics, Consumer Price Index for all Urban Consumers, U.S. City Average, Medical Care.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Utilize Supplemental Payments for General Fund Relief
Priority Number: R-10

Dept. Approval by: John Bartholomew 10/14/11 Date

OSPB Approval by: 10/18/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$3,853,688,855	$0	$3,869,621,035	($1,006,752)	($1,015,229)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	($1,006,752)	($1,015,229)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$763,229,728	$0	$689,442,170	$0	$0
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,901,056,618	$0	$1,911,581,435	$0	$0
(2) Medical Services Premiums[a]	Total	$3,543,863,749	$0	$3,559,795,929	$14,889,488	$14,881,011
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	($1,006,752)	($1,015,229)
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$0	$534,529,617	$7,948,120	$7,948,120
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$0	$1,756,668,882	$7,948,120	$7,948,120
(4) Indigent Care Program; Safety Net Provider Payments[b]	Total	$309,825,106	$0	$309,825,106	($15,896,240)	($15,896,240)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$154,912,553	$0	$154,912,553	($7,948,120)	($7,948,120)
	RF	$0	$0	$0	$0	$0
	FF	$154,912,553	$0	$154,912,553	($7,948,120)	($7,948,120)

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

[a] Of this amount, ...~~$7,722,438~~ $15,670,558 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program...

[b] Of this amount, $144,686,653 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4) C.R.S., and ~~$10,225,900~~ $2,277,780 shall be from public funds certified as representing expenditures by hospitals that are eligible for federal financial participation under the Medicaid upper payment limit and the Medicaid Disproportionate Share Payments to Hospitals program.

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

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-10
Request Title: Utilize Supplemental Payments for General Fund Relief

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Request	($1,006,752)	($1,006,752)	0.0

Request Summary:
The Department requests to use $1,006,752 federal funds in FY 2012-13 to provide General Fund relief to the Medical Services Premiums line item. Similarly, the Department requests to use $1,015,229 federal funds in FY 2013-14, to provide General Fund relief to the Medical Services Premiums line item. These General Fund savings would be achieved by a reduction to certain certified public expenditure (CPE) based supplemental payments in the Medical Services Premiums line item. The Department also requests to move the inpatient high volume CPE supplemental payment currently in the Safety Net Provider Payments line to the Medical Services Premiums line item.

Currently, the Safety Net Section of the Department manages and calculates several payments utilizing the CPE methodology, and is continuously working on new and innovative ways to increase payments to providers in order to reduce the uncompensated costs of providing care to under and uninsured Coloradans. However, due to the increasing strain on the state's General Fund, the Department is requesting to withhold 10% of the federal funds drawn under some of these payments in order to offset General Fund costs in the Department. Specifically, the Department requests to withhold 10% of the federal funds drawn under the physician supplemental payment and the inpatient high volume CPE supplemental payment currently in the Safety Net Provider Payments line item as authorized pursuant to the Department's FY 2011-12 DI-7 "Maximize Reimbursement for High Volume Medicaid and CICP Hospitals." Please see Table 2 in Appendix A below for more detailed information on these individual payments and the withholding calculations. For FY 2012-13, the Department projects the federal funds drawn under these payments to equal $10,067,515, resulting in General Fund relief in the amount of $1,006,752 after 10% of these funds are withheld. Similar withholding of federal funds is already being done with some of the CPE based payments within the Medical Services Premiums line item, particularly the Home Health and Nursing Facility payments made under the Upper Payment Limit (UPL).

The physician supplemental payment applies only to Denver Health Medical Center at this time. The inpatient high volume CPE supplemental payment applies to University Hospital and Memorial Hospital in Colorado Springs, with approximately 70% of the payment being allocated to University Hospital and 30% to Memorial Hospital. Denver Health Medical Center, which is also a High Volume Medicaid and CICP Hospital, has its hospital-specific UPL maximized under the Hospital Provider Fee supplemental payments, so would not receive any additional inpatient high volume CPE

supplemental payments pursuant to the Department's FY 2011-12 DI-7.

In addition to the requested General Fund savings, the Department also requests to move the $15,896,240 inpatient high volume CPE supplemental payment in the Safety Net Provider Payments line item to the Medical Services Premiums line item to place it with the other payments made under the Upper Payment Limit. This action will make both lines more transparent and limit the purpose of the Safety Net Provider Payment line item to only Hospital Provider Fee payments. This will take place prior to the withholding discussed above. Please see Table 1 in Appendix A for more detail on this transfer.

Anticipated Outcomes:
If this request is approved, the Department anticipates savings in the amount of $1,006,752 General Fund in FY 2012-13 and $1,015,229 General Fund in FY 2013-14.

Assumptions for Calculations:
Assumptions used in the calculations for this request include the approval of a State Plan Amendment (SPA) by the Centers for Medicare and Medicaid Services (CMS), which would allow the Department to implement the inpatient high volume CPE supplemental payment currently budgeted for in the Safety Net Provider Payments line item. The Department expects approval of this SPA by March 1, 2012. The Department also assumes that it will have received the data it needs from all hospitals in order to calculate the payments, and that the data support payments in the amounts budgeted. Please see Appendix A for detailed calculations for this request.

Consequences if not Funded:
If this request is not approved, the Department will forego General Fund relief in the amount of $1,006,752 in FY 2012-13 and $1,015,229 in FY 2013-14. This process of retaining a portion of the federal funds distributed to providers has already been approved by CMS, and not approving this would limit the Department's ability to reduce its overall General Fund need.

Current Statutory Authority or Needed Statutory Change:
There are no federal regulations that prohibit the State from retaining all or a portion of the federal funds it earns through the CPE methodology. Indeed, Colorado already retains all federal funds from the Public Nursing Facility Supplemental Payment and the Public Home Health Agency Supplemental Payment. While the text of State Plan Amendments does not currently address State retention of federal funds specifically, the State must notify CMS if it intends to do so in its response to standard funding questions that are submitted with any proposed State Plan Amendment that modifies provider reimbursement methodologies or amounts.

Appendix A: Tables and Calculations

Table 1: Transfer of Inpatient High Volume Supplemental Payment			
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds
(4) Safety Net Provider Payments	($15,896,240)	($7,948,120)	($7,948,120)
(2) Medical Services Premiums	$15,896,240	$7,948,120	$7,948,120
Net Transfer Request	$0	$0	$0

Table 2: Payments and Withholding Calculations				
FY 2012-13				
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds	Withholding for General Fund
Physician Supplemental Payment	$4,238,789	$2,119,394	$2,119,395	($211,940)
Inpatient High Volume CPE Supplemental Payment	$15,896,240	$7,948,120	$7,948,120	($794,812)
Total	$20,135,029	$10,067,514	$10,067,515	($1,006,752)
FY 2013-14				
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds	Withholding for General Fund
Physician Supplemental Payment	$4,408,341	$2,204,170	$2,204,171	($220,417)
Inpatient High Volume CPE Supplemental Payment	$15,896,240	$7,948,120	$7,948,120	($794,812)
Total	$20,304,581	$10,152,290	$10,152,291	($1,015,229)

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CHIPRA Bonus Payment True-up

Priority Number: R-11

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$91,156,720	$0	$91,156,720	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	$0	$60,127,929	($15,036,785)	($49,048,695)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$0	$31,028,791	$15,036,785	$49,048,695
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$91,156,720	$0	$91,156,720	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	$0	$60,127,929	($15,036,785)	($49,048,695)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$0	$31,028,791	$15,036,785	$49,048,695

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XXI

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

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

Schedule 13s from Affected Departments: None.

Other Information: None.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-11
CHIPRA Bonus Payment True-up

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	$0	($15,036,785)	0.0

Request Summary:
The Department requests reductions to the General Fund appropriation to the Medicaid Modernization Act of 2003 State Contribution Payment (MMA) line item in the amount of $15,036,785 in FY 2012-13, with a corresponding increase in the federal funds appropriation. The requested change is the result of updated calculations for the State's projected CHIPRA bonus payments for FFY 2010 forward. In addition, the Department estimates that CHIPRA bonus will result in additional federal funds of $9,974,968 in FY 2011-12 to be used as General Fund offset in this line item. This estimate is provided for informational purposes only.

As discussed in the Department's November 1, 2010 DI-6 "Cash Fund Insolvency Financing" and February 15, 2011 "Cash Fund Insolvency True-Up," under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities. Five of eight outreach and retention policies must be in place for at least half of the federal fiscal year for a state to qualify to receive a bonus. Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target.

The CHIPRA bonuses are made in two distinct payments- an initial payment in the December following the end of the federal fiscal year for which the bonus payment is being made, and a second payment in approximately the following August. The second payment is made in order to allow for retroactive enrollments or disenrollments to occur, which makes the enrollment number used to calculate the payment more comparable to the baseline enrollment level.

The Department received notification that Colorado qualified for the FFY 2010 payment on December 23, 2010, and the Department received the first payment of $13,671,043 in late December 2010. The Department received an award letter for the second payment in the amount of $4,532,230 on August 10, 2011.

The Department's MMA line item was appropriated $25,010,105 federal funds in FY 2011-12 for the initial FFY 2011 CHIPRA bonus payment, with a corresponding decrease in the General Fund appropriation. This request is to adjust this appropriation for two factors. First, the Department did not receive an appropriation for the second FFY 2010 payment, which was received in FY 2011-12. Second, the Department is adjusting the projected CHIPRA bonus

payments for FFY 2011 forward to account for the revised Medicaid caseload forecast that is included in the Department's November 1, 2011 Budget Request.

Please note that the Department's request for FY 2011-12 includes a reduction of $30,000 from the full amount of the second FFY 2010 payment. Pursuant to HB 10-1264, the Department submitted an IDEA application to reward 11 Department employees for the extraordinary effort that went into ensuring that the State qualified for the FFY 2010 bonus payment. In accordance with 24-50-903 et seq. C.R.S. (2011), this application was approved by the Executive Director of the Department, the savings were reviewed and verified by the State Auditor, and the State Auditor presented these findings to the Legislative Audit Committee on July 11, 2011. As such, the Department has been granted authority to reduce the federal award by $30,000: $25,000 in discretionary funds for the Department and $5,000 to be equally distributed among the 11 Department employees on the team that won the award. This amount will be placed in a non-appropriated line item by the Office of the State Controller for disbursement.

Assumptions for Calculations:
The projected bonus payments for FFY 2011 forward are based on formulas set in federal law at 42 U.S.C. 1397ee(a)(3), and have been updated for the revised Medicaid caseload forecast that is included in the Department's November 1, 2011 Budget Request. Please see Attachment A, Tables 2a through 2c for the calculation of the projected initial payments. For the calculation of the projected final total bonus payments, including the second payment, the Department has assumed that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17% based on enrollment data from the Medicaid Management Information System (MMIS) for January through December 2009 as well as the FFY 2010 final retroactive adjustment, though this percent is not known at this time. Please see Tables 2d and 2e for the calculation of the projected total payments.

Tables 3 and 4 of Attachment A show the estimated bonus payments to be received by the Department by state fiscal year, as well as the requested incremental increase in the federal funds appropriation to the MMA line item.

Current Statutory Authority or Needed Statutory Change:

42 U.S.C. 1397ee(a)(3) Performance bonus payment to offset additional Medicaid and CHIP child enrollment costs resulting from enrollment and retention efforts

(A) In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

Attachment A
CHIPRA Bonus Payment True-up

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities.

Bonus payments were made available beginning in federal fiscal year (FFY) 2009. For each year, bonuses will be paid by December 31st following the end of the federal fiscal year (e.g., FFY 2011 bonuses will be paid by December 31, 2011). Five of the eight policies must be in place for at least half of the federal fiscal year for a state to qualify to receive a bonus. The qualifying policies are shown in Table 1, along with Colorado's status. Colorado received approval for a Medicaid State Plan Amendment in FY 2010-11 that will clarified that Colorado's Medicaid Health Insurance Buy-In program meets all of the requirements for the Premium Assistance Subsidy provisions set forth in CHIPRA. This State Plan Amendment qualified Colorado to receive the CHIPRA bonus payment beginning in FFY 2010.

The CHIPRA bonuses are made in two distinct payments- an initial payment in the December following the end of the federal fiscal year for which the bonus payment is being made, and a second payment in approximately the following summer. The second payment is made in order to allow for retroactive enrollments or disenrollments to occur, which makes the enrollment number used to calculate the payment more comparable to the baseline enrollment level. The Department has assumed that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17% based on enrollment data from the Medicaid Management Information System (MMIS) for January through December 2009 as well as the FFY 2010 final retroactive adjustment, though this percent is not known at this time.

Table 1: 8 Enrollment and Retention Provisions

Provision	Description	Medicaid	CHP+
12-Month Continuous Eligibility under Title XIX and Title XXI *	Establishment of a 12-month continuous eligibility period for children under age 19 in the Medicaid and/or CHIP State Plans.		✓
Elimination of Asset Test under Title XIX and Title XXI*	The State has liberalized asset test requirements for determining eligibility of children for Medicaid or CHIP by either removing asset/resource tests or reducing the documentation requirements for eligibility.	✓	✓
Elimination of In-Person Interview under Title XIX and Title XXI*	The State has eliminated in-person interview requirements for applying for Medicaid or CHIP (with exception for circumstances that justify a face-to-face interview).	✓	✓
Joint Application	The State has established a joint application and verification process for initial enrollment into Medicaid or CHIP and renewals of enrollment.	✓	✓
Auto Renewal under Title XIX and Title XXI	The State's Medicaid or CHIP program utilizes a renewal form with pre-printed eligibility information that is sent to the parent/caretaker relative of the child with notice that the child's eligibility will be automatically renewed unless other information is provided to the State that affects the child's continued eligibility.		
Presumptive Eligibility under Title XIX and Title XXI*	The State has implemented presumptive eligibility for children under the Medicaid and/or CHIP State Plans.	✓	✓
Express Lane under Title XIX and Title XXI*	The State is implementing the option to utilize express lane agencies under the Medicaid and CHIP State Plans.		
Premium Assistance Subsidy under Title XIX and Title XXI	The State has implemented the option of providing premium assistance subsidies under the Medicaid and/or CHIP State Plans.	✓	✓
* Both Medicaid and CHIP must implement these provisions.			

Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target. The enrollment target will be set each year by applying the formula set out in CHIPRA to state enrollment data. Specifically, the Centers for Medicare and Medicaid Services will calculate the target for each state, which is based on the state's child enrollment in Medicaid in 2007 adjusted each year by the state's child population growth and a standard enrollment growth factor that changes over time as specified in CHIPRA. The standard enrollment growth factor, which is the same for all states, is based on national projected caseload growth. Because of the recession, it is pegged at a fairly high rate. The rate starts at 4% but drops to 3.5%, 3%, and ultimately to 2%.

The CHIPRA bonus payment is equal to a percentage of the state's share of the average per capita cost of a Medicaid child, applied to the number of Medicaid children that exceed the enrollment target. The percentage depends on how much enrollment exceeds the enrollment target. A state with enrollment between the target level and 110% of the target level (Tier 1 enrollment) would receive a bonus payment equal to 15% of the state's share of the average per capita cost of a Medicaid child, multiplied by the number of children above the target. The percentage would rise to 62.5% of the state's share of the average cost per child for enrollment above 110% of the target (Tier 2 enrollment).

Table 2a: CHIPRA Bonus Caseload Calculations- Initial Payment

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Baseline Enrollment	263,497	276,400	288,230	300,912
Estimated Child Population Growth Factor[1]	4.90%	4.28%	4.40%	4.07%
Tier 1 Bonus Target Enrollment Estimate[2]	276,400	288,230	300,912	313,159
Tier 2 Bonus Target Enrollment Estimate[3]	304,040	317,053	331,003	344,475
Projected Enrollment	313,759	343,918	368,568	381,204
Projected Tier 1 Bonus Enrollment	27,640	28,823	30,091	31,316
Projected Tier 2 Bonus Enrollment	9,719	26,865	37,565	36,729

[1] Estimated Child population growth equals estimated population growth for age 0-18. The FFY 2010 estimate is provided by the Centers for Medicare and Medicaid Services, and future growth rates are estimates from the U.S. Census Bureau plus 3.5% in FFY 2011 through FFY 2012, and 3.0% in FFY 2013 thereafter.
[2] Tier 1 Bonus target is the Baseline Enrollment increased by the Estimated Child Population Growth Factor.
[3] Tier 2 Bonus target is 10% above the Tier 2 Bonus Enrollment target.

Table 2b: CHIPRA Bonus Per Capita Calculations

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Kaiser State Health Facts CO Child Medicaid Cost[4]	$2,478.75	$2,675.28	$2,887.39	$3,116.32
Estimated Increase in National Health Expenditures	7.93%	7.93%	7.93%	7.93%
State FMAP Rate	50.00%	50.00%	50.00%	50.00%
Applicable Per Capita	$1,337.64	$1,443.70	$1,558.16	$1,681.70

[4] Per capita costs used to calculate the bonus payment is the average cost of a non-SSI, non-waiver child in Medicaid including retroactivity. Because the Department does not report a similar per capita cost in its budget, the Kaiser State Health Facts CO Child Medicaid Cost is used as the closest available proxy to that used by the Centers for Medicare and Medicaid Services to calculate the payment.

Table 2c: CHIPRA Bonus Payment Calculation- Initial Payment

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Projected Tier 1 Bonus Enrollment	27,640	28,823	30,091	31,316
Projected Tier 1 Per Capita Bonus[5]	$200.64	$216.56	$233.72	$252.26
Projected Tier 1 Bonus Payment	**$5,545,765**	**$6,241,909**	**$7,032,869**	**$7,899,774**
Projected Tier 2 Bonus Enrollment	9,719	26,865	37,565	36,729
Projected Tier 2 Per Capita Bonus[5]	$836.02	$902.31	$973.85	$1,051.06
Projected Tier 2 Bonus Payment	**$8,125,278**	**$24,240,934**	**$36,582,763**	**$38,604,278**
Projected Total Initial CHIPRA Bonus Payment	**$13,671,043**	**$30,482,843**	**$43,615,632**	**$46,504,052**

[5] Projected Tier 1 Bonus Per Capita is equal to the estimated base per capita cost for Medicaid children multiplied by the State's FMAP rate multiplied by 15%. Projected Tier 1 Bonus Per Capita is equal to the estimated base per capita cost for Medicaid children multiplied by the State's FMAP rate multiplied by 62.5%.

Table 2d: CHIPRA Bonus Payment Calculation- Final Caseload Projections				
Projected Enrollment with Retroactivity[6]	319,961	347,942	372,880	385,664
Projected Tier 1 Bonus Enrollment	27,640	28,823	30,091	31,316
Projected Tier 2 Bonus Enrollment	15,921	30,889	41,877	41,189
Applicable Per Capita	$1,291.35	$1,393.74	$1,504.24	$1,623.50

[6] Based on enrollment data from the MMIS for January through December 2009 as well as the FFY 2010 final retroactive adjustment, the Department estimates that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17%.

Table 2e: CHIPRA Bonus Payment Calculation- Final Payment				
	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Projected Tier 1 Bonus Enrollment	27,640	28,823	30,091	31,316
Projected Tier 1 Per Capita Bonus	$193.70	$209.06	$225.64	$243.53
Projected Tier 1 Bonus Payment	**$5,353,937**	**$6,025,765**	**$6,789,613**	**$7,626,229**
Projected Tier 2 Bonus Enrollment	15,921	30,889	41,877	41,189
Projected Tier 2 Per Capita Bonus	$807.09	$871.09	$940.15	$1,014.69
Projected Tier 2 Bonus Payment	**$12,849,336**	**$26,907,022**	**$39,370,662**	**$41,793,963**
Projected Total CHIPRA Bonus Payment	**$18,203,273**	**$32,932,787**	**$46,160,275**	**$49,420,192**
Projected Second Payment	**$4,532,230**	**$2,449,944**	**$2,544,643**	**$2,916,140**

Table 3: CHIPRA Bonus Payments by State Fiscal Year					
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Projected Initial Bonus Payment (December of Respective State Fiscal Year)	$13,671,043	$30,482,843	$43,615,632	$46,504,052	$0
Projected Second Bonus Payment (August of Following State Fiscal Year)*	$0	$4,502,230	$2,449,944	$2,544,643	$2,916,140
Projected Total Bonus Payments by State Fiscal Year	**$13,671,043**	**$34,985,073**	**$46,065,576**	**$49,048,695**	**$2,916,140**

* The amount appropriated from the second payment from FFY 2010 is reduced by $30,000 for IDEA awards. Please see narrative for details.

Table 4: Estimated/Requested Appropriation Adjustments for CHIPRA Bonus Payments				
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Projected Total Bonus Payments by State Fiscal Year	$13,671,043	$34,985,073	$46,065,576	$49,048,695
Appropriation/Base Request	$13,671,043	$25,010,105	$31,028,791	$0
Estimated/Requested Incremental Increase in Federal Funds Appropriation (Corresponding Decrease in General Fund Appropriation)	**$0**	**$9,974,968**	**$15,036,785**	**$49,048,695**

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: R-12

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$96,766,237	$0	$98,483,655	($52,769)	($52,769)
	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	$0	$11,183,319	$28,596	$28,596
	RF	$121,320	$0	$121,810	$0	$0
	FF	$59,349,711	$0	$59,905,691	($81,365)	($81,365)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects[a]	Total	$6,596,052	$0	$6,410,052	($120,000)	($120,000)
	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	$0	$497,500	($60,000)	($60,000)
	RF	$0	$0	$0	$0	$0
	FF	$4,443,384	$0	$4,425,384	($60,000)	($60,000)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts[b]	Total	$32,412,990	$0	$31,767,217	($613,974)	($613,974)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,581,901	$0	$6,459,471	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,479,670	$0	$1,698,513	($356,987)	($356,987)
	RF	$100,328	$0	$100,328	$0	$0
	FF	$24,251,091	$0	$23,508,905	($256,987)	($256,987)
(1) Executive Director's Office; (C) Information Technology Contracts, Centralized Eligibility Vendor Contract Project[c]	Total	$2,221,482	$0	$4,584,648	$514,139	$514,139
	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	$0	$2,129,467	$404,737	$404,737
	RF	$0	$0	$0	$0	$0
	FF	$1,257,313	$0	$2,455,181	$109,402	$109,402
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards[d]	Total	$120,000	$0	$120,000	$9,240	$9,240
	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	$0	$0	$4,620	$4,620
	RF	$1,593	$0	$1,593	$0	$0
	FF	$59,204	$0	$59,204	$4,620	$4,620
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration[e]	Total	$33,547,878	$0	$34,008,773	($2,581,071)	($2,581,071)
	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	$0	$6,671,332	($1,290,536)	($1,290,536)
	RF	$0	$0	$0	$0	$0
	FF	$16,733,806	$0	$16,964,253	($1,290,535)	($1,290,535)

Line Item Information	Fund	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
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration *(new line item)*[f]	**Total**	$0	$0	$0	$2,581,071	$2,581,071
	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	$0	$0	$1,290,536	$1,290,536
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$1,290,535	$1,290,535
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach[g]	**Total**	$5,213,157	$0	$4,895,961	$31,057	$31,057
	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	$0	$71,333	$15,528	$15,528
	RF	$0	$0	$0	$0	$0
	FF	$2,606,578	$0	$2,447,979	$15,529	$15,529
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts[h]	**Total**	$7,670,839	$0	$7,801,722	$112,729	$112,729
	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	$0	$100,654	$13,678	$13,678
	RF	$0	$0	$0	$0	$0
	FF	$5,509,932	$0	$5,600,698	$99,051	$99,051
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System[i]	**Total**	$8,983,839	$0	$8,895,282	$14,040	$14,040
	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	$0	$14,520	$7,020	$7,020
	RF	$19,399	$0	$19,889	$0	$0
	FF	$4,488,403	$0	$4,444,087	$7,020	$7,020

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

For FY 2012-13

a Of this amount, ~~$2,220,707~~ $2,160,707 shall be from the Hospital Provider Fee Cash Fund...

b Of this amount, ~~$1,449,800~~ $1,092,813 shall be from the Hospital Provider Fee Cash Fund...

c Of this amount, ~~$2,129,467~~ $2,534,204 shall be from the Hospital Provider Fee Cash Fund...

d 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.

e Of this amount, ~~$1,290,536~~ $0 shall be from the Hospital Provider Fee Cash Fund...

f Of this amount, $1,290,536 be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

g Of this amount, ~~$71,333~~ $86,861 shall be from the Hospital Provider Fee Cash Fund...

h Of this amount ~~$100,654~~ $114,332 shall be from the Hospital Provider Fee Cash Fund...

i Of this amount, $7,020 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: None.

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

Schedule 13s from Affected Departments: Department of Human Services.

Other Information: None.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Human Services
Request Title: Hospital Provider Fee Administrative True-up
Priority Number: NP-3

Dept. Approval by: [signature] 10-20-11 Date

OSPB Approval by: [signature] 10/24/11 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	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
Total of All Line Items	Total	$18,858,730	$0	$18,978,289	$14,040	$14,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,585,647	$0	$4,668,267	$0	$0
	CF	$1,034,792	$0	$1,050,388	$0	$0
	RF	$6,924,731	$0	$6,836,174	$14,040	$14,040
	FF	$6,313,560	$0	$6,423,460	$0	$0
	MCF	$6,924,731	$0	$6,836,174	$14,040	$14,040
	MGF	$3,439,002	$0	$3,394,179	$0	$0
	NGF	$8,024,649	$0	$8,062,446	$0	$0
(2) Office of Information Technology Services, Colorado Benefits Management System (CBMS), Operating Expenses	Total	$18,858,730	$0	$18,978,289	$14,040	$14,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,585,647	$0	$4,668,267	$0	$0
	CF	$1,034,792	$0	$1,050,388	$0	$0
	RF	$6,924,731	$0	$6,836,174	$14,040	$14,040
	FF	$6,313,560	$0	$6,423,460	$0	$0
	MCF	$6,924,731	$0	$6,836,174	$14,040	$14,040
	MGF	$3,439,002	$0	$3,394,179	$0	$0
	NGF	$8,024,649	$0	$8,062,446	$0	$0

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

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

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

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

Other Information:

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: NP - 2

Dept. Approval by: 10-20-11 Date

OSPB Approval by: 10/24/11 Date

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

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

Letternote Text Revision Required? Yes: [ ] No: [x] **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: [x] No: [ ] Not Required: [ ]
Schedule 13s from Affected Departments: Departments of Health Care Policy & Financing and Human Services
Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Funding Request
November 1, 2011

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: R-12
Request Title: Hospital Provider Fee Administrative True-up

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Request	($52,769)	$0	0.0

Request Summary:
The Department requests a decrease of $52,769 total funds, comprised of an increase of $28,596 hospital provider fee cash funds and a decrease of $81,365 federal funds in FY 2012-13, 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.

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

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 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 2012-13.

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. The current FY 2011-12 appropriation is $4,402,843, with the FY 2012-13 base request being $4,885,226. In addition to the FY 2011-12 Long Bill appropriation, 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. The total FY 2011-12 spending authority is $5,490,462. The Department will adjust the FY 2011-12 spending authority for the MMIS projects in a separate supplemental. It should be noted that the incremental change for FY 2012-13 consists of two separate items. First, the Department requests a reduction to the appropriation in the amount of $813,974 total funds due to lower than anticipated postage costs. This reduction is offset by a requested increase in the amount of $200,000 for system development. There is currently no appropriation in FY 2012-13 for system development, and the Department requests this funding for any unforeseen changes to the MMIS which may be needed due to the implementation of the Disabled Buy-In and Adults without Dependent Children (AwDC) expansions in FY 2011-12. Please see Table A.1 below for the MMIS costs for FY 2012-13.

Table A.1: FY 2012-13 MMIS Need	
Claims Processing	$3,971,252
Postage	$100,000
Additional Need	$200,000
Total	$4,271,252

Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project
This line has a FY 2011-12 appropriation of $2,221,482, with the FY 2012-13 base request being $4,584,648. 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 2012-13 appropriations to the amounts shown in Table A.2 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.

Table A.2: Revised Centralized Eligibility Vendor Costs

	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Eligibility and Enrollment Vendor Cost for CHP+- Eligibility	**$843,877**	**$843,877**	**$843,877**
State Costs (Provider Fee)	$406,749	$406,749	$406,749
Federal Funds	$437,128	$437,128	$437,128
Estimated Eligibility and Enrollment Vendor Cost for Disabled Buy-In and AwDC	**$3,608,545**	**$4,254,910**	**$5,306,068**
State Costs (Provider Fee)	$1,804,273	$2,127,455	$2,653,034
Federal Funds	$1,804,272	$2,127,455	$2,653,034
Total	**$4,452,422**	**$5,098,787**	**$6,149,945**
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 2012-13.

Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations
This line has a FY 2011-12 appropriation of $5,602,536, with continuation funding in the FY 2012-13 base. 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, with the FY 2012-13 base request being $2,581,071. 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% and 4.6% hospital provider fee and federal matching funds for FY 2011-12 and FY 2012-13, respectively. 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 2012-13. 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% and 1.28% hospital provider fee and federal matching funds for FY 2011-12 and FY 2012-13, respectively. However, because Continuous Eligibility for Medicaid Children is not currently scheduled to be implemented in either FY 2011-12 or FY 2012-13, 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%. and 5.42% hospital provider fee and federal matching funds for FY 2011-12 and FY 2012-13, respectively. 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 2012-13.

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 estimates a need of $1,466,040 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. Please note that the FY 2011-12 estimated need also 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 estimated to be needed 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. For correspondence costs in FY

2012-13, $117,238 is allocated for the clients that the Department expects to be enrolled, while $50,000 is for those on the waitlist and those who are denied. The amount for correspondence for those on the waitlist and denials is reduced because 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. The Department is also requesting $200,000 in FY 2012-13 for system development. There is currently no appropriation in FY 2012-13 for system development, and the Department requests this funding for any unforeseen changes to CBMS which may be needed due to the implementation of the Disabled Buy-In and Adults without Dependent Children (AwDC) expansions in FY 2011-12. Please see Tables A.3 and A.4 below for the CBMS costs for FY 2011-12 and FY 2012-13. Please note that the FY 2011-12 estimates are provided for informational purposes only.

Table A.3: FY 2011-12 CBMS Need

	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
Total	17,090		$2,063,520

Table A.4: FY 2012-13 CBMS Need

	Total Cost
CBMS Correspondence	$167,238
Additional CBMS Need	$200,000
Total	$367,238

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	**Expansion Adults to 100% as % of Medicaid Caseload (Row 4 / Row 1)**	**5.35%**
11	**All Medicaid Expansions as % of Medicaid (Row 7 / Row 1)**	**7.15%**
12	**All Expansions as % of Medicaid and CHP+ (Row 9 / Row 3)**	**7.92%**

Table B.2: Summary of Incremental Request FY 2012-13				
	Total Funds	**General Fund**	**Cash Funds (Provider Fee)**	**Federal Funds**
Total Request	**($52,769)**	**$0**	**$28,596**	**($81,365)**
(A) General Administration, General Professional Services and Special Projects	($120,000)	$0	($60,000)	($60,000)
(C) Information Technology Contracts and Projects, Information Technology Contracts	($613,974)	$0	($356,987)	($256,987)
(C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$514,139	$0	$404,737	$109,402
(D) Medical Identification Cards	$9,240	$0	$4,620	$4,620
(D) Eligibility Determinations and Client Services, County Administration	($2,581,070)	$0	($1,290,536)	($1,290,535)
(D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration (*new line item*)	$2,581,070	$0	$1,290,536	$1,290,535
(D) Eligibility Determinations and Client Services, Customer Outreach	$31,057	$0	$15,528	$15,529
(E) Utilization and Quality Review Contracts, Professional Services Contracts	$112,729	$0	$13,678	$99,051
(6) (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$14,040	$0	$7,020	$7,020

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CBMS Electronic Document Management System

Priority Number: R-13

Dept. Approval by: John Bartholomew 10/20/11 Date

OSPB Approval by: 10/24/11 Date

- [x] **Decision Item FY 2012-13**
- [ ] **Base Reduction Item FY 2012-13**
- [ ] **Supplemental FY 2011-12**
- [ ] **Budget Amendment FY 2012-13**

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$8,983,839	$0	$8,895,282	$464,126	$32,515
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	$0	$4,416,786	$230,708	$16,162
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$0	$14,520	$462	$33
	RF	$19,399	$0	$19,889	$1,392	$98
	FF	$4,488,403	$0	$4,444,087	$231,564	$16,222
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	$8,983,839	$0	$8,895,282	$464,126	$32,515
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	$0	$4,416,786	$230,708	$16,162
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$0	$14,520	$462	$33
	RF	$19,399	$0	$19,889	$1,392	$98
	FF	$4,488,403	$0	$4,444,087	$231,564	$16,222

Letternote Text Revision Required? Yes: [x] No: [ ] **If yes, describe the Letternote Text Revision:** The Department is authorized to roll forward into FY 2013-14 any remaining funding for this line.

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

Reappropriated Funds Source, by Department and Line Item Name: Old Age Pension Fund managed by Department of Human Services

Approval by OIT? Yes: [x] No: [ ] Not Required: [ ]

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

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Human Services
Request Title: CBMS Electronic Document Management System
Priority Number: NP-2

Dept. Approval by: Will Kyl 10-20-11 Date

OSPB Approval by: Emil Malone 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$18,858,730	$0	$18,978,289	$1,257,600	$88,100
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,585,647	$0	$4,668,267	$303,065	$21,231
	CF	$1,034,792	$0	$1,050,388	$43,576	$3,053
	RF	$6,924,731	$0	$6,836,174	$464,126	$32,515
	FF	$6,313,560	$0	$6,423,460	$446,833	$31,301
	MCF	$6,924,731	$0	$6,836,174	$464,126	$32,515
	MGF	$3,439,002	$0	$3,394,179	$230,707	$16,162
	NGF	$8,024,649	$0	$8,062,446	$533,772	$37,393
(2) Office of Information Technology Services, Colorado Benefits Management System (CBMS), Operating Expenses	**Total**	$18,858,730	$0	$18,978,289	$1,257,600	$88,100
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,585,647	$0	$4,668,267	$303,065	$21,231
	CF	$1,034,792	$0	$1,050,388	$43,576	$3,053
	RF	$6,924,731	$0	$6,836,174	$464,126	$32,515
	FF	$6,313,560	$0	$6,423,460	$446,833	$31,301
	MCF	$6,924,731	$0	$6,836,174	$464,126	$32,515
	MGF	$3,439,002	$0	$3,394,179	$230,707	$16,162
	NGF	$8,024,649	$0	$8,062,446	$533,772	$37,393

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

[h] Of these amounts, ~~$1,130,795~~ $1,174,371 shall be from the Old Age Pension Fund created in Section 1 of Article XXIV of the State Constitution and $168,499 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4) (a), C.R.S.

[j] Of these amounts, it is estimated that ~~$4,879,375~~ $5,151,653 shall be from the U.S. Department of Agriculture for the Supplemental Nutrition Assistance Program and ~~$3,361,890~~ $3,536,445 shall be from the Temporary Assistance for Needy Families Block Grant.

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

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

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

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Governor's Office of Information Technology
Request Title: CBMS Electronic Document Management System
Priority Number: NP - 1

Dept. Approval by: [signature] 10-19-11 Date

OSPB Approval by: [signature] 10/24/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 6 Continuation Amount FY 2013-14
Total of All Line Items	Total	19,007,729	-	19,127,288	1,257,600	88,100
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	-	19,127,288	1,257,600	88,100
	FF	-	-	-	-	-
(5) Office of Information Technology, (E) Colorado Benefits Management System, Operating Expenses	Total	19,007,729	-	19,127,288	1,257,600	88,100
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	-	19,127,288	1,257,600	88,100
	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 and Human Services
Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2012-13 Funding Request
November 1, 2011

Department Priority: R-13
CBMS Electronic Document Management System

Summary of Incremental Funding Change for FY 2012-13 HCPF	Total Funds	General Fund for HCPF	FTE
CBMS Electronic Document Management System	$464,126	$230,708	0.0

Request Summary:
The Colorado Department of Health Care Policy and Financing (HCPF), the Colorado Department of Human Services (DHS), and the Colorado Governor's Office of Information Technology (GOIT) request $1,257,600 total funds and $533,792 General Fund to develop and implement an Electronic Document Management System to be integrated into Colorado PEAK that is part of the Colorado Benefits Management System (CBMS) to meet requirements of the recent federal Centers for Medicare and Medicaid Services (CMS) audit.

The Electronic Document Management System is the hardware and software used for the process of scanning and storing documents in the CBMS database and associating each document with the eligibility client by one or more indices so that the documents can be retrieved electronically. The Electronic Document Management System will also become integrated into the Colorado PEAK system that is already currently available to Colorado citizens to apply for medical assistance or other financial assistance programs managed by the Department of Health Care Policy and Financing or the Department of Human Services.

Colorado PEAK is the Program Eligibility Application Kit that is the web based system through which assistance applications can be initiated by Colorado citizens with access to a computer, and county departments of social services workers can review and complete the applications. Development and upgrades of PEAK were fully completed and implemented in FY 2010-11. The Electronic Document Management System added to Colorado PEAK would capture and maintain the hard copy records that applicants must supply to substantiate their eligibility for assistance programs. The original paper records could include driver's licenses, birth certificates, tax returns, pay stubs, and other similar documents.

The Electronic Document Management System would include 6,800 hours of development and computer programming changes as estimated by the CBMS vendor, purchase of a large storage server with storage space of 20 terabytes of storage that is capable of storing the documents for the foreseeable future, two models of scanners for testing compatibility, and purchase of software licenses. Ongoing costs would include maintenance of the storage server and annual renewal of the software licenses.

There would also be implementation costs for OIT to purchase one or two scanners per county as needed to be distributed to the counties. Those costs would be to purchase scanners for the county offices to upload scanned documents into the CBMS database. A few county offices already have scanners for a local small scale

electronic document system, but most of the counties would need new scanners.

An Electronic Document Management System was first requested by the Department of Health Care Policy and Financing in S-1A, BA-A1A "Building Blocks to Health Care Reform" submitted February 15, 2008. At that time, the estimated costs for development of such a system were $1,750,000 in FY 2009-10 and $3,500,000 in FY 2010-11. The Department did not go forward with this development due to an economic downturn that was occurring nationally, as well as in Colorado, that placed constraints on funding available to state government. The Department abandoned the Electronic Document Management System as a budget balancing measure after JBC staff recommended budget reductions in Request JBC-1 discussed in the HCPF Supplemental Requests hearing on January 29, 2009, page 73. However, the Department did go forward with a smaller scale project as requested in BA-35 "Revised Implementation of DI–5 - Improved Eligibility and Enrollment Processing" submitted January 23, 2009 and discussed in the HCPF FY 2009-10 Figure Setting on March 18, 2009, page 95. This smaller scale project applied only to the Children's Basic Health Plan and cost $100,000. By delaying until FY 2012-13, the technology has advanced so that the requested large scale project would now cost much less than in 2008.

The need for an Electronic Document Management System has come to the fore again because of several findings in an audit by the federal Centers for Medicare and Medicaid Services released July 1, 2011. That audit found that the Department lacked management control of the CBMS processes, including, among other findings, lack of timeliness of Medicaid eligibility determinations and re-determinations, lack of providing a reasonable period of time for applicants to present satisfactory documentary evidence of citizenship, lack of reasonable time frames in terminating eligibility, and in completing periodic redeterminations. The Department has developed a plan for addressing the findings, and that plan is pending federal approval. Improvements in the aforementioned areas are highly dependent on having quickly available documentation to prove eligibility as required by federal guidelines, thus the Electronic Document Management System is part of the improvement plan.

The same improvements in the Electronic Document Management System would also benefit assistance programs managed by the Department of Human Services because this process would allow the electronic capture, archiving, and retrieval of documents for DHS programs. For this reason, it is appropriate that both Departments participate in this request. Since the Governor's Office of Information Technology manages the technology to maintain the CBMS database, this requirement would impact their appropriations as well.

After the Electronic Document Management System development and implementation is completed, this new process will capture and archive all new documentation provided on a go-forward basis. However, counties will need to scan all physical client documentation residing in their files currently. It is not known at this time the timeframe for completion of the scanning of the older documents by the counties.

Due to the complexities associated with the planning and implementation of a project of this scale and the potential for unforeseen contingencies, the Departments request that any remaining funds in the CBMS line item left over for this project at the end of FY 2012-13 be authorized for roll forward into FY 2013-14 for completion of the project at the county level.

Anticipated Outcomes:
The anticipated outcomes from approval and completion of this request would be improved compliance with federal guidelines preventing possible loss of federal matching funding for the CBMS program or other federal programs; reduced county worker workload; increased client satisfaction by decreasing frustration about

misplaced or delayed retrieval of paperwork; reduced archival costs of paper documentation; and additional efficiencies in the operation of the CBMS database.

Assumptions for Calculations:
The Colorado Benefits Management System line item uses random moment sampling (RMS) for calculating cost sharing between HCPF and DHS for various programs. The Department assumes that random moment sampling would be used to allocate costs in this request.

It is also assumed that:

- The State share of the Children's Basic Health Plan related costs will be 35% and the federal funds will be 65%.
- The State share of costs related to Old Age Pension will be 100%.
- Costs related to Temporary Aid to Needy Families (TANF or Colorado Works) will be 100% from the federal block grant.
- Costs associated with the Supplemental Nutrition Assistance Program (SNAP or Food Stamps) will be 50% State share and 50% federal share.
- Costs related to Foster Care will be 100% State share.
- Costs related to the Title XX Block Grant will be 100% State share.
- Costs related to Adult Protective Services will be 100% State share.
- Costs related to Medicaid will be 50% General Fund and 50% federal funds.
- The FY 2012-13 hourly rate for the CBMS vendor to develop the programming changes would be $112 as stated in the vendor contract.
- Funding appropriated to HCPF and DHS for development and implementation of the Electronic Document Management System will be transferred to GOIT as reappropriated funds.
- Funding for the purchase of scanners would be included in the GOIT allocation for CBMS because a large group purchase would allow GOIT to utilize a discount achieved through economies of scale. In later years when replacement of the scanners may become necessary, the counties would have responsibility for the replacement costs.

See attachments for cost calculations.

Consequences if not Funded:
Failure to address the findings of the audit of CBMS by the federal Centers for Medicare and Medicaid Services could result in loss of federal financial participation for CBMS. County workload could continue to increase unabated. Client frustration could continue due to lost or delayed paper documentation. Continued untimely eligibility determination could lead to more lawsuits against the Department(s).

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 attachments for financial impacts.

Cash Fund Projections:
The Old Age Pension Fund, managed by DHS and the Children's Basic Health Plan Trust Fund, managed by HCPF, would provide part of the funding for this request, as calculated by the RMS calculator. The Old Age Pension Fund, created in Article XXIV of the State Constitution, does not have a specific balance but is managed by the State Controller to have the amount needed for programs for eligible Old Age Pension clients.

The Children's Basic Health Plan Trust projection is below.

Cash Fund Name	Children's Basic Health Plan Trust Fund
Cash Fund Number	11G
FY 2010-11 Expenditures	$43,062,875
FY 2010-11 End of Year Cash Balance	$7,745,026
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385

Relation to Performance Measures:
This request relates to strategic goals of increasing the number of insured Coloradans that leads to increased access to health care. The strategic goals tie with performance measures to meet timely processing requirements for 95% of all new applications for medical assistance and to meet timely processing requirements for 95% of all redeterminations for medical assistance.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
Not applicable.

Current Statutory Authority or Needed Statutory Change:
Statutory authority is under 25.5-4-106 (3), C.R.S. (2010 and 25.5-4-204 (1), C.R.S. (2010). No changes to statutes are needed.

Attachment 1 Cost Calculations

CBMS Electronic Document Management System Costs	
Colorado Benefits Management System Line Item	
Year of Implementation FY 2012-13	*Costs*
6,800 Development Hours at $112 per Hour	$761,600
Purchase Storage Server with 20 Terabytes of Storage Space	$305,000
Purchase Test Gear: Two Different Models of Scanners	$2,000
Purchase Software License	$93,000
Purchase by GOIT of Scanners for Distribution to the Counties	$96,000
Total Costs for First Fiscal Year	**$1,257,600**
Estimated HCPF Share	**$464,126**
Estimated DHS Share	**$793,474**
Estimated GOIT Reappropriated Funds	**$1,257,600**
Year after Implementation and Ongoing FY 13-14	*Costs*
Annual Maintenance of Storage Server	$67,100
Annual Maintenance of Software License	$21,000
Total Costs for Each Future Ongoing Fiscal Year	**$88,100**
Estimated HCPF Share	**$32,515**
Estimated DHS Share	**$55,585**
Estimated OIT Reappropriated Funds	**$88,100**

Attachment 2 Agency Impacts

Summary of Request FY 2012-13 Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$464,126**	**$230,708**	**$462**	**$1,392**	**$231,564**
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$464,126	$230,708	$462	$1,392	$231,564

Summary of Request FY 2012-13 Department of Human Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Medicaid Cash Funds	Medicaid General Fund	Net General Fund
Total Request	**$1,257,600**	**$303,065**	**$43,576**	**$464,126**	**$446,833**	**$464,126**	**$230,707**	**$533,792**
(2) Office of Information Technology Services; Colorado Benefits Management System, Operating Expenses	$1,257,600	$303,065	$43,576	$464,126	$446,833	$464,126	$230,707	$533,772

Summary of Request FY 2012-13 Governor's Office of Information Technology	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$1,161,600**	**$0**	**$0**	**$1,161,600**	**$0**
(5) Office of Information Technology; (E) Colorado Benefits Management System, Operating Expenses	$1,257,600	$0	$0	$1,257,600	$0

Summary of Request FY 2013-14 Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$32,515**	**$16,162**	**$33**	**$98**	**$16,222**
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$32,515	$16,162	$33	$98	$16,222

Summary of Request FY 2013-14 Department of Human Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Medicaid Cash Funds	Medicaid General Fund	Net General Fund
Total Request	**$88,100**	**$21,231**	**$3,053**	**$32,515**	**$31,301**	**$432,515**	**$16,162**	**$37,393**
(2) Office of Information Technology Services; Colorado Benefits Management System, Operating Expenses	$88,100	$21,231	$3,053	$32,515	$31,301	$32,515	$16,162	$37,393

Summary of Request FY 2013-14 Governor's Office of Information Technology	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	**$88,100**	**$0**	**$0**	**$88,100**	**$0**
(5) Office of Information Technology; (E) Colorado Benefits Management System, Operating Expenses	$88,100	$0	$0	$88,100	$0

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - New Funding – Developmental Disabilities Services

Priority Number: NP R-1

Dept. Approval by: John Bartholomew 10/12/11 Date

OSPB Approval by: 10/15/11 Date

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$328,231,550	$0	$330,772,221	$4,877,540	$8,955,998
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$164,115,774	$0	$165,386,111	$2,438,770	$4,477,999
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$164,115,775	$0	$165,386,109	$2,438,770	$4,477,999
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	Total	$328,231,550	$0	$330,772,221	$4,877,540	$8,955,998
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$164,115,774	$0	$165,386,111	$2,438,770	$4,477,999
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$164,115,775	$0	$165,386,109	$2,438,770	$4,477,999

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

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Statewide Vehicle Replacement

Priority Number: NP R-2

Dept. Approval by: John Bartholomew PN for JB 10/18/11 (Date)

OSPB Approval by: 10/19/11 (Date)

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

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	$0	$5,184,971	$15,149	$15,149
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	$0	$2,592,486	$7,574	$7,574
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	$0	$2,592,485	$7,575	$7,575
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	$0	$5,184,971	$15,149	$15,149
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	$0	$2,592,486	$7,574	$7,574
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	$0	$2,592,485	$7,575	$7,575

Letternote Text Revision Required? Yes: [ ] No: [x] **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: [ ] No: [ ] **Not Required:** [x]

Schedule 13s from Affected Departments: Department of Human Services

Other Information: