Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medical Services Premiums Request
Priority Number: R-1

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,736,824,877	-	5,323,832,795	180,948,596	501,903,486
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	64,326,142	155,189,155
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	(60,431,827)	(59,730,048)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	177,054,281	406,444,379
(2) Medical Services Premiums	**Total**	4,736,824,877	-	5,323,832,795	180,948,596	501,903,486
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	64,326,142	155,189,155
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	(60,431,827)	(59,730,048)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	177,054,281	406,444,379

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: See Exhibit D

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

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- The Department requests an increase of $180,948,596 total funds, $64,326,142 General Fund, in FY 2014-15.

Link to Operations

- Medical Services Premiums is part of an entitlement program and ensures that both State and federal funding is available to cover the health care costs and preventive care needs of Colorado's Medicaid population.

Problem or Opportunity

- Changes in caseload and per capita costs put the Department at risk for expenditure over the Department's FY 2014-15 spending authority for Medicaid physical health programs.

Consequences of Problem

- This problem creates a high risk for over-expenditure due to changes in actual program usage and costs compared to those previously expected.

Proposed Solution

- The Department requests $180,948,596 total funding in addition to the current FY 2014-15 spending authority to lessen the risk of over-expenditure.

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2013-14, FY 2014-15, and FY 2015-16 Budget Request

November 1, 2013

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MEDICAL SERVICES PREMIUMS

I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, people with disabilities, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year. The first section of the Medical Services Premiums Budget Narrative describes the Medicaid caseload projection. The second section describes the development of the per capita cost, the application of per capita caseload and bottom-line adjustments. A series of exhibits in this budget request support the narrative.

Further discussion depends on several key points that complicate the projection of this line item. They are summarized as follows:

1. In June 2010, the Governor's Office of State Planning and Budgeting and the State Controller directed the Department to withhold payments to Medicaid providers for the final two weeks of FY 2009-10. The Department subsequently released payments in the first week of July 2010. The payment delay understates actuals for FY 2009-10 when compared to prior fiscal years. Further, this creates difficulties from a forecasting perspective, as cash-based actuals do not reflect similar periods.

   To account for the delayed payments, the Department has taken the following steps:

   - Additional pages showing the effect of the delay are included in Exhibit C, Exhibit M, and Exhibit N.
   - In all cases, the Department's forecasts are based on the delay-adjusted cash-based actuals. As a result, the Department consistently forecasts a 52-week period in Exhibits F, G, H, and I.

2. The Department's request includes a number of references to various budget items and early supplemental budget reductions. July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced-budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding.

3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom-line impacts. Bottom-line impacts can be found by service category (e.g., Acute Care, Community-Based Long-Term Care, Long-Term Care, Insurance, etc.) in the respective sections of this request. Those bottom-line impacts include the identification number

of the originally submitted request, so that the bottom-line impact in the current year may be traced to the originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom-line impacts. Revisions to bottom-line impacts between requests are primarily limited to changes in implementation timeline. The Department generally does not adjust fiscal impact assumptions unless a deviation from assumptions in the original budget action is clear and significant.

4. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J.

5. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations, which gain eligibility as a result of HB 09-1293 and SB 13-200. This includes the expansion of eligibility to Adults without Dependent Children and parents with Medicaid-eligible children up to 133% of the federal poverty level in FY 2013-14. These expansions increase Medicaid caseload and are discussed further in Sections II and III of this narrative.

6. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for administration and case management are included in Exhibit I. The Department's revised estimates are described in section V of this narrative.

7. The Department's request includes a forecast for FY 2013-14, FY 2014-15, and FY 2015-16. Some previous requests included only forecasts for the current and request years, therefore additional exhibits and changes in formatting to accommodate the additional year are present throughout.

8. The Department's request also includes the FY 2013-14 R-13 1.5% rate increase to providers affected by prior year rate decreases, as well as additional rate increases approved by the Joint Budget Committee.

9. The Department has added a new calculation for its Money Follows the Person grant program, known as Colorado Choice Transitions, to Exhibit G. Please see the narrative for Exhibit G and section V for additional information.

10. Effective November 2012, the Department changed the way it forecasts expenditure for Community-Based Long-Term Care services. Previously, the forecast was done at the eligibility category level for all services. Now, the forecast is specific to each individual service.

11. Previously, the Department assumed that the cash fund for the Breast and Cervical Cancer Program would continue once HB 08-1373 sunsets on June 30, 2014. This request has been adjusted to remove that assumption. Continuation of the program would require statutory changes.

12. Non-emergent medical transportation for the Metro area experienced higher than expected utilization by clients and the contract had to be updated to account for that, resulting in the provision of approximately $3,000,000 in additional funds.

13. The Department's request includes the addition of SB 13-242, which created an adult dental benefit as well as the Adult Dental Benefit Fund to finance the design and implementation of the adult dental benefit program, effective April 1, 2014.

14. The presence of varying funding mechanisms makes the Department's request more complex. Different Medicaid services have different federal match rates and are pertinent to different populations under Medicaid. Certain categories of service have historically been federally matched at different percentages than others. Indian Health Services, described further in this narrative, have historically received a 100% FMAP while Family Planning Services receive a 90% FMAP. BCCP services are matched at 65% FFP. Medicaid expansion populations receive a different match rate than existing populations. Expansion Adults to 133% and the Adults without Dependent Children populations for instance, receive a 50% FMAP in the first half of FY 2013-14 and a 100% FMAP in the second half of FY 2013-14, FY 2014-15 and FY 2015-16.

15. Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing. The recommended services are those that have been given an A or B rating by the United States Preventive Services Task Force. The preventive services that are currently not included in the Colorado Medicaid benefit package are depression screening for adults, aspirin for the prevention of cardiovascular disease, counseling about screening for breast cancer susceptibility (BRCA), BRCA testing, shingles vaccines, and counseling interventions about tobacco use for non-pregnant adults. There is a bottom line adjustment in Exhibit F, Acute Care, for the estimated impact of providing these services. A further explanation of how these amounts were calculated is contained in this narrative under Acute Care.

The Department's exhibits for Medical Services Premiums remain largely the same as previous budget requests. Minor differences are noted in the description of each exhibit and/or program in sections IV and V.

II. MEDICAID CASELOAD

The Medicaid caseload analysis, including assumptions and calculations, are included in a separate section of this request. Please refer to the section titled "Medicaid Caseload."

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts. Inherent in the per capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, pre-existing condition, etc.), generally healthy clients are less costly to serve (lower "risk") than clients with severe acute or chronic medical needs requiring medical intervention (higher "risk"). For example, on average, a categorically eligible low-income child is substantially less costly to serve than a disabled person each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums needed for current and request years. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

A detailed discussion of how the projection was prepared for this budget request follows.

Rationale for Grouping Services for Projection Purposes

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to cluster services that have like characteristics (e.g., community-based long-term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physician services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

Following are the service groupings used in computing the projections or summarizing individual service calculations in this Budget Request.

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services

- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long-Term Care:

- Home- and Community-Based Services: Elderly, Blind and Disabled
- Home- and Community-Based Services: Community Mental Health Supports
- Home- and Community-Based Services: Disabled Children
- Home- and Community-Based Services: Persons Living with AIDS
- Home- and Community-Based Services: Consumer Directed Attendant Support
- Home- and Community-Based Services: Brain Injury
- Home- and Community-Based Services: Children with Autism
- Home- and Community-Based Services: Pediatric Hospice
- Home- and Community-Based Services: Alternative Therapies
- Private Duty Nursing
- Hospice

Long-Term Care:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-inclusive Care for the Elderly

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

Financing:

- Hospital Provider Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing
- Outstationing Payments
- Other Supplemental Payments

Note that for services in the Long-Term Care, Insurance, Service Management and Financing categories, separate forecasts are performed. Only Acute Care is forecast as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from page EA-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

For the request year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the out year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-6. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the out year.

Totals for the base request on this page correspond with Columns 2, 4, and 5 on the Schedule 13, where appropriate.

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service each year and is based on a statewide per capita earnings formula that is set in federal law.

Certain populations and services receive different FMAPs than the standard 50%. This is summarized below. Clients transitioning from CHP+ to Medicaid receive the CHP+ FMAP, which is 65%. Clients in the BCCP program also receive a 65% match. The expansion populations, Expansion Adults to 133% and Adults without Dependent Children, receive a match of 100% beginning January 1, 2014. The Disabled Buy-In population receives the standard 50% match for expenditures net of patient premiums.

Calculation of expenditure by financing type can be found in Exhibit A.

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
FY 2013-14	65%	Clients transitioning from CHP+ to Medicaid, Clients in the BCCP program	Please see Exhibit F
	50% until Jan 2014, then 100%	Expansion Adults to 133%, Adults without Dependent Children	Please see Exhibit J
	50%	Disabled Buy-In	Hospital Provider Fee portion matched at 50%, Medicaid Buy-In Fund 0%
FY 2014-15	65%	Clients transitioning from CHP+ to Medicaid, Clients in the BCCP Program	Please see Exhibit F
	100%	Expansion Adults to 133%, Adults without Dependent Children	Please see Exhibit J
	50%	Disabled Buy-In	Hospital Provider Fee portion matched at 50%, Medicaid Buy-In Fund 0%
FY 2014-15	65%	Clients transitioning from CHP+ to Medicaid	Please see Exhibit F
	100%	Expansion Adults to 133%, Adults without Dependent Children	Please see Exhibit J
	50%	Disabled Buy-In	Hospital Provider Fee portion matched at 50%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2013-14	0%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Physicians to 100% of Medicare: ACA Section 1202	Please see bottom line adjustment in Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2014-15	0%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Physicians to 100% of Medicare: ACA Section 1202	Please see bottom line adjustment in Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2015-16	0%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F

Calculation of Fund Splits

These pages take the total estimated expenditure by service group and calculate the required source of funding for each. For each service category, the federal medical assistance percentage (FMAP) is listed on the right-hand side of the table. The FMAP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services (CMS), as reported through the Federal Register or as specified in federal law and/or regulation.

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g., Acute Care) by programs funded with either a different state source or a different FMAP rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate. To determine State funding, the population is separated into two groups: traditional clients and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308(9), C.R.S. (2013). For FY 2013-14, 50% of state funding for traditional clients comes from the Breast and Cervical Prevention and Treatment Fund and 50% comes from the General Fund. The program sunsets on June 30, 2014; except claims runout in FY 2014-15, there is no new expenditure expected in future years.

- Family Planning: The Department receives a 90% FMAP available for all documented family planning expenditures. This includes those services rendered through health maintenance organizations. Please see Exhibit F for calculations.

- Indian Health Services: The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the State. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure.

- Affordable Care Act Preventive Services: Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing.

- SB 11-008: "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children from ages six to 19. Effective January 1, 2013, children under the age of 19 are eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for these clients will remain at the same level as if the clients had enrolled in the Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%.

- SB 11-250: "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients.

- Expansion Adults to 133% Adjustment: HB 09-1293, the Colorado Health Care Affordability Act of 2009, authorizes the Department to collect provider fees from hospitals for the purpose of obtaining federal financial participation for the State's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medical assistance; to 100% of the federal poverty line and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate the hospital provider fee to each applicable service categories. Additionally, SB 13-200 amended Medicaid eligibility for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line in keeping with Medicaid expansion under the Affordable Care Act, which also ensures that Expansion Adults to 133% of the federal poverty line will receive a 100% federal match rate effective January 1, 2014. See Exhibit J for additional information and detailed calculations.

- Adults without Dependent Children: This population began participation in Medicaid in FY 2011-12. The population is funded with a combination of federal funds and Hospital Provider Fee. Additionally, SB 13-200 amended the Medicaid eligibility criteria for adults without dependent children to 133% of the federal poverty line in accordance with Medicaid expansion under the Affordable Care Act. Effective January 1, 2014, the Affordable Care Act provides this population a 100% federal match rate. Calculations and information regarding this population can be found in Exhibit J.

- Disabled Buy-In: Funds for this population come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.

- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per-diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.

- Adult Dental Benefit Financing: SB 13-242 creates a limited dental benefit for adults in the Medicaid program, to be implemented by April 1, 2014. To fund the design and implementation of the adult dental benefit, SB 13-242 created the Adult Dental Fund effective July 1, 2013, financed by the Unclaimed Property Trust Fund. The majority of the design and implementation of the dental benefit is funded by a federal funds appropriation of $22,625,118. The general fund appropriation is decreased by $738,262 for FY 2013-14 and the Adult Dental Fund cash fund appropriation is increased by $11,185,718. Due to the implementation of SB 13-200, the Hospital Provider Fee cash fund is decreased by $213,659, bringing the total cash fund impact for FY 2013-14 to $10,972,059.

- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare reimbursement. The difference in rates between July 1, 2009, and January 1, 2013, will be paid for by the federal government through an enhanced FMAP of 100%. Additional details are provided in sections IV and V.

- Tobacco Tax Funded Disease Management: The Department annually receives funding from the Department of Public Health and Environment (DPHE) for the operation of disease management programs that address cancer, heart disease, lung disease, and the risk factors associated therewith. The funding for these programs is a constant $2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by DPHE. For FY 2012-13, the Department received authority to use a portion of the funding for chronic disease management programs administered by the Unit on Aging in DPHE; see Exhibit I for further details. In accordance with SB 08-118, Money Transfer for Medicaid Programs, FY 2012-13 was the last year in which this transfer would occur; however, SB 13-232 extended the tobacco tax Medicaid management transfer indefinitely, effective July 1, 2013. However, the bill did not authorize the Department to use the funds for any purpose other than General Fund offset. Consequently, there is currently no funding for disease management programs.

- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to 75 children living with autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to approximately $1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Clients are limited to a cap of $25,000 in waiver services. The Department estimates the funding needed from the Colorado Autism Treatment Fund based on the program estimate in Exhibit G, which includes $163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 84.5% of the total will receive federal financial participation in FY 2013-14, 84.5% in FY 2014-15, and 81.0% in FY 2015-16. The Department anticipates the decline in the portion of premiums matched with federal funds as a result increased Disabled Buy-In enrollment over time.

- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The State share of funding is through certification of public expenditure.

- Coordinated Care for People with Disabilities Program: The coordinated care for people with disabilities pilot program, as authorized by SB 06-128, allowed the Department to pay per-member per-month administration fees to a nonprofit organization which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations. The State funding for this program came from the Coordinated Care for People with Disabilities Fund, which was created by SB 06-128 and was generated by interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund. SB 13-276 repealed the Coordinated Care for People with Disabilities Fund effective July 1, 2014 and any money held in it as of July 1, 2013 is to be transferred to the Disability Investigational and Pilot Support Fund, which will be used to fund projects and studies designed to improve the quality of life or increase the independence of people with disabilities.

- Upper Payment Limit Financing: Offsets General Fund as a bottom-line adjustment to total expenditures. This is further described in Exhibit K.

- Department Recoveries Adjustment: Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in Exhibit L.

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health Federally Qualified Health Centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2013-14, FY 2014-15, and FY 2015-16 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund was insolvent and no longer covered the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

- Service Fee Fund: SB 13-167 moved collection authority for provider fees collected from intermediate care facilities from the Department of Human Services (DHS) to the Department as of July 1, 2013. This eliminates the need to transfer funds between DHS and the Department in order to obtain the federal match to reimburse covered expenses incurred at intermediate care facilities. This changes the source of the provider fees from a reappropriated fund from DHS to a cash fund for the Department.

- Hospital Provider Fee for Continuous Eligibility: Continuous eligibility for children provides children with twelve months of continuous coverage through Medicaid, even if the family experiences an income change during any given year. The Department has the authority to use the Hospital Provider Fee Cash Fund to fund the State share of continuous eligibility for Medicaid children through FY 2014-15, after which time the General Fund will fund the State share. Because this population is not an expansion population, it receives a 50% federal financial participation rate.

- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers.

  The table below shows the impact by cash fund for FY 2013-14, FY 2014-15, and FY 2015-16.

Cash Funds	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Prevention, Early Detection, and Treatment Fund (Reappropriated funds from DPHE)	$2,000,000	$2,000,000	$2,000,000
Tobacco Tax Cash Fund (SB 11-210)	$2,230,500	$2,230,500	$2,230,500
Hospital Provider Fee Cash Fund (SB 13-200, SB 13-230)	$17,218,521	$22,131,818	$15,700,000
Old Age Pension Health and Medical Care Fund (SB 13-200)	$1,745,639	$5,495,027	$5,369,479
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$23,395,120**	**$32,057,805**	**$25,500,439**

The Department's request no longer includes an adjustment for "Prenatal Costs for Optional Legal Immigrants." In FY 2008-09, prenatal services were provided as a state-only option and therefore required to be funded through 100% General Fund with the exception that delivery costs qualify for the standard 50% federal financial participation rate. However, effective July 1, 2010, the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Because the Department is now receiving a 50% federal match on these services, the Department no longer needs to separate out prenatal expenditure.

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2015-16. Adjustments for caseload effects which are not captured in trends are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3.

Pages EB-4 and EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2012-13.

A description of the forecasting methodology for Medicaid caseload, including all adjustments, is located in the section titled "Medicaid Caseload" of this request.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

Medical Services Premiums per capita costs history through the most recently completed fiscal year and projections are included for historical reference and comparison. The Department provides two separate tables. On page EC-1, the Department provides the per capita cost history based on the cash-based actuals (i.e., the actual expenditure paid in the fiscal year). On page EC-2, the Department provides the per capita cost history adjusted for the FY 2009-10 payment delay; that is, the claims delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals.

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. These expenditures are included in the Baby Care Program – Adults aid category for FY 2009-10 and forward.

EXHIBIT D - CASH FUNDS REPORT

This exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented on Exhibit A. In addition, for the current year, total spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letternote amount on the Schedule 13. The Department also provides the specific requested changes to special bill appropriation clauses, when appropriate.

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

This exhibit is a summary of the requests by service group and by eligibility category for the current year, request year, and out year. It aggregates information from the calculations contained in Exhibits F, G, H, and I, along with presenting totals for populations without specific exhibits (Disabled Buy-In and Adults without Dependent Children), financing and supplemental payments, and caseload information.

Comparison of Request to Long Bill Appropriation and Special Bills

This exhibit contains a detailed summary of the Department's Budget Request by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation, as well as compares the current request to the Department's most recent prior requests for Medical Services Premiums. The Department has isolated individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. This exhibit includes all bottom-line impacts and financing but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical per capita costs and the annual percent changes are also provided. The first step of the calculation is to select a historical per capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom-line adjustments are made for legislation and other impacts not included in historical trends. Total expenditure after bottom-line adjustments is divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita, including a per capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2012-13. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the bottom of page EF-1, the Department has provided a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per capita costs is used to modify the request-year per capita costs, although the Department makes adjustments to the selected trend where necessary.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload or changes accounted for as bottom-line adjustments. The eligibility categories differ in eligibility requirements, demographics, and utilization, so different trends are used for each eligibility category.

The table below describes the trend selections for FY 2013-14, FY 2014-15, and FY 2015-16. In some cases, though not all, the Department has held the trend constant between the three years. In Exhibit F, the selected trend factors have been bolded for clarification. As described in the Department's caseload narrative, populations sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth has led to per capita declines due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2013-14, FY 2014-15, and FY 2015-16, with the rationale for selection, are as follows:

Aid Category	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.96% One-fifth the per capita growth rate in FY 2008-09 and FY 2010-11	0.96% One-fifth the per capita growth rate in FY 2008-09 and FY 2010-11	0.96% One-fifth the per capita growth rate in FY 2008-09 and FY 2010-11	Following several years of rate and budget reductions, per capita expenditure is expected to revert to an underlying pattern of growth in the population. The Department has selected a trend that captures the underlying stability in the per capita growth pattern for this population for FY 2013-14 through FY 2015-16.
Disabled Adults 60 to 64 (OAP-B)	2.06% The per capita growth from FY 2007-08 through FY 2009-10	2.06% The per capita growth from FY 2007-08 through FY 2009-10	2.06% The per capita growth from FY 2007-08 through FY 2009-10	This eligibility type displayed growth between roughly 1% and 3% in the past three years. The Department anticipates continued per capita growth over the next three years comparable to what was experienced between FY 2007-08 and FY 2009-10.
Disabled Individuals to 59 (AND/AB)	0.60% The per capita growth in FY 2005-06	0.60% The per capita growth in FY 2005-06	0.60% The per capita growth in FY 2005-06	Lower than expected growth experienced in FY 2012-13 year is likely attributable to Department interventions for cost containment that were particularly effective for this population. These reductions are now partly built into the base expenditure for this population. Therefore, the Department expects a trend equal to the per capita growth in FY 2005-06. This trend is expected to continue in the out years.
Disabled Buy-in	10.31% The average of second year growth for Expansion Adults to 60% and Expansion Adults to 133%	0.60% The AND/AB per capita growth rate in FY 2014-15	0.60% The AND/AB per capita growth rate in FY 2015-16	The Department has limited expenditure data for this newly eligible population. Consequently, the Department assumes per capita expenditure will be equal to the second year average per capita growth rates for the Expansion Adults to 60% and the Expansion Adults to 133% populations and will assume the same growth rate as Disabled Adults to 59 in FY 2014-15 and FY 2015-16.

Aid Category	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	0.41% The per capita growth rate in FY 2012-13	2.36% The per capita growth rate between FY 2006-07 and FY 2011-12 inflated by 50%	2.36% The per capita growth rate between FY 2006-07 and FY 2011-12 inflated by 50%	With high growth in caseload, per capita figures have declined in the last three years. Caseload is anticipated to continue to grow but at a less aggressive rate over the next three years. Consequently, the Department has selected a trend that accounts for the expected reversion to per capita growth for this population.
Expansion Adults to 60%	1.57% The per capita growth rate for the AFDC-A population between FY 2006-07 and FY 2011-12	2.36% The AFDC-A per capita trend estimate for FY 2014-15	2.36% The AFDC-A per capita trend estimate for FY 2015-16	Large increases in caseload have placed negative strain on per capita expenditure for this eligibility group. Although the rate of caseload expansion has slowed, the increase in caseload continues to affect per capita expenditure. Outpatient hospital expenditure, one of the largest cost drivers for this population, has placed slight positive pressure on expenditure, though overshadowed by decreases in other large service categories such as physician and EPSDT services. Therefore, the Department has selected a growth rate that is equal to the AFDC-A forecasted trend in FY 2013-14, FY 2014-15, and FY 2015-16. The Department expects that this population will converge with other low-income adult populations, and consequently expects a growth rate equal to the AFDC-A population in FY 2014-15 and FY 2015-16.

Aid Category	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Expansion Adults to 133%	1.57% Expansion Adults to 60% growth rate for FY 2013-14	1.57% Expansion Adults to 60% growth rate for FY 2014-15	1.57% Expansion Adults to 60% growth rate for FY 2015-16	In recent months, per capita expenditure for Expansion Adults to 133% has appeared to converge to the per capita of Expansion Adults to 60%. This occurrence is consistent with previous Department assumptions, which are based on the expectation that marginally higher income is correlated with marginally better health status and thus lower costs. Therefore, expenditure is expected to align half with the Expansion Adults to 60% population growth for out years.
Adults without Dependent Children	44.30%	2.36%	2.36%	The Department has limited data for this newly implemented population and has selected a trend that allows per capita expenditures to reach $7,500. This is based on ten months of expenditure data that the Department has collected since the program's inception. Out year growth rate projections are expected to align with other disabled populations.
Breast & Cervical Cancer Program (Page EF-7)	-2.36%	0%	0%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program per Capita Detail and Fund Splits" for a description of this trend factor.

Aid Category	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Eligible Children (AFDC-C/ BCKC-C)	0%	0%	0%	Per capita costs for children have historically been declining, with the exception of FY 2012-13 where costs were relatively flat. The Department assumes that negative growth in per capita expenditure in the past was related to Department interventions for cost containment and aggressive caseload growth. The trend selected for FY 2013-14 is therefore assumed to be zero. In out years, the Department expects per capita costs to be negligible. Therefore, the trends selected for FY 2014-15 and FY 2015-16 are set to zero as previously forecasted.
Foster Care	-3.17% The average per capita growth rate between FY 2011-12 and FY 2012-13	1.48%	1.48%	Historically, this eligibility category has had significant variation in per capita growth from year to year. The Department expects growth to be largely negative in FY 2013-14 and returning to a slightly positive trend in out years.
Baby Care Program - Adults (BCKC-A)	0.29% The average per capita growth from FY 2008-09 through FY 2009-10	0.15% One half the average per capita growth from FY 2008-09 through FY 2009-10	0.07% One quarter the average per capita growth from FY 2008-09 through FY 2009-10	The FY 2012-13 growth rate showed a large increase in per capita growth. However, to account for a long-term history of stability, the Department assumes a growth rate that is equal to the average per capita growth from FY 2007-08 through FY 2009-10 in FY 2013-14 and decreasing slightly in out years.
Non-Citizens	7.45% The average per capita growth from FY 2010-11 through FY 2011-12	7.45% The average per capita growth from FY 2010-11 through FY 2011-12	7.45% The average per capita growth from FY 2010-11 through FY 2011-12	Per-capita expenditure growth for this population has been relatively consistent over recent years, and actual growth rates from FY 2012-13 indicate that this is still the case. The Department has selected a per capita trend for these clients that reflects the FY 2010-11 and FY 2011-12 per capita growth, while maintaining consideration for the volatile history of the population.

Aid Category	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Partial Dual Eligibles	4.12%	4.12%	4.12%	Continued aggressive growth is expected for this population, as both utilization and the portion of expenditure not covered by Medicare increase over time. Therefore, the Department expects an aggressive growth rate equal to the per capita growth rates from FY 2005-06, not including outliers present in FY 2009-10 and FY 2010-11.

Legislative Impacts and Bottom-line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. These impacts are described briefly below and in detail in section V, Additional Calculation Considerations:

- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Saving estimates were previously reported under S-6 (FY 2010-11), BA-9 (FY 2011-12) and LRFI-6 (FY 2012-13); savings estimates have been consolidated. Additional detail can be found both in section V and in the Service Management section of the narrative.
- BRI-1 (FY 2011-12), Client Over-Utilization, expanded the Department's Client Over-Utilization Program (COUP). The program reduces expenditure by identifying clients that over-utilize ER, pharmaceutical, or physician services and assisting them in managing their care in a more cost-effective manner.
- Estimated Impact of Increasing PACE Enrollment accounts for the Department's initiative to increase enrollment of new PACE clients. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community-Based Long-Term Care service groups to the PACE service category.
- SB 10-167, Colorado False Claims Act, has four components. The first component increases enrollment in the Health Insurance Buy-In (HIBI) program. As of June 2013, there were 421 enrollees in the program. The Department expects to enroll over 1,500 more clients in the next two years. The second component of SB 10-167 is an automated prepayment review of claims through the National Correct Coding Initiative (NCCI). This system will produce savings by identifying coding errors prior to reimbursement of claims. The third component is a systems change that allows for coordination of the Department's pharmacy benefit with other

payers. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid who are eligible to enroll in the Medicaid programs of other states.

- Colorado Choice Transitions adjusts for increased home health service expenditure associated with clients transitioning to alternative care settings. Additional detail can be found in Exhibit G.
- R-6 (FY 2012-13), Dental Efficiency, reflects a refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated.
- R-6 (FY 2012-13), Augmentative Communication Devices, accounts for the availability of new, cheaper, communication assistance technology for clients with disabilities impairing their ability to communicate.
- R-6 (FY 2012-13), Pharmacy Rate Methodology Transition, is a significant fiscal impact driven by a change in reimbursement methodology for pharmaceuticals.
- R-5 (FY 2012-13) ACC Gainsharing allows the Department to share budgetary savings with primary care medical providers (PCMPs) and Regional Care Collaborative Organizations (RCCOs) in the ACC. Prior Behavioral Health Organization (BHO) and Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Gainsharing have been consolidated under ACC Gainsharing.
- Presumptive Eligibility Settlement is a one-time expenditure associated with payment of a settlement. The fiscal impact is limited to the 'Baby Care Adults' eligibility type.
- Fifty-Three Pay Periods in FY 2013-14 accounts for the Department's claims processing cycle including a 53rd payment period every seven years; the next occurs in FY 2013-14. This adjustment accounts for the addition payment period in FY 2013-14. The annualization of this one-time impact returning to expenditure to a 52-week base is found in FY 2014-15.
- SB 11-008, Aligning Medicaid Eligibility for Children, is an adjustment made to account for lower average per capita expenditure expectations for clients migrating from CHP+ to Medicaid under the implementation of the bill.
- R-7 (FY 2013-14), Substance Use Disorder Benefit, accounts for added expenditures associated with enhancing the existing substance abuse disorder benefit by adding appropriate services to make a more robust program.
- R-9 (FY 2013-14), Dental ASO, accounts for additional expenditures associated with implementing a dental administrative service organization (ASO) for the Medicaid children's dental benefit.
- R-13 (FY 2013-14), 2% Provider Rate Increase, accounts for added expenditures associated with increasing provider rates by 2% for services impacted by rate reductions in recent years.
- SB 13-242, Adult Dental Benefit accounts for added expenditures associated with providing a dental benefit for adults in the Medicaid program.
- SB 13-200 Medicaid Expansion adjustment is an adjustment made to account for lower average per capita expenditure expectations for clients newly entering the Medicaid program. Through this adjustment, the Department has maintained all assumptions regarding costs for expansion clients that were utilized in SB 13-200.

- Preventive Services accounts for the differences in the benefits packages between the expansion requirements and the current Colorado Medicaid benefits package. Colorado Medicaid offers preventive services not required under the expansion but still available to clients. An adjustment is made to account for this difference.
- NEMT Utilization Adjustment in Contract accounts for additional clients in the metro area utilizing NEMT services due to increased Medicaid caseload.
- Fluoride Benefit Expansion for Children accounts for additional costs associated with the expansion of fluoride varnish services to certain providers as required in a 2013 Long Bill footnote.

Initiatives that impact FY 2013-14 or FY 2014-15 only:

- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year, regardless of prior authorization.

Breast and Cervical Cancer Program per Capita Detail and Fund Splits

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program within the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. The Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 funds. The Department suggested the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection, and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" clients.

Per Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed the expenditure and per capita costs in FY 2005-06 grew at an unexpected rate. The Department investigated the issues involved and determined the total expenditure in FY 2005-06 contained a large amount of retroactive transactions, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the affected caseload is very small and changes to total expenditure, therefore, have a large impact on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as -32.73%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per capita expenditures. The Department assumes the decline in the per capita expenditures is a temporary product of increasing caseload and, as the new clients incur costs, the per capita rate will begin to slow down in its decline. For the current year trend, the Department analyzed per capita data in FY 2012-13 and applied the three month rolling average monthly percent change, -2.36%, in FY 2012-13 to the FY 2013-14 trend. The trend factor for each year is applied to the base per capita on page EF-5. At the end of FY 2013-14, the legislation authorizing the Breast and Cervical Cancer Prevention and Treatment fund sunsets. Therefore, there is no funding requested for these years. However, due to claims run-out, an adjustment for expenditure is added as a bottom line impact in FY 2014-15.

Fund Splits

The second half of this exhibit calculates the portion of Breast and Cervical Cancer Program expenditure that will be allocated to the Prevention, Early Detection, and Treatment Fund and the amount allocated to the Breast and Cervical Cancer Prevention and Treatment Program Fund.

Per 25.5-5-308(9)(d) and (e), C.R.S. (2013), enacted in HB 08-1373, State funding for ”traditional” Medicaid Breast and Cervical Program clients comes, in part, from the Breast and Cervical Cancer Prevention and Treatment Fund. According to the original legislation, beginning in FY 2009-10 and into the future, State funding would be split: 50% from General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 09-262 revised the statute, requiring 100% of state funding in FY 2009-10 through FY 2011-12 for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Beginning FY 2012-13, State funding is split, with 50% coming from the General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117(2)(d)(II), C.R.S. (2013), To the extent possible, based on appropriated revenue, State funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

As previously stated, after FY 2013-14, the legislation authorizing the Breast and Cervical Cancer Prevention and Treatment fund sunsets and new expenditure is not expected in FY 2014-15 or FY 2015-16, with the exception of claims runout from prior years.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department’s premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services’ portion of the budget and located

those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group within the Pharmaceutical Drug service category. Exhibit F, page EF-8 through EF-9, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational-only line item in Long Bill group (3), effective with HB 08-1375.

The Department experienced a large decrease in gross aggregate and per-capita acute antipsychotic pharmaceutical expenditure in FY 2012-13 due to several antipsychotic drugs going generic and per-unit costs decreasing significantly.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on data through quarter four of FY 2012-13. Historical actuals have been restated as the Department has transitioned from accrual-based accounting to cash-based accounting.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. Some family planning services are provided through fee-for-service, and, beginning in late FY 2001-02, the Department was also able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. Totals listed on page EF-10 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, the Department no longer has contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not

claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

The Department believes the 40.31% increase in reported total expenditure between FY 2007-08 and FY 2008-09 represents a level shift in expenditure that is the result of a concerted effort to educate providers as to which services are billable as family planning services. This effort was motivated by research indicating that, at the time of the study, only a fraction of allowable services were being appropriately billed.

In light of the Department's view of the increase between FY 2007-08 and FY 2008-09 as a one-time level shift, the FY 2013-14 estimate for total reported expenditure is the average of annual total reported expenditures for FY 2008-09 through FY 2012-13. This methodology is motivated by the Department's expectation of an upward expenditure trend, despite the sporadic behavior of total annual expenditures observed over the previous four fiscal years. As the Department anticipates family planning expenditures to resolve into a more stable growth pattern, estimates for FY 2014-15 and FY 2015-16 total expenditures are the result of the application of the average of annual growth rates for FY 2005-06 and FY 2006-07 to the previous year's estimated expenditure. The Department selected this time period as a model for future expenditure growth because it represents the most recent occasion for which moderate growth was observed in consecutive fiscal years.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" is expected to contribute $29,489 in local funds for FY 2013-14, $30,492 in local funds for FY 2014-15, and $5,253 in local funds for FY 2015-16. These contributions represent a substantial decrease relative to previous estimates. This is largely attributable to the Montrose County Department of Health and Human Services discontinuing their implementation of the program due to funding limitations. The Department will continue to explore opportunities to expand this program.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) was passed with the goal of improving the health status of American Indians and Alaskan Natives and encouraging tribes to participate as much as possible in the management of their health services. The law specified that the payments for inpatient and outpatient services and emergency transportation for Medicaid clients who are Indians with a legal tribe affiliation receive 100% federal financial participation. The Indian Health Service is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities.

The Department uses historical expenditure to estimate total expenditure for services to these clients. In FY 2008-09, Indian Health Service expenditure grew by 44.48%; in FY 2011-12, expenditure decreased by 14.21%. In an effort to forecast future expenditure

growth in a fashion representative of more regular patterns observed in other fiscal years, half the average annual growth for FY 2008-09 through FY 2012-13 was applied to FY 2013-14 expenditure. Estimated FY 2012-13 expenditure is then the sum of expenditures incurred in the first six months of FY 2012-13 and estimated second half expenditure. This growth is increased slightly in future years.

Prior-Year Expenditure

As an additional reasonableness check, this section presents last fiscal year's actual and per capita expenditure by six month intervals. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The change in per capita by six-month period can be quickly compared, and the prior year's per capita costs may be referenced with pages EF-1 and 2 of this request.

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home- and Community-Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2011-12, the Department paid HCBS claims for an average of 23,651 clients per month.

Clients receiving CBLTC services have access to 12 HCBS waivers each targeted to specific populations. Of the 12 waivers, nine are administered by the Department, and the other three are managed by the Department of Human Services. The waivers administered by the Department of Health Care Policy and Financing include:

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[1]
- Disabled Children's Waiver
- Persons Living with AIDS Adult Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver[2]

[1] Previously known as "Persons with Mental Illness"
[2] Previously known as "Pediatric Hospice Waiver"

- Spinal Cord Injury Adult Waiver

Calculation of Community-Based Long-Term Care Expenditure

In FY 2012-13, the Department adjusted the CBLTC forecasting methodology from an eligibility-type forecast to one that forecasts each of the Department's HCBS waivers individually. The Department believes this to be a more accurate way of forecasting CBLTC because each waiver targets certain populations and provides services targeted at those clients. In CBLTC, each eligibility type has clients receiving services in a number of waivers. Because each waiver's services vary depending on the target population, any change to a program could impact multiple eligibility types thus making it difficult to forecast and identify the root of significant changes in historical trend.

The new methodology includes a forecast for each waiver's enrollment and cost per enrollee. Percentages selected to modify enrollment or per-enrollee costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, trend factors must not take into account changes accounted for as bottom-line adjustments. Because each HCBS waiver differs in eligibility requirements, demographics, and utilization, different trends are used for each waiver.

The selected enrollment trend factors for FY 2013-14, FY 2014-15, and FY 2015-16, with the rationale for selection, are below. In most cases, the Department kept the trend for the out year the same as the request year. In situations where the out years do not carry the same trend, the variation is noted.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2013-14 through FY 2015-16: Linear Forecast: 4.87%, 4.74%, and 4.53% respectively	FY 2013-14: 2.67% - Service utilization adjustment. FY 2014-15 through FY 2015-16: 1.98%, 1.94%, linear trend	Enrollment history is very steady, growing at a little over 5% per year. The enrollment trend selected continues historical growth both in the request year and the out year. Many service per-enrollee costs have increased in the past year (CDASS, IHSS, Homemaker), as well as the CDASS per utilizer cost . Due to the increase cost per enrollee in high cost areas, The Department has increased the cost per enrollee slightly higher than the past five-years average growth of 2.24%. However, the Department expects the cost per enrollee trend to continue in the out year but at a trend that is closer to the historical average.
Community Mental Health Supports Waiver (CMHS)	FY 2013-14 through FY 2015-16: Linear: 8.06%, 5.83%, and 5.51% respectively	FY 2013-14 through FY 2015-16: Linear: 1.90%	This waiver has seen growth beyond a linear trend over the last 12 months. To account for the recent growth, a one-time level shift to 8.06% was selected. The Department expects growth to continue, but at a rate similar to historical growth. While per-enrollee cost for alternative care facilities (the highest per-enrollee expenditure category) have decreased, the per-utilizer and per-enrollee costs for CDASS have increased rapidly. In addition, utilization of personal care and participant directed care programs continue to grow. Because the per-utilizer and per-enrollee cost for CDASS is much higher than the average CMHS client, the Department chose a positive linear trend for FY 2013-14 through FY 2015-16.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2013-14 through FY 2015-16: Average Growth from FY 2012-13: -1.23%, 1.07%, and 1.06% respectively	FY 2012-13 through FY 2015-16: Linear Growth, 37.71%	Enrollment growth has been significantly negative over time, as the waiver eligibility criteria changed. This trend reversed in FY 2012-13, showing over-all positive growth, with a decrease toward the end of the year. The Department expects this positive growth to continue and has chosen a linear forecast. Only two services are offered on the waiver: In-home Supportive Services - Health Maintenance Activities and case management. Extremely large growth in per-utilizer costs were driven by In-home Supportive Services (IHSS) - Health Maintenance Activities enrollment and expenditures. The number of clients nearly doubled, while the per-utilizer and per-enrollee costs increased at 15.06% and 104% respectively for IHSS-Health Maintenance. With only 124 out of 1,134 clients on the waiver enrolled in IHSS, the Department does not foresee per-utilizer cost growth slowing during the request period as more families enroll in IHSS.
Persons Living with AIDS Waiver	FY 2013-14 through FY 2015-16: Linear Growth: 11.11%, 4%, and 5.77% respectively	FY 2013-14 through FY 2015-16: Linear Growth: -13.21%, -9.91%, and -7.43% respectively	Enrollment has increased steadily. This trend was selected to be consistent with the history, as there are no indications that this should change. Per-utilizer costs have been dropping over the last few years. There have been major advances in drug therapy for these clients, so it is likely they do not need as intensive services provided in the waiver, as their health is more easily stabilized with medication.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Consumer Directed Attendant Support-State Plan	FY 2013-14 through FY 2015-16: Linear Growth: -9.09%, 10%, and -11.11% respectively	FY 2013-14 through FY 2015-16: no growth	Additional enrollment in this program is currently prohibited; the negative growth rates reflect clients leaving the program. The Department chose a trend consistent with a small number of clients leaving the program each year. The Department expects this pattern of attrition to continue. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit; interestingly, the average cost per-enrollee reached its peak in FY 2011-12 and then decreased in FY 2012-13, suggesting that client allocations have reached stability. Therefore, the Department chose to keep the growth of the per-enrollee cost flat, at the FY 2012-13 rate.
Brain Injury Waiver	FY 2013-14 through FY 2015-16: Linear Growth: 9.72%, 3.32%, and 2.86% respectively	FY 2013-14 through FY 2015-16: Linear Growth: 4.52%, 3.39%, and 2.54% respectively	Historically there has been slow and steady growth in BI enrollment. The Department saw this growth increase rapidly in FY 2012-13. To account for the most recent growth, there is a one-time level shift in FY 2013-14. The Department expects waiver enrollment to grow in FY 2014-15 and beyond at a linear growth rate. There has been small, positive per-enrollee cost growth over the last several years. Due to the large waiver growth and clients slowly entering the HCBS system, the cost per-enrollee trend decreased in FY 2012-13. Recently, policy has made several changes

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
			to the waiver to make services more accessible. Therefore, the Department doesn't expect negative growth to continue, as clients find providers and start receiving services. Thus a linear positive growth trend was chosen.
Children with Autism Waiver	FY 2013-14 through FY 2015-16: Linear Growth: 1.56%, 1.54%, and 3.03% respectively	FY 2013-14 through FY 2015-16: Linear Growth: 2%	This waiver is capped at 75 clients. This cap has already been met, and the waiver currently has a waiting list. Average monthly enrollment is consistently below 75 clients because of client churn; however, there are no available spots on the waiver. The waiver has seen above average growth in FY 2012-13. The growth is linear, but because of recent waitlist prioritization changes, slight growth is expected to continue. It is likely the reason costs per enrollee have been dropping is that clients are not on the waiver very long before they age out. As a result, the clients do not receive many services while on the waiver. Client access issues have been addressed and service utilization should increase. The Department anticipates this growth and chose 2% growth rate.
Children with Life Limiting Illness Waiver	FY 2013-14 through FY 2015-16: no growth	FY 2013-14 through FY 2015-16: Linear Growth: 6.31%	Recently, waiver programmatic changes have improved the program resulting in large positive growth. The waiver is capped at 200 clients and average enrollment is anticipated to be around 190

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
			clients. Therefore, the Department anticipates a 0.00% growth rate, as the waiver is capped at 200 clients. In the last two years, cost per enrollee have stabilized. The Department anticipates this to continue and used the FY 2011-12 to FY 2012-13 growth rate and trended that forward.
Alternative Therapies Waiver	FY 2013-14 through FY 2015-16: growth to the cap, 700%, 4.69%, and 0% respectively	FY 2013-14 through FY 2015-16: No change	Enrollment in the waiver grew slower than anticipated in FY 2012-13, but the Department anticipates the waiver enrollment to be around the cap of 67 clients by the end of FY 2013-14. There will be little turnover as clients are likely to remain on the waiver for an extended period of time as they receive services. For per-enrollee growth, the Department chose the cost per enrollee from FY 2012-13 and kept that constant. As clients will cost more in the first year of receiving services than in later years, and more clients are enrolling in year two.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-enrollee or trend factors, the Department adds total-dollar bottom-line impacts to the projected enrollment or expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the Request for Community-Based Long-Term Care:

Expenditure

- Annualization of HB 09-1047 "Alternative Therapies for Clients with Spinal Cord Injuries" - HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services include massage, acupuncture, and chiropractic care. The Department received approval for the waiver in July 2012.
- Annualization of SB 12-159 "Evaluate Children with Autism" – SB 12-159 enabled the Department to review the CWA waiver program at the time of federal renewal, assess the outcome of client therapies prior to age six, and determine if there was enough funding to increase the wavier cap.
- Adjustment for 53 pay periods – there are normally 52 periods, in FY 2013-14 there is an extra pay period.
- Colorado Choice Transitions - The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community-based services. The program began enrolling clients in May 2013.
- CLLI Audit Recommendations – Audit recommendations for the CLLI waiver increased the access to services, by simplifying access and billing, and increased the number of services to match the needs of children with life limiting illnesses.
- 8.26% Rate Adjustment – In FY 2012-13, the Joint Budget Committee approved an 8.26% rate increase for HCBS services.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community-Based Long-Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services, and home health services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. Savings from the enhanced match are required to be used to improve the long-term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the two types of services the Department will offer through the program, demonstration (new services offered through the program), and qualified services (existing waiver services and home health). These costs are reflected in Exhibits F and G, Community-Based Long-Term Care as a bottom line impact. The exhibit then reports the savings anticipated from transitioning clients from nursing facilities which is reflected in Exhibit H, Class I Nursing Facilities as a bottom-line impact. Following the net impact of the program, the Department reports on the rebalancing funds the Department anticipates earning. Rebalancing funds are calculated as 25% of total expenditure and are 100% federal funds.

The Department has delayed implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented on March 1, 2013, with the first client transitioning in May 2013. The

Department currently anticipates approximately 100 clients will transition per 365 day beginning in May 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of $106,050 total funds in FY 2013-14 and a reduction of $1,443,085 in FY 2014-15. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2012-13 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2013-14, FY 2014-15, and FY 2015-16 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – are expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. These expenditures represented approximately 79% of total hospice expenditure in FY 2012-13. The remaining portion of hospice expenditure is represented under the Hospice Services category and includes Hospice General Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

Payments made to nursing facilities for services provided to hospice clients differ from payments made for Class I Nursing Facility clients, most significantly in two predominant ways: there is no patient payment component of the per diem, and the per diem for hospice clients is prescribed to 95% of the per diem for Class I Nursing Facility clients. Otherwise, the methodology for forecasting nursing facility room and board expenditures for hospice clients mirrors the Class I Nursing Facility forecast.

To create the patient days forecast, the Department used claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day counts; then, the Department used an autoregressive model with seasonality to estimate patient days for the years covered in this request. As hospice client nursing facility per diems are linked to the per diem for Class I Nursing Facility clients, they are assumed to grow at the same 3% per-year rate. Rate reductions are accounted for in the same fashion as they are for nursing facilities: their impact is included in calculations as a bottom-line impact. Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted patient per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year.

Please refer to the portion of the narrative devoted to Class I Nursing Facilities for a more detailed description of IBNR analysis, the 3% general fund growth cap for nursing facility rates, and nursing facility rate reductions. Additional information is available in footnotes (1) through (6) in the footnotes section of the hospice forecast.

The second category of hospice expenditure, referred to throughout the hospice forecast as Hospice Services, contains all hospice expenses other than those accrued as payments to nursing facilities for room and board for hospice clients.

The largest component of this expenditure category is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two to three times per week, generally by nurses. In FY 2012-13, Hospice Routine Home Care expenditure was approximately $7.8 million and thus represented 84% of hospice services expenditure and 18% of total hospice expenditure. Hospice Routine Home Care expenditures are computed as a product of patient days and the daily rate. The Department arrives at estimates for days for FY 2013-14, FY 2014-15, and FY 2015-16 by using an autoregressive model with seasonality and linear time trend. The Hospice Routine Home Care per diem is forecasted by applying a linear time trend to observed daily rates between FY 2007-08 and FY 2011-12.

The next-largest component of hospice services expenditures is Hospice General Inpatient Care. These expenditures are incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2012-13, the Department paid approximately $1.7 million for Hospice General Inpatient Care. The Department selected a linear time trend applied to historical claims data with seasonal dummy variables added depending on whether the expenditure took place in the first or second half of the year to develop expenditure forecasts for FY 2013-14, FY 2014-15, and FY 2015-16.

The remaining components of hospice services expenditures in total represent less than $45,000 of expenditure for FY 2012-13; in every prior year except FY 2011-12, they accounted for less than $50,000 of combined expenditure. As such, the Department chose to aggregate the remaining expenditure and apply the average growth rate for FY 2011-12 and FY 2012-13 to the FY 2012-13 observation for the same aggregation to develop an estimate for FY 2013-14 expenditure. FY 2014-15 and FY 2015-16 expenditure estimates are results of the application of the same growth rate to the previous fiscal year's estimate.

Private Duty Nursing

Private Duty Nursing (PDN) services are face-to-face skilled nursing services provided in a more individualized fashion than comparable services available under the home health benefit or in hospitals or nursing facilities and are generally provided in a client's home. PDN services are billed hourly; maximum daily eligibility is 16 hours for adults and 24 hours for pediatric clients. There are five categories of PDN expenditure: individual services provided by a registered nurse (RN), group services provided by a registered nurse (RN-group), individual services provided by a licensed practical nurse (LPN), group services provided by a licensed practical nurse (LPN-group), and blended services. RN services are associated with the highest hourly rate and LPN-group services with the lowest. The remaining three services – RN-group, LPN, and blended – charge the same intermediate rate. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change.

As PDN expenditure is the product of the hourly rate and the number of hours, and the Department expects rates to remain constant, expenditure forecasts for FY 2013-14, FY 2014-15, and FY 2015-16 are primarily based on days forecasts for those fiscal years. The days forecast is separated into three pieces that are consistent with the three rate groups: RN hours; RN-group, LPN, and blended hours; and LPN-group hours.

In FY 2012-13, the Department paid claims for 1,126,357 total hours for PDN services; 658,438 were billed as RN hours. Linearly regressing RN hours between FY 2008-09 and FY 2011-12 explains 98.8% of the variation in hours. As such, the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2013-14, FY 2014-15, and FY 2015-16. This model predicts growth at around 12% annually over the course of the next three fiscal years.

RN hours were stable prior to FY 2008-09 but began increasing significantly in FY 2009-10. The Department examined RN hours per distinct client per month between FY 2005-06 and FY 2011-12 in an effort to investigate potential causes for the increase in hours. While there was a slight upward trend in RN hours per distinct client per month over the course of this period, this alone is far from sufficient to explain the growth in aggregate hours. This analysis was extended to the other two groups of PDN service. No discernible trend exists in changes of hours per distinct client per month. For all three categories of PDN service, changes in usage appear to be driven entirely or almost entirely by the addition of new clients.

As is consistent with RN services, paid hours for the intermediate-rate group of PDN services – RN-group, LPN, and blended – were largely stable between FY 2005-06 and FY 2008-09 before reporting rapid growth in FY 2009-10 and FY 2010-11. Unlike RN services, however, growth for these services was very small between FY 2010-11 and FY 2011-12, but then jumped up again from FY 2011-12 to FY 2012-13. To this end, the Department elected to estimate hours for the next three fiscal years for these services by applying the average annual growth rate between FY 2005-06 and FY 2012-13. This methodology produces a more moderate increase in hours relative to the previous year than a linear forecast.

LPN-group services have both the smallest rate and represent by far the smallest portion of PDN claims. In FY 2012-13, these services accounted for only 28,805 hours of claims, or 2.5% of total hours. Due to erratic growth rates in recent years, the Department chose to forecast the next three fiscal years LPN-group hours by applying the annual growth rate from FY 2009-10 to FY 2012-13, 8.76%.

Final expenditure estimates for FY 2013-14, FY 2014-15, and FY 2015-16 are produced by multiplying projected hours by the projected rate for each of the three service category and then summing these figures. The Department is forecasting between 9% and 10% growth in annual total expenditure for PDN services in each of the three upcoming fiscal years.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

This section is for a series of services that, for a variety of reasons, are individually computed and then allocated to the eligibility categories based on experience. Those services are:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request

This exhibit summarizes the total requests from the worksheets within Exhibit H.

Class I Nursing Facilities

Class I Nursing Facility costs are a function of the application and interpretation of rate reimbursement methodology specified in detail in State statute, the utilization of the services by Medicaid clients, and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict: 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% (through the FY 2009-10 total) since FY 1999-00. This is due to efforts by the Department to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Recent history makes it difficult for the Department to anticipate the behavior of patient days; patient days had been trending upward, but fell unexpectedly in the past six months.

Patient payment is primarily a function of client income. As clients receive cost-of-living adjustments in their supplemental security income, their patient payment has increased accordingly.

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities that do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

The new reimbursement methodology was further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

HB 10-1324 imposed a 1.5% reduction to FY 2009-10 rates, effective March 1, 2010. HB 10-1379 imposed a 2.5% reduction to FY 2010-11 rates, effective July 1, 2010. The effect of the rate reductions is not cumulative; that is, the total reduction in FY 2010-11 is 2.5%. The rate is restored to the full level effective July 1, 2011. HB 10-1379 also reduced the maximum General Fund growth of the core per-diem rate to 1.9% for FY 2010-11, increasing to 3% in FY 2011-12 and subsequent years.

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non-Medicare day. These changes, however, had no impact on the General Fund portion of nursing facility rates. SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

HB 12-1340 extended the 1.5% rate reduction of SB 11-125 into FY 2012-13. The reduction expired June 30, 2013.

HB 13-1152 extended the 1.5% rate reduction of HB 12-1340 permanently, effective July 1, 2013. As all other rate reductions expired before the start of FY 2013-14, this reduction represents the total value of the rate reduction for FY 2013-14. For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[3]:

[3] For clarity, FY 2013-14 is used as an example. The estimates for FY 2014-15 and FY 2015-16 are based on the estimate for FY 2013-14, and follow the same methodology.

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2013-14.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment for claims that will be incurred in FY 2013-14. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2013-14 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2013-14.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2013-14.
- Of the estimated total reimbursement for claims incurred in FY 2013-14, only a portion of those claims will be paid in FY 2013-14. The remainder is assumed to be paid in FY 2014-15. The Department estimates that 92.95% of claims incurred in FY 2013-14 will also be paid during FY 2013-14. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2013-14.
- During FY 2013-14, the Department will also pay for some claims incurred during FY 2012-13 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2012-13 to calculate an estimate of outstanding claims to be paid in FY 2013-14.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2013-14 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2013-14, this includes run out from HB 12-1340, which introduced a 1.5% rate reduction effective July 1, 2012. HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013, is also included.
- There are 53 payment cycles in FY 2013-14 rather than the typical 52. Footnote 9 calculates the adjustment derived from the difference in expected expenditure between four-payment and five-payment months, which is added as a bottom-line impact.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2013-14 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation

Considerations. The following impacts have been included in the FY 2013-14, FY 2014-15, and FY 2015-16 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2013-14 through FY 2015-16. Please refer to Footnote 6 on page EH-8 for more detail. The estimate for FY 2013-14 is calculated by multiplying the average rate increased by inflation by 12 times the average days per month by first date of service. The percentage increase of the FY 2013-14 estimate over the FY 2012-13 actuals is applied over FY 2014-15 and FY 2015-16 to estimate the expenditure for those years.
- Prior to FY 2010-11, the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2013-14, FY 2014-15, and FY 2015-16. FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform," increased the number of Department auditors resulting in additional audits of nursing facilities. As such, there was a large increase in recoveries observed in FY 2011-12 related to the prior fiscal year and the following fiscal years. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-8 contains additional detail about these recoveries.
- HB 12-1340 implemented a 1.5% rate reduction for Class I Nursing Facilities per diems effective July 1, 2012, through June 30, 2013. As a result of claims run-out, the fiscal impact of this bill extends into FY 2013-14. Footnote 8 on page EH-9 contains additional detail regarding the fiscal impact of this bill.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non-Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments but will be unable to fully fund growth beyond the General Fund cap. The Department estimates approximately 57% of growth beyond the General Fund cap will be supported by the provider fee.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.
- The Colorado Choice Transitions adjustment accounts for the reduction in Class I Nursing Facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in Exhibit G.

Incurred-But-Not-Reported Adjustments

As part of the estimates for the allowable per-diem rate, patient payment, and patient days, the Department utilizes the most recent four years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model which examines past claims by month of service and month of payment to estimate the amount of claims that will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. IBNR adjustment analyzes the prior pattern of expenditure (specifically, the lag between the time past claims were incurred and when they were paid) and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly footnotes 4 and 5 of Exhibit H, page EH-7. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2012-13 that will be paid in FY 2013-14 and the percentage of claims incurred in FY 2013-14 that will be paid in FY 2013-14 and subsequent years. The Department applies the same factor to the FY 2014-15 and FY 2015-16 estimates.

The Department uses the IBNR adjustment calculation for the November 2013 Budget Request using paid claims data through April 2013. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting the time between the date of service and the payment date of a typical claim may be decreasing.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009, November 2009, February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%
November 2012	92.43%
February 2013	92.75%
November 2013	92.95%

Patient Days Forecast Model

To forecast patient days, the Department selected a seasonal with a linear time trend. This model was selected because the data exhibits monthly seasonality and follows a trend over time. An auto-regressive model could not be applied due to the presence of a unit root, indicating that the data exhibits non-stationarity.

The Department presents statistical results supporting the selection of this forecasting model: the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. The Adjusted R Squared of the model is 0.978, indicating that 97% of the variance in the data is explained by this model.

Testing the Overall Predictive Ability of the Model

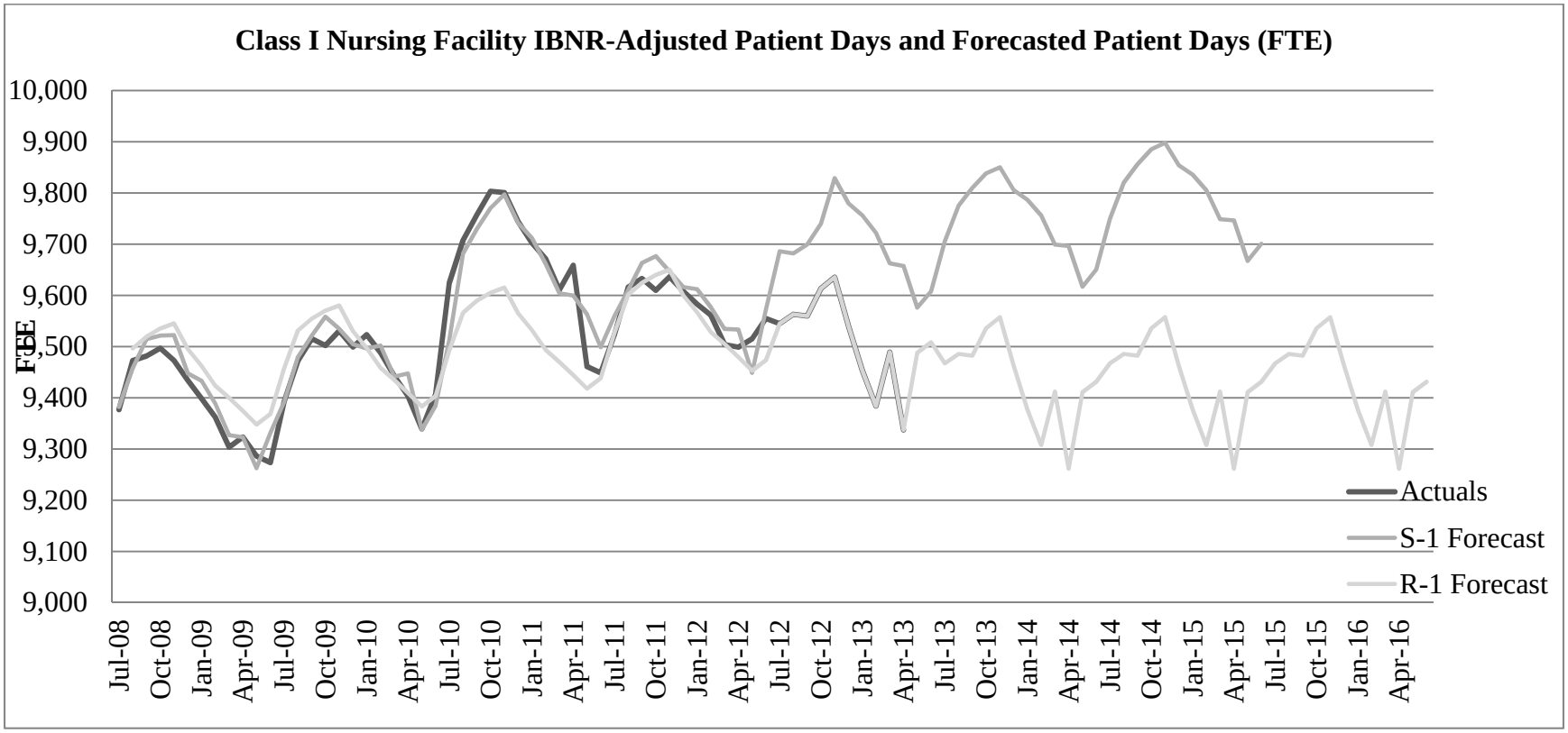
The F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. This test indicates how well the components of the model together generate valid forecasts. With a p-value of 0.0000, the patient days model is statistically significant at the 99% confidence level.

Forecasting Patient Days

Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the

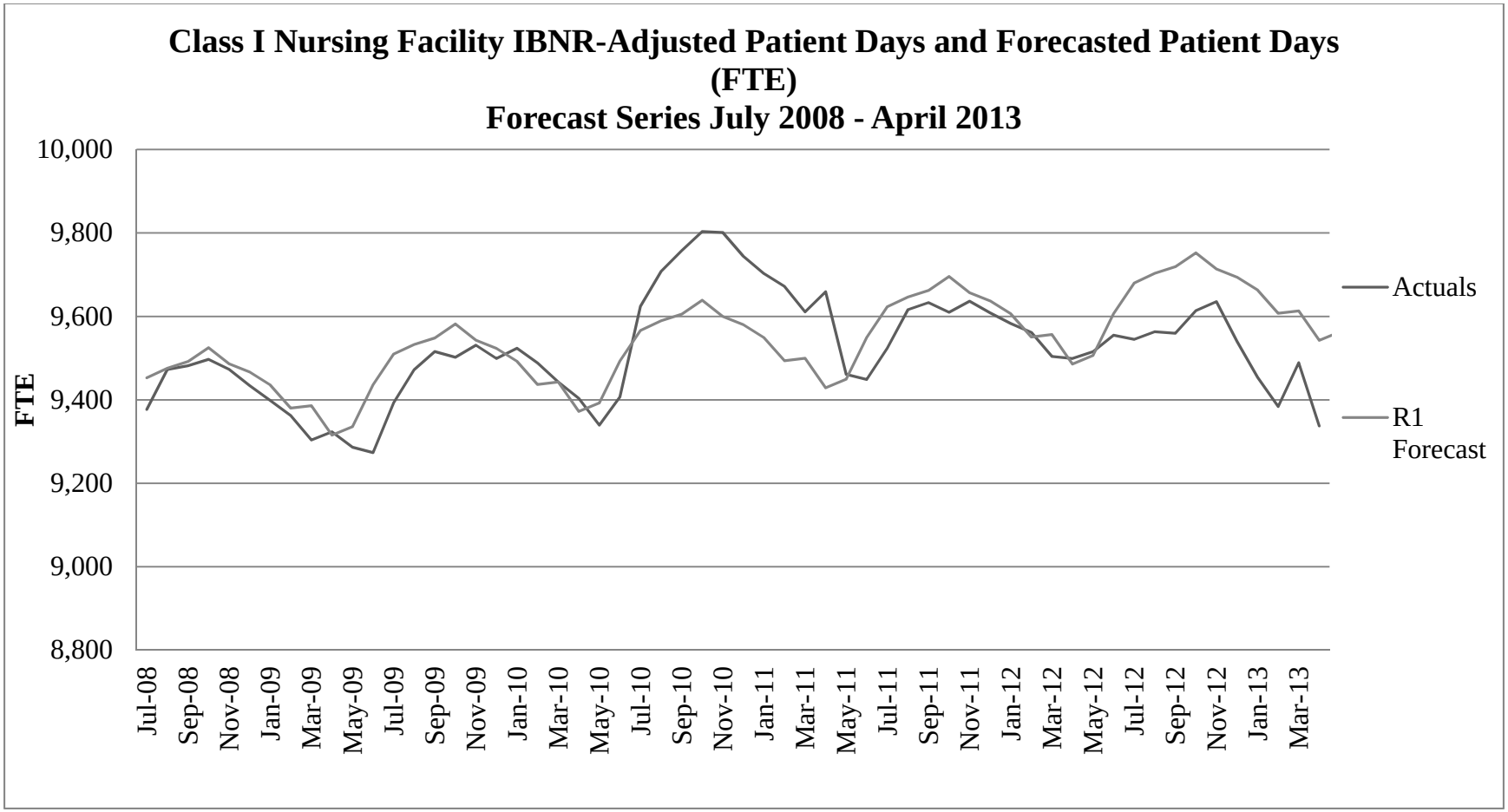
number of FTE (full time equivalent) days. Trending is done using the FTE days, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month.

Historically, the Department's efforts toward increasing utilization of Home- and Community-Based Services have resulted in downward pressure on the Class I Nursing Facility days trend. However, in the face of an aging population and ever-increasing demand for long-term care services, recent years have displayed a return to marginal annual growth in patient days. The most recent six months of data has shown a drop in patient days. Because of the uncertainty of future behavior of patient days, the Department assumes days will fall slightly in FY 2013-14 and estimates no growth for FY 2014-15 and FY 2015-16 to remain fiscally conservative.



Ex Post/In-sample Forecasts

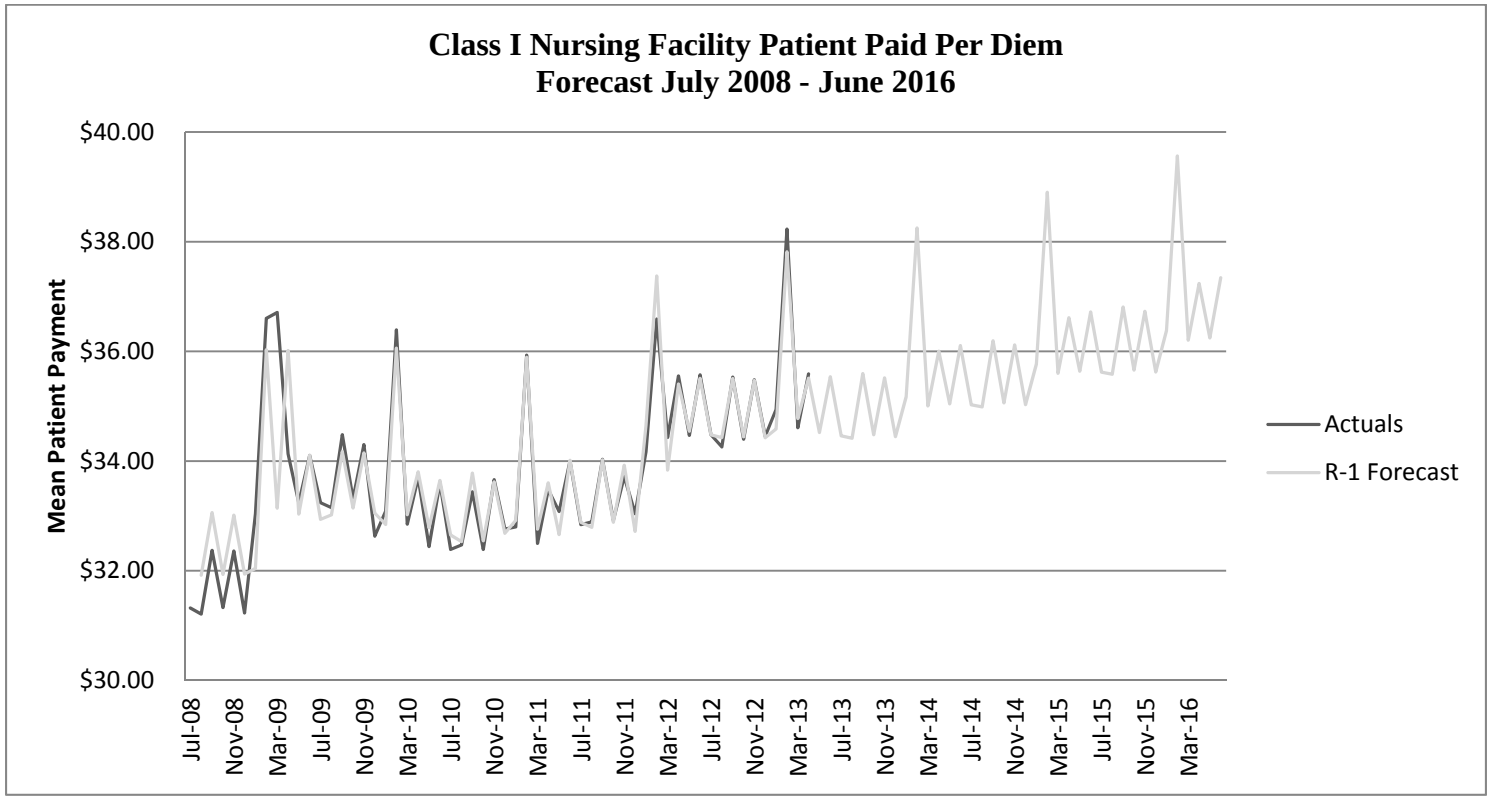
Because ex post/in-sample forecasts usually serve as an additional test of the reasonableness and robustness of the forecasts, the Department calculated an in-sample forecast (using the data from July 2008 through October 2012) and compared the results to actual data reported for November 2012 through April 2013. Rather than serving as a test of reasonableness and robustness, the in-sample forecast highlights the abnormality of the most recent data points.



The Ex Post Forecast model overestimates FTE in the forecast period For May 2012 through April 2013. Observed patient days in FY 2012-13 make a departure from previously observed seasonality. More information is necessary to determine whether the data will return to previous levels. Currently, it is assumed that it will do so.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted autoregressive model with a dummy variable to account for cost of living adjustment (COLA) increases to forecast patient payment.



Testing the Stationarity of the Model

To test the stationarity of the patient paid series, a t-test testing the null hypothesis that the series exhibits non-stationarity is used. The series is stationary.

Hypothesis Testing	
t-statistic	-2.92483
Rejection Region for 99% confidence	-2.624
Conclusion: Reject the null hypothesis that there is a unit root at the 99% confidence level. An auto-regressive model can be used with this series.	

Testing the Overall Predictive Ability of the Model

Again utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. Like the patient days model, the patient payment model also has a p-value of 0.0000 and is statistically significant at the 99% confidence level. R-squared for the model is 0.969, suggesting 96.9% of the variation in this series can be explained by the linear trend.

Nursing Facility Rate Methodology Changes

The following is a timeline of changes to Class I Nursing Facility policy:

FY 1997-98	8% Health Care Cap and 6% Administrative Cap Implemented
FY 1998-99	No change
FY 1999-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 2000-01	No change
FY 2001-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program/Resident Centered Quality Improvement Program discontinued
FY 2002-03	Administrative Incentive Allowance removed for three months then reinstated
FY 2004-05	8% Health Care Cap reinstated
FY 2005-06	No change
FY 2006-07	8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.

FY 2007-08	Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
FY 2008-09	New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.
FY 2009-10	The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.
FY 2010-11	HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.
FY 2011-12	SB 11-125 increased the level of the provider fee to $12.00 per non-Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
FY 2011-12	SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2012.
FY 2012-13	HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2013.
FY 2013-14	HB 13-1152 extended the 1.5% rate reduction from the prior year. The rate reduction is permanent.

Department Forecast Methodology Change

With the Department's November 1, 2011 Budget Request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate-setting methodology in statute. To generate the nursing facility forecast using the previous methodology, claims that were 100% patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100% patient payment impact the next year's rate. To more accurately forecast the per-diem rates, the revised

forecast methodology, claims with 100% patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

This methodology allows for a more accurate forecast of the statewide aggregate per-diem net of patient payments. Additionally, with this methodology, patient payment and patient days more accurately reflect what were actually paid or incurred.

The Department updated its methodology for calculating the nursing facility per diem for the November 2012 request. The Department developed the weighted average per diem for FY 2012-13 by weighing FY 2012-13 per diems for each provider by the FY 2011-12 provider days distribution. Previously, the Department forecasted per diems in aggregate; this methodology would only be accurate if the provider-days distribution were uniform. As this is not the case, the Department's new methodology addresses variance between the forecasted per diem and the observed per diem in two ways: first, the current year per diem is based on actual rates rather than a projection of rates, and, second, the Department uses provider days from FY 2011-12 as a proxy for provider days for FY 2012-13 rather than assume the distribution to be uniform.

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category

For comparison purposes to other service categories, this exhibit lists prior-year expenditure along with the projected expenditure from page EH-3. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year. Supplemental payments made to Class I Nursing Facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

Totals for each aid category are used to calculated total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. At the end of FY 2005-06, the provider increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility remained constant**.** Additionally, this facility received an annual cost-based rate adjustment, similar to Class I Nursing Facilities. As a result, this service category experienced expenditure growth that differs sharply from previous years. FY 2009-10 enrollment rates were

slightly lower than in the previous years. However, for FY 2010-11 and FY 2011-12, enrollment returned to the 20 client enrollment level. There was a rate increase for FY 2012-13 based on audited cost reports from CY 2011, which more than doubled expenditure for FY 2012-13 compared to the previous year. The estimated growth rate for FY 2013-14 is based on anticipated changes in per-diem reimbursement using information from unaudited cost reports for CY 2012, which show a 30% drop in the rate from FY 2012-13 to FY 2013-14. Because all clients are paid the same rate regardless of aid category, the Department anticipates that expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 50 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

Effective with the November 1, 2007 Budget Request, the Department has substantially revised the methodology used to calculate the projections for PACE expenditure. In prior years, the Department performed a per capita-based estimate, similar to the Acute Care and Community-Based Long-Term Care projections. However, enrollment trends in PACE are different from the overall Medicaid population. Therefore, the standard per capita measure is unreliable, in that it does not reflect the true cost of serving a client enrolled in PACE.

HB 08-1374 removed the requirement that the Department reimburse PACE providers at 95% of the equivalent fee-for-service cost, effective July 1, 2008. The Department now pays providers the lesser of the 100% rate or the federal upper payment limit.

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: average monthly enrollment and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System (MMIS). The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

In recent years, the Department has added a number of new PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in the spring of 2010, however this plan is on hold. Rocky Mountain Health Care began serving

clients on December 1, 2008, in El Paso County. Total Long Term Care, the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo, and another facility is scheduled to open in northern Colorado in late summer of CY 2014.

Expenditure estimates for PACE for FY 2013-14, FY 2014-15, and FY 2015-16 are the product of two pieces: projected enrollment and cost per enrollee. As is consistent with convincing historical enrollment data suggesting linear trends for PACE enrollment, linear regression models are used to estimate future enrollment on a by-provider by-eligibility-type basis. Enrollment caps are not anticipated to limit growth for the forecast period as a result of the manner in which PACE services are provided: that is, clients are not full-time residents of PACE facilities. The Department observed dramatic growth in PACE enrollments during the first six months of FY 2012-13; a substantial majority of this growth is attributable to growth in clients enrolled in a single PACE provider. The growth resumed usual levels for the remainder of FY 2012-13, however. The Department anticipates a new facility in northern Colorado to begin serving clients during late summer of 2014. The Department received enrollment estimates from the future administration of the new facility and anticipates that the initial enrollment pattern for this facility will follow these estimates, rather than those for more mature facilities in other parts of the state.

Per-enrollee costs for FY 2013-14 are determined by cross-walking the actual FY 2013-14 rates for PACE services with an eligibility-type distribution estimate derived from FY 2013-14 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2013-14 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

PACE rates have been declining since FY 2008-09. The Department believes rate cuts for other services that are components of the PACE rate calculations have contributed significantly to this trend. Additionally, there has been a shift in the methodology for the calculation of institutional-to-non-institutional client splits for PACE, which has resulted in a dramatically different view of the client population. Previously, the calculation – prepared externally – reflected a proportion of high-cost institutional clients as high as 85%. A revision to this process resulted in estimates of high-cost clients of only 50% to 55%. As the Department views this revision as representative of a level-shift in reported client distribution, this source of downward rate pressure is not expected to drive changes in PACE rates in the future. PACE rates for FY 2013-14 increased by an average of more than 10% over the previous year's rates, considered to be due to the rate increase for Home- and Community-based Long-Term Care. Further, the Department anticipates other components of the PACE rate calculation will demonstrate upwardly-trending behavior. To this end, the Department is projecting moderate growth in cost-per-enrollee figures for FY 2014-15 and FY 2015-16. The rate trend is the average of FY 2006-07 through FY 2011-12 cost-per-enrollee growth (1.31%) and is applied to each eligibility type separately rather than in an aggregate fashion.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[4] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as "Medicare Qualified Individual (1)." Legislation for the second group, referred to as "Medicare Qualified Individual (2)," comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[5]

[4] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

[5] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%
2013	$441.00	-2.21%	$104.90	5.01%

These premiums reflect the standard Medicare premiums paid by most Medicare recipients or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium. Additionally, some clients pay higher Part B premiums based on higher adjusted gross income, however, the Department is only required to pay the base premium cost.

To forecast FY 2013-14, the Department inflates the actual expenditure from the second half of FY 2012-13 by the increase in caseload from FY 2012-13 to FY 2013-14. This generates the anticipated expenditure for the first half of FY 2013-14, as there will be no increases to Medicare premiums during this period. Expenditure for the second half of FY 2013-14 is calculated by inflating the estimated first half of the year's expenditure by the anticipated increase in Medicare premiums effective January 1, 2014, or 6.34%. This change in premiums is based on the average change in premiums from CY 2004 to CY 2013. Rates for CY 2014 have not yet been announced by CMS. The Department will update this component of the forecast in the February supplemental request. The total estimated expenditure for FY 2013-14 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2014-15, the Department first inflates the estimated expenditure from the second half of FY 2013-14 by the estimated caseload trend for FY 2014-15 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2014-15. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2014-15 is the sum of the first half and second half estimates. The forecast of FY 2015-16 expenditure utilizes the same methodology as the forecast of FY 2014-15.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost-effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2013). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost-effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB) for clients who do not qualify for the Medicare Part D benefit.

In FY 2006-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency had referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 2006-07, the Department examined and upgraded the existing process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget, for FY 2013-14 through FY 2015-16, the Department examined total expenditure trends to estimate expenditure. The Department believes this methodology to be more accurate as per capita growth has fluctuated significantly historically because HIBI enrollment does not bear a direct relationship to Medicaid caseload. The Department selected -2.18%, the FY 2012-13 expenditure growth rate for AND/AB clients to trend expenditure in FY 2013-14 for the Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), Eligible Children, Categorically Eligible Low-Income Adults (AFDC-A), and Baby Care Program Adults aid categories. All FY 2013-14 trend selections were held constant for FY 2014-15 and FY 2015-16.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2013-14, FY 2014-15 and FY 2015-16 calculations for the Health Insurance Buy-In Program:

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacts the HIBI program in FY 2013-14 by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the state. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per-member per-month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline and enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

This service group includes administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary of Service Management

This exhibit summarizes the total requests from the worksheets within Exhibit I.

Single Entry Points

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to section 25.5-6-105, C.R.S. (2013). A single entry point agency is an agency in a local community through which persons 18 years or older, who are in need of long-term care services, can access needed long-term care services.

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home- and Community-Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of

institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

Single entry point agencies are paid a case-management fee for each client admitted into a community-based service program. Single entry point agencies also receive payment for services provided in connection with the development and management of long-term home health prior authorization requests for work associated with client appeals and for utilization review services related to home- and community-based services and nursing facilities.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for single entry point agencies. However, recently it has come to light the process described in the footnote report is not being used. Instead, individual single entry point agency contract amounts are determined using data from each single entry point agency's previous year's history of client and activity counts. At the end of the contract year, the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to single entry point agencies for services delivered in excess of funds received or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjusts for underpayment up to the amount allocated. This payment methodology, combined with close Department oversight, encourages single entry point agencies to enroll only those clients who are appropriate for community-based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and to assure single entry point agency compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to add a pediatric hospice effective January 1, 2008.

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer directed care to home- and community-based waiver services. These services must be approved by single entry point agencies. The Department received approval from CMS to add consumer-directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007. The Department began to provide these services effective January 1, 2008.

Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although

this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in Home- and Community-Based Services (HCBS) utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs, nor do they reflect actual single entry point caseload; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the cash accounting basis of Medical Services Premiums. The Department believes that growth in paid enrollment is a good proxy for growth in single entry point caseload.

In FY 2010-11 the Department began reporting cost per HCBS waiver utilizer to provide additional information about SEP expenditure and to use in trending expenditure forward.

For FY 2013-14, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2013-14 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). In FY 2013-14, the Joint Budget Committee agreed to a 2% provider increase in FY 2013-14, resulting in an increase, outside of enrollment increases, of $567,726 For FY 2013-14 through FY 2015-16, The Department's projection uses the total waiver enrollment forecast and the number of clients utilizing services in FY 2012-13 to proportion trends for all eligibility categories.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2013-14 through FY 2015-16.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316, C.R.S. (2013)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

During the pilot program, the Department initiated seven disease management programs to identify the most appropriate strategies to contain rising health care costs, improve access to services, and improve the quality of care for the fee-for-service Medicaid clients. The targeted disease conditions included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, female clients with breast and cervical cancer, and clients with chronic obstructive pulmonary disease. Additionally, the Care Management Organization pilot was established to coordinate all of the disease management programs and to establish a means for additional fee-for-service clients to obtain intensive case management or health counseling.

The pilot programs revolved around three, key, managed care principles: appropriate and timely access to health care services, evaluation and support for adherence to appropriate medical regimens/treatments, and provision of nationally recommended practice guidelines for each chronic disease. The pilot programs enabled the Department to obtain actual Colorado Medicaid disease management data and experience to be utilized for future program development.

As a result of the pilot programs, the Department entered into permanent contracts with two disease management companies for two health conditions: clients with asthma and clients with diabetes. In order to provide appropriate management to achieve cost-savings, reducing hospitalizations, and reducing emergency room visits, the Department contracted with Alere Medical Incorporated for clients with asthma and with McKesson Health Solutions for clients with diabetes. Over time, the Department has added and changed contracts as appropriate to ensure that Medicaid clients continue to receive quality care.

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), high risk obstetrics, and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117(2)(d)(IV.5), C.R.S. (2013), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

The Department's disease management contractors operated on a fixed budget (specified in the contract), and client enrollment could not exceed a fixed number of clients that the Department has determined shall be managed on that budget. Contractors accepted new clients only up to the enrollee limit as specified in the contract.

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2013) (further described in Exhibit A). The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered

amount of $63,488 is included in the FY 2009-10 request. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

FY 2013-14, FY 2014-15, and FY 2015-16 expenditures are affected only by caseload and bottom line impacts. In FY 2011-12, the Department requested a transfer of spending authority from DPHE for the purpose of attaining federal funds to establish the Smoking Cessation Quitline for Medicaid Clients. This change is reflected as a bottom line impact in FY 2013-14 as $323,930.

Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Since then, the Department contracted with only one prepaid inpatient health plan Rocky Mountain Health Plans until FY 2009-10. The Department then contracted with three additional prepaid inpatient health plans in FY 2009-10. These include Colorado Access and Kaiser Foundation Health Plan, which are jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost-avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care and Community-Based Long-Term Care. In the current request, the Department forecasts enrollment and costs for each program separately.

Rocky Mountain Health Plans

Through HB 12-1281, the Department accepted proposals for innovative payment reform pilots. The Department solicited proposals from the seven RCCOs in the state and on July 1, 2013, announced that it selected a Medicaid payment reform proposal submitted by Rocky Mountain Health Plans. The two-year pilot program will begin on or before July 1, 2014 and will focus on clients in certain counties within the state. As part of Rocky Mountain Health Plan's proposal, the pilot will also disenroll clients in the prepaid inpatient health plan and enroll clients into this pilot. Therefore, administrative fees associated with Rocky Mountain Health Plans in FY 2014-

15 and FY 2015-16 are removed to account for this adjustment. It is unclear how quickly this enrollment shift will transpire. Therefore, the Department will update future requests accordingly as information is available.

The administrative fees remain the same in FY 2013-14. As such, the Department uses actual enrollment to forecast expenditure for Rocky Mountain Health Plan for FY 2013-14. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group. For this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

To forecast enrollment in Rocky Mountain Health Plan for the current year, the Department assumes the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its health plan. Therefore, the Department estimates that the linear growth from FY 2003-04 of -22.15% will be appropriate. The Department assumes in this request that Rocky Mountain Health Plan will transition all clients into the pilot program in FY 2014-15 and FY 2015-16 and assumes no enrollment in the prepaid inpatient health plan for these years.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost-avoidance payments to Rocky Mountain Health Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was made. At that time, the Department anticipated it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09 with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department has completed all CMS requirements pertaining to Rocky Mountain Health Plan and made a cost-avoidance payment to Rocky Mountain Health Plan for services rendered in FY 2009-10 in the latter half of FY 2011-12. Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department also made a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the year prior to it.

For FY 2013-14, the Department assumes the cost avoidance payments will be similar in magnitude to the calculated payment for FY 2012-13 and carried that amount forward. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

Colorado Regional Integrated Care Collaborative Programs (Colorado Access and Kaiser Foundation Health Plan)

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access was completed in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. This program was discontinued effective June 30, 2012.

Colorado Alliance & Health Independence (CAHI)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64 designed to provide a network of services that are high-quality and cost-effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. Effective January 1, 2013 clients currently enrolled in the CAHI program began transitioning into the Accountable Care Collaborative program. No expenditure is anticipated in FY 2013-14 or subsequent request years.

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6 "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5 "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." The Department has since expanded enrollment in the program and is projected to reach an enrollment total of 275,000 by the end of FY 2012-13. The cost savings

estimated for this program are included in Acute Care; please see Exhibit F and Section V for more information on its impact to acute care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2013-14 include $3,200,000 paid to the SDAC, a weighted average PMPM of $9.300 PMPM paid to the RCCOs, $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. An additional $3 PMPM was added to AwDC PMPMs to RCCOs in FY 2012-13 and will not be included in request years.

Based on the experience from the first year of program operations, the Department assumes that approximately 25% of clients enrolled in the ACC program will not be attributed to a PCMP and that only the RCCO administrative fee will be paid for these clients. The fees in FY 2014-15 and FY 2015-16 are the same. In the current and request years, the Department assumes the full $2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members even though the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in FY 2014-15 and may estimate a lower PMPM depending on the average percentage of the incentive payments paid to providers.

Dually Eligible Medicaid and Medicare Pilot Project

The Department is currently engaged in negotiations with the Centers for Medicare and Medicaid Services (CMS) regarding the implementation of a pilot program targeting clients covered by both Medicare and Medicaid. Research has shown that coordinating care for this population has the potential to create significant cost savings. However, to achieve these savings, both payers must work collaboratively to ensure providers have the support and data needed to provide coordinated care, and that savings are distributed between the payers equitably. To provide this coordinated care environment, the Department has proposed to leverage existing infrastructure and enroll dually eligible clients in the Accountable Care Collaborative with an enhanced PMPM to account for the greater resource intensity needed to provide care coordination for this complex population. It is unclear when the pilot will be approved by CMS and what the final enhanced PMPM will be. Extensive analysis by the Department and the Department's actuaries has shown that, even with an enhanced PMPM, there is significant savings opportunity. Consequently, if the pilot program is approved by CMS, the Department will move forward with enrolling this population in the ACC. The impact of this pilot program will be incorporated in future requests should the pilot be implemented.

Legislative Impacts and Bottom- Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A. Information regarding Tobacco Tax funds has been removed from this exhibit with the Department's November 1, 2011 request as Tobacco Tax funding is now appropriated to the Department at a fixed value that is independent of the actual caseload or per capita costs associated with clients that would have otherwise been funded by Tobacco Tax.

Hospital Provider Fee Fund

HB 09-1293 established this fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

Expansion Adults to 133%

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level (FPL). This expansion population receives the standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund is funding this expansion in the interim before the Affordable Care Act's 100% enhanced federal match begins on January 1, 2014.

The Department assumes the medical and mental health per capita costs for this expansion group will be approximately 95% of those for the Medicaid Expansion Adults to 60% FPL. Per capita cost estimates for this population have been updated to reflect the most recent projection of per capita costs for the Expansion Adults population.

For caseload estimates and methodology, please see the Section II of this narrative.

Adults without Dependent Children

This expansion allows Adults without Dependent Children to be eligible for Medicaid benefits. Eligibility for this population began in May 2012. The Department was granted a Section 1115 Demonstration Waiver in order to implement the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012. With the advent of SB 13-200, effective July 1, 2013, Adults without Dependent Children are now covered up to 133% FPL. Similarly to Expansion Adults 133%, the Hospital

Provider Fee Fund is funding this population in the interim before the enhanced federal match begins on January 1, 2014 for the expansion.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed there were 143,191 uninsured Adults without Dependent Children in Colorado in 2009, 49,511 of which were in the 0-10% FPL bracket. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion at 10,000.

The Department assumes the per capita costs for this population will be a blend of the historical per capitas trended forward for the Low-Income Adults from approximately 24% to 60% of the FPL and the Disabled Individuals to 59 (AND/AB). The experiences from other states and a literature review on this population confirm this assumption. As the Department is only implementing up to 10% FPL, the Department assumes these clients will be the most high-need clients, with a lot of pent-up demand. With these assumptions, the Department assumed a blended per capita with 10% resembling the Low-Income Adults from approximately 24% to 60% of the FPL, with the other 90% resembling the Disabled Individuals to 59 (AND/AB) population., which is consistent with assumptions made in the Department's federal waiver for this population. These proportions were applied to the per capitas for the Low-Income Adults and the Disabled Individuals to 59 calculated by the Department's contractor using the historical data of both populations. To allow for potentially higher-than-anticipated costs with the rollout of a new population, the Department is requesting additional funding beyond the amount indicated in the per capita estimates. If expenditure falls short of the requested amount, all funds will remain in the hospital provider fee cash fund.

Medicaid Buy-in Fund

This fund is administered by the Department to collect buy-in premiums and support expenditures for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with eligibility to children with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost

of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed penetration rates depending on FPL bracket and adult/child category. The Department assumed children would have a higher penetration rate than adults and assumed the penetration rate would vary by FPL group due to interactions with other programs. Furthermore, while the Department acknowledges that, as individuals' incomes increase, they may be more likely to obtain their own insurance. The Department learned many may buy into the program to receive "wraparound" benefits, where they would receive benefits not available through their own plan.

The Department assumes the Medical Services Premiums expenditure for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department also assumes most clients in the Buy-In program will have lower utilization of many Home- and Community-Based Services (HCBS) waivers and other Long-Term Care services. The Department assumes proportionally fewer individuals with the ability to work would meet the level of care for either a waiver or nursing facility than in the current Disabled Adults to 59 population. In addition, clients who are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. In addition, the Department also assumes 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services. Overall, the Medicaid Disabled Individuals to 59 Acute Care per capita has been adjusted based on all of the above factors, some of which act to increase and some of which act to decrease the per capita. These adjustments were applied to the total per capita rather than at the service category level.

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit (UPL) financing methodology accomplishes the following:

- Increases the 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.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

The basic calculation for UPL financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

Funds received through the UPL for home health services and nursing facilities are used to offset General Fund expenditures. These offsets started in FY 2001-02. While nursing facilities account for the larger portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison and will experience little impact related to changes in reimbursement rates.

In FY 2005-06, the Department certified expenditure for only a half year due to a federal audit requiring the Department to certify expenditure on a calendar-year basis. During Figure Setting in March 2006, the Department's FY 2006-07 Base Reduction Item 2 (November 15, 2005) was approved. Starting in FY 2006-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process as long as it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

In prior fiscal years, the Department was able to utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department was able to certify public expenditure for Outpatient Hospital services. This was due to HB 09-1293, which allowed the Department to use other State funds to draw federal funds to the upper payment limit.

EXHIBIT L – DEPARTMENT RECOVERIES

This exhibit displays the Department's forecast for estate recoveries, trust recoveries, and tort/casualty recoveries. Prior to FY 2010-11, these recoveries were utilized as an offset to expenditure in Medical Services Premiums. In compliance with State Fiscal Rule 6-6, the Department now reports the recovery types listed above as revenue.

In addition to anticipated recovery revenue, Exhibit L also shows the anticipated contingency fee to be paid to contractors for recovery efforts. The Department's revised forecast for the activity reflects changes to contingency fee paid to the contractor as the contract was reprocured in FY 2011-12. Total revenue used to offset General Fund and federal funds, as shown in Exhibit A, is the sum of all recoveries less contingency fee paid to contractors.

Recoveries made for dates of service under periods where the State received an enhanced federal match are given the same federal match as was applicable when the services were rendered. The Department previously assumed a larger percentage of recoveries would fall under periods of enhanced federal match. However, the most recent expenditure data indicates a smaller percentage of recoveries are from periods with enhanced federal match. Consequently, the Department has revised assumptions regarding federal match on recoveries accordingly.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 11 years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12-month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is data obtained from the Department's Medicaid Management Information System (MMIS). This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community-Based Long-Term Care, Long-Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

This exhibit also includes six-month cash-based actuals for July 2012 through December 2013.

Effective with the November 1, 2007 Budget Request, the Department has made several labeling changes to this exhibit:

Service Group	**Old Title**	**New Title**
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community-Based Long-Term Care	Home- and Community-Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community-Based Long-Term Care	Home- and Community-Based Services - Mentally Ill	HCBS - Mental Illness
Community-Based Long-Term Care	Home- and Community-Based Services-Children	HCBS - Disabled Children
Community-Based Long-Term Care	Home- and Community-Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community-Based Long-Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community-Based Long-Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

Effective with the February 15, 2008 Budget Request, the Department restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2006-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

Effective with the November 3, 2008 Budget Request, the Department restated actuals for Single Entry Points from, by using HCBS utilization rates as opposed to total expenditure in Community-Based Long-Term Care and Long-Term Care service categories.

Effective with the November 1, 2010 Budget Request, the Department provided three pages for FY 2009-10 expenditure: cash-based actuals, the total amount delayed in FY 2009-10 as a result of a mandated payment delay, and the estimated FY 2009-10 expenditure adjusted for the payment delay.

Effective with the November 1, 2011 Budget Request, the Department made numerous changes to this exhibit:

- The Department restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2002-03 forward. The Department altered the methodology for distributing expenditure between eligibility types to more accurately reflect expenditure actually incurred in the service category.
- The Department separated Expansion Adults into Expansion Adults to 60% and Expansion Adults to 100%.
- The Department included totals for financing categories in Medical Services Premiums. As a result, this exhibit now matches the totals shown in other places in the budget, notably the Schedule 3.
- The Department removed historical totals prior to FY 2002-03. These pages remain available on the Department's website and upon request.

Effective with the November 1, 2012 Budget Request, the Department is reporting expenditure for Adults without Dependent Children and Disabled Buy-in eligibility types.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2012-13 final actual expenditures are included in this Budget Request for historical purpose and comparison.

Effective with the November 1, 2010 Budget Request, the Department included a second version of this exhibit that adjusts for the payment delays imposed in FY 2009-10.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2012-13 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2012-13 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations for FY 2008-09, FY 2009-10, FY 2010-11, FY 2011-12, and FY 2012-13 in the chronological order of the requests/appropriations. Shaded areas indicate the request or appropriation has not yet taken place.

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during prior legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

New Legislation and Impacts from FY 2013-14 Budget Cycle Requests

This section describes the impact from legislation passed during the 2013 Legislative Session and includes impacts from the Department's FY 2013-14 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

SB 13-230 – FY 2013-14 Long Bill

The FY 2013-14 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2013 Legislative Session that impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- FY 2013-14 R-7: Substance Abuse Disorder Benefit: The Department was approved funding to enhance the current substance use disorder benefit through the Behavioral Health Organizations (BHOs), expanding limitations on current services and adding appropriate services to create a more robust program due to a high number of individuals with mental health disorders having a co-occurring substance abuse disorder. Integrating substance use disorder services with the BHO benefit will provide clients with better care coordination and ensure that clients receive services necessary for recovery. Previously, substance use disorder services are provided in a fee-for-service setting and were unmanaged. This program has a $415,440 impact in FY 2013-14.

- FY 2013-14 R-9: Dental ASO for Children: The Department was approved funding to implement a dental administrative services organization (ASO) for the Medicaid children's benefit. The program will allow the Department to deliver and manage dental services for children and increase the available provider network while increasing savings through the reduction of preventable and costly restorative services. This program is anticipated to have a budget savings of $576,072 in FY 2013-14.

- FY 2013-14 R-13: 2% Provider Rate Increase: The Department increased provider rates for services impacted by rate reductions in recent years. During the economic recession, the state imposed multiple provider rate reductions to create General Fund relief. This placed financial strain on providers and potentially put client's health care at risk. Rate increases are expected to increase expenditures by $53,320,422 in FY 2013-14.

- SB 13-167 Intermediate Care Facilities for Individuals with Intellectual Disabilities: This bill transfers the authority to collect service provider fees for intermediate care facilities for individuals with intellectual disabilities from the Department of Human Services (DHS) to the Department, improving efficiency by eliminating the need to transfer funds between DHS and the Department multiple times in order to receive an enhanced federal match for covered expenses incurred at these intermediate care facilities. The amount that was previously transferring as a reappropriated fund from DHS is now transferring directly from the Service Fee Fund created in section 25.5-6-204 (1) (c) (II), Colorado Revised Statutes. The impact of this program is $228,953 for FY 2013-14.

- SB 13-200 Medicaid Expansion: This bill amends Medicaid eligibility criteria for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line. It also amends the Medicaid eligibility criteria for adults without dependent children to 133% of the federal poverty line and ages 19 through 64. This bill also expanded the funds to the SDAC by $250,000 per year.

- SB 13-242 Adult Dental Benefit: This bill implements a limited dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit. Dental services were previously available to only children 21 years of age and under through the EPSDT program. For clients over 21, the Department previously only reimbursed for emergency dental services. This program is expected to increase State expenditures by $32,858,915 in FY 2013-14 as well as an increased service management cost of $567,726.

- SB 13-276 Disability and Investigational Pilot Support Fund: This bill creates the Disability Investigational and Pilot Support fund and repeals the Coordinated Care for People with Disabilities Fund effective July 1, 2014. Any money held in the

Coordinated Care for People with Disabilities Fund as of July 1, 2013 is to be transferred to the Disability Investigational and Pilot Support Fund. The FY 2013-14 impact of this bill is a $100,000 decrease in the medical service premiums' appropriation.

- HB 13-1152 Nursing Facility Per Diem Reduction: This bill serves to reduce Class I Nursing Facility expenditures for FY 2013-14 and all subsequent years by a permanent 1.50% per diem reduction beginning July 1, 2013.

- The 2013 Long Bill also added a requirement that the Department will allow primary care providers to receive reimbursement for providing oral health risk assessments and applying fluoride varnishes up to three times per year for children five years and older. The fiscal impact of this implementation is included as a bottom line adjustment in Exhibit F.

- The 2013 Long Bill included a $3,000,000 appropriation to adjust the contract for non-emergent medical transportation service utilization, due to higher than expected use of the service by Medicaid clients.

Prior-Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments

SB 10-117 – Concerning Over-the-Counter Medication for Medicaid Clients

SB 10-117 allows pharmacists to directly prescribe certain medications, as approved by the Department, to Medicaid clients. By including only drugs that, when access is increased, reduce the likelihood of more expensive exacerbation of conditions, savings can be achieved. Avoided ER visits, physician office visits to obtain prescriptions for over-the-counter drugs (as is current policy for over-the-counter drug coverage under Medicaid), and avoided births are the primary vectors of savings. Through an extensive stakeholder outreach process, the Department has developed a list of medications that is anticipated to generate savings.

Emergency contraceptives generate the most significant amount of savings as the costs associated with birth are nontrivial. The Department's analysis excludes first-year-of-life costs and thus represents a conservative estimate of savings.

Because of the significant health consequences associated with smoking, expenditure on nicotine replacement therapies have been shown to reduce health care expenditure as quickly as one year post investment. Returns continue to increase over time. While there is an initial increase in expenditure associated with covering nicotine replacement therapy under the provisions of SB 10-117, the Department anticipates short-term returns on investment. Further, the increase in expenditure is completely offset by savings achieved by other drugs in the program.

Over-the-counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the

Department believes that, as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

The Department anticipates full implementation by January 1, 2014. The Department will continue to evaluate the list of medications to determine any needed changes or additional opportunities for savings.

Section 1202 of the Health Care and Education Reconciliation Act – Primary Care Physician Rates to 100% of Medicare

Section 1202 of the Health Care and Education Reconciliation Act (part of the Affordable Care Act) 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.

The Department estimates the difference in rates between July 1, 2009, and January 1, 2013, will generate an estimated $31,305,493 total funds impact in FY 2013-14 and a negative $9,575,251 total funds impact in FY 2014-15, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July 1, 2009. This gap represents rate cuts that were taken since July 1, 2009, due to budget reduction measures. The Department estimates increasing rates to the July 1, 2009, level will increase expenditure by $3,536,873 in FY 2013-14 and a negative $1,069,610 in FY 2014-15. These amounts will be matched by the federal government at the standard FMAP rates. The enhanced federal funding is not available in CY 2015. Consequently, the bottom line impact in Acute Care, Exhibit F for FY 2014-15 accounts for a half year impact after which expenditure returns to original levels.

ACC Savings

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefits package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients' care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The program began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently at an enrollment level of 226,112 for FY 2012-13. The central goals of the program are

to improve health outcomes through a coordinated, client-centered system and to control costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

The key components of the ACC are the Regional Care Collaborative Organizations, the Primary Care Medical Providers, and the Statewide Data and Analytics Contractor, which are outlined below.

The Regional Care Collaborative Organizations (RCCOs) are regional entities that provide for the coordination and integration of care within the ACC framework and are contracted with the Department through competitive procurement. There are seven RCCOs, which provide the following services:

- medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- care-coordination among providers and with other services such as behavioral health, long-term care, single entry point (SEP) programs, and other government social services such as food, transportation, and nutrition; and
- provider support, such as assistance with care-coordination, referrals, clinical performance and practice improvement, and redesign.

Primary Care Medical Providers (PCMPs) are contracted with RCCOs and act as "health homes" for ACC members. As a health home, the PCMP provides comprehensive primary care and coordinates and manages a client's health needs across specialties and along the continuum of care.

The Statewide Data and Analytics Contractor (SDAC) builds and implements the ACC data repository, creates reports using advanced health care analytics, hosts and maintains a web portal, provides a continuous feedback loop of critical information, fosters accountability and ongoing improvement among RCCOs and providers, and identifies data-driven opportunities to improve care and outcomes. The SDAC is paid through a fixed-price contract.

Medicaid clients who are enrolled in the ACC are assigned to a RCCO based on the client's county of residence and are linked with a PCMP via existing claims data that shows a relationship between the client and the provider, if that data is available. The RCCO and the PCMP are both paid a per-member per-month (PMPM) amount and are responsible for providing enhanced care coordination services, improving health outcomes, and reducing unnecessary costs.

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. Due to attrition and replacement enrollments, it is no longer possible to isolate an original 60,000 member cohort or expansion cohort. Consequently, expenditure and savings adjustments are shown in aggregate for the program. Because children make up a large portion of caseload in Medicaid, the

greatest opportunity for ACC expansion lies within this population. As children also have relatively lower per capita expenditure, the savings opportunity from enrollment in the ACC for this population is smaller than other populations. The Department has assumed a decreasing return to investment in each subsequent year on a per client basis. Further, RCCO rates have been adjusted to reflect the new case mix under an expanded program. In FY 2013-14 and subsequent years, the savings distribution has been adjusted to account for more actual savings in the disabled populations than children.

The chart below shows program expenditure and estimated savings for FY 2013-14, FY 2014-15, and FY 2015-16.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Program Administration (Exhibit I, PIHP)	**SDAC**	$650,000	$2,700,000	$3,000,000	$3,200,000	$3,250,000	$3,250,000
	RCCO	$182,819	$12,303,473	$29,718,299	$51,672,311	$66,208,196	$81,033,858
	PCMP	$54,592	$2,904,360	$8,140,044	$14,972,185	$19,292,183	$23,612,185
	Total Administration	**$887,411**	**$17,907,833**	**$40,858,343**	**$69,844,496**	**$88,750,379**	**$107,896,043**
Program Savings (Exhibit F, Acute)	**Total**		**($20,616,544)**	**($47,777,380)**	**($81,934,534)**	**($103,549,895)**	**($126,009,539)**
	Incremental(1)			**($27,160,836)**	**($34,157,154)**	**($21,615,361)**	**($22,459,644)**
Net ACC Program Fiscal Impact				**($6,919,037)**	**($12,090,038)**	**($14,799,516)**	**($18,113,496)**

(1) The incremental value shown is equal to the annualization values in Exhibit F, Acute Care.

- *Client Overutilization Program Expansion (BRI-1):* This BRI increases enrollment to 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. The Department projects to ramp-up in fall 2013 through more outreach efforts by its utilization management vendor and by completing the system change that will broaden the pool of providers who can participate. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department will continue to evaluate whether this payment is necessary to maintain at least 200 clients in the program.
- *Medicaid Budget Balancing Reductions (2011-12 BA-9):* In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization

efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions. Only one part of this initiative remains to be implemented, limiting the number of physical and occupational therapy units for adults.

- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until January 2015, as the Department is awaiting feedback from a new utilization management contractor to appropriately implement the proposal. The Department adjusted its request accordingly. For FY 2014-15, expenditure is reduced by $277,534, and for FY 2015-16, it is reduced by an additional $277,534.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider –in the instance of a PACE provider, the payment covers acute care and long-term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to Acute Care and Community-Based Long-Term Care (CBLTC) is not "dollar-for-dollar." The PACE program is designed to keep clients who have high community-based long-term care needs out of nursing facilities. The clients who move into the PACE program, typically, are those clients whose needs are no longer met by an HCBS program. Thus, clients are moving from a lower-cost option (HCBS) to a higher-cost option (PACE). However, the Department still anticipates the move is at least budget neutral in the long-term; clients who do not move to a PACE program will typically require nursing facility coverage, which is more expensive than PACE coverage.

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost per enrollee attributable to those services (based on the actuarially certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as one-twelfth the total enrollment impact and distributed proportionally to the acute care and HCBS reductions.

The estimated decrease in expenditures due to increased PACE enrollment is $1,965,656 in FY 2013-14, $2,621,180 in FY 2014-15, and $2,590,577 in FY 2015-16.

SB 10-167 - Concerning Increased Efficiency in the Administration of the "Colorado Medical Assistance Act," and, in Connection Therewith, Creating the "Colorado Medicaid False Claims Act"

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, and annualizing to $3,699,827 in FY 2011-12, by requiring the Department to implement a number of initiatives. The Department has been able to partially implement the components of SB 10-167, though full implementation is ongoing. Consequently, a portion of the savings originally anticipated in FY 2012-13 has been shifted to FY 2013-14 and subsequent years. The initiatives are as follows:

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over 3 million in total) to achieve savings despite delays in implementation. NCCI was fully implemented in April 2013. The Department expects a partial year savings in FY 2013-14 of $629,100 and for savings to be incorporated into the base in subsequent years.

Health Insurance Buy-In Program Expansion

The Department anticipates purchasing private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the State by enrolling clients into individual insurance plans where enrollment is deemed cost-effective. This initiative has been delayed to implement in FY 2013-14 to allow for contract execution. The Department has identified a vendor and has begun the enrollment process. The vendor anticipates approximately 70 clients will be enrolled per month until the maximum of 2,000 clients is reached.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2012-13 per capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2013-14 through FY 2014-15.

FY 2013-14 and FY 2014-15 Total HIBI Impact from SB 10-167

Item	FY 2013-14	FY 2014-15
Provider Payment	$267,795	$525,525
Premiums Payment	$708,640	$1,287,393
Savings (Realized in Acute Care)	($1,932,762)	($1,932,762)
Total Impact	**($956,327)**	**($119,844)**

Colorado Choice Transitions (Money Follows the Person Grant)

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community-Based Long-Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services, and long-term home health services. Savings from the enhanced match are required to be used to improve the long-term care service system, as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting.

The Department had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented March 1, 2013, with the first client transitioning in May 2013. The Department anticipates approximately 100 clients will transition per 365 day period beginning in May 2013. The Department estimates the total impact to Medical Services Premiums to be $106,050 total funds savings in FY 2013-14, $1,443,085 savings in FY 2014-15, and $4,877,620 savings in FY 2015-16. These figures do not include any expenditure from the rebalancing fund.

- Medicaid Budget Reductions (2012-13 R-6): This budget action encompassed 16 different policy initiatives targeted at addressing the statewide budget shortfall. The majority of the proposals are efficiency measures that align Medicaid practices with industry standards to maximize clinical efficacy while maintaining fiscal responsibility. Only some elements of this budget action have not been implemented.
  - *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. Until the Dental Benefits Collaborative process is complete in January 2014, full implementation of this reduction cannot be implemented. The adjustment of a negative $1,449,199 in FY 2013-14 indicates a partial implementation. Full implementation is noted in FY 2014-15 with an additional reduction of $410,399.

- *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 $8,166,667 total funds will be achieved.

- Medicaid Fee-for-service Reform (2012-13 R-5): Three initiatives were included in the budget action: Behavioral Health Organization gainsharing, Federally Qualified Health Center and Rural Health Center gainsharing, and Accountable Care Collaborative gainsharing. Each of these initiatives provides financial incentives for different provider types to engage clients and care management differently to improve outcomes and generate savings. Because these changes require an investment on the part of the provider, gainsharing becomes a mechanism for compensating providers for the investment without an upfront outlay of funding by the State. Through stakeholder engagement with CMS and the provider community, the Department has revised the gainsharing proposal to facilitate an alignment of financial incentives to support the Accountable Care Collaborative care management system. All three gainsharing activities have been streamlined into a single gainsharing program wherein care management entities, behavioral health organizations, and primary care providers must work together collaboratively to produce savings through integration of behavioral health and physical health to improve total health outcomes. The Department estimates a savings of $2,802,007 in FY 2013-14 and a savings of $1,401,004 in FY 2014-15.

- Presumptive Eligibility Settlement – one-time expenditure associated with payment of a settlement. The fiscal impact is limited to the 'Baby Care Adults' eligibility type by $3,075,000.

- 53 Pay Periods in FY 2013-14: The Department must account for an additional pay period in FY 2013-14. The impact is $32,659,616 in FY 2013-14 and a negative $37,557,127 in FY 2014-15.

- SB 11-008: "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children between the ages of six to 19. Beginning January 1, 2013, children under the age of 19 will be eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for clients these clients will remain at the same level had the clients enrolled in the Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%. The Department estimates the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes. This decreases expenditure by $12,001,745 in FY 2013-14.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Behavioral Health Request
Priority Number: R-2

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	385,638,470	-	461,739,445	26,923,840	74,598,639
	FTE	-	-	-	-	-
	GF	153,461,111	-	155,827,511	9,087,725	22,656,805
	GFE	-	-	-	-	-
	CF	2,033,883	-	12,646,178	(9,039,333)	(9,289,446)
	RF	-	-	-	-	-
	FF	230,143,476	-	293,265,757	26,875,448	61,231,280
(3)Behavioral Health Community Programs; Behavioral Health Capitation Payments	**Total**	380,837,424	-	456,935,528	25,484,748	72,893,997
	FTE	-	-	-	-	-
	GF	151,060,588	-	153,425,552	8,368,180	21,804,485
	GFE	-	-	-	-	-
	CF	2,033,883	-	12,646,178	(9,039,333)	(9,289,446)
	RF	-	-	-	-	-
	FF	227,742,953	-	290,863,799	26,155,901	60,378,958
(3)Behavioral Health Community Programs; Medicaid Mental Health Fee for Services Payments	**Total**	4,801,046	-	4,803,917	1,439,092	1,704,642
	FTE	-	-	-	-	-
	GF	2,400,523	-	2,401,959	719,545	852,320
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,400,523	-	2,401,958	719,547	852,322

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

Cash or Federal Fund Name and COFRS Fund Number: See Exhibit BB

Reappropriated Funds Source, by Department and Line Item Name: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests $26,923,840 total funds, $9,087,725 General Fund, for FY 2014-15. No additional FTE is needed.

Link to Operations

- The Behavioral Health Community Programs benefit is part of an entitlement program that ensures the Medicaid population receives adequate treatment for mental health disorders.

Problem or Opportunity

- Caseload and per capita costs are constantly changing over time which can lead to either an over or under expenditure for the program.

Consequences of Problem

- This problem creates a risk of either over or under expenditure on a yearly basis.

Proposed Solution

- The Department requests $26,923,840 total funds, $9,087,725 General Fund, for FY 2014-15 to lessen the risk of an over-expenditure.

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2013-14, FY 2014-15, and FY 2015-16 Budget Request

November 1, 2013

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BEHAVIORAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Behavioral Health Community Programs.

History and Background Information

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide behavioral health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Behavioral Health Capitation Program in 51 counties of the State was complete, with the remaining 12 counties added in 1998. A 64th county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight behavioral health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible adults 65 and older, disabled individuals through 64, low-income adults, adults without dependent children, eligible children, foster care children, and Breast and Cervical Cancer Program adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to: inpatient hospitalization, psychiatric care, rehabilitation, and outpatient care; clinic services, case management, medication management, and physician care; and non-hospital residential care as it pertains to behavioral health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Behavioral Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations, and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY 2004-05 Long

Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Behavioral Health Community Programs – Program Administration to the Executive Director's Office Long Bill group; (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums; and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Behavioral Health Community Programs expenditures are addressed in this section.

The recent history of the Behavioral Health Community Programs is summarized as follows:

- HB 02-1420 provided funding for three alternative programs in the Behavioral Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Behavioral Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.

- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Behavioral Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 through FY 2003-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of

when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for behavioral health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's prospective per-capita budget methodology did not require the use of historical data prior to FY 2002-03.

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 2003-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund, and the remaining $500,000 was from federal funds for behavioral health capitation and performance incentive awards.

- Within the appropriation for Behavioral Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005, began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.

- HB 04-1422 reorganized the Behavioral Health Community Programs Long Bill group into the following sections:

  1. Behavioral Health Capitation Payments, which included Capitation Base Payments, Behavioral Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Behavioral Health Capitation Payments line item in FY 2005-06.

  2. Other Behavioral Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency, and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Behavioral Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from CMS to cease making Child Placement Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December, and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated behavioral health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection, and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the current year and the out-year requests and are elaborated below.

- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Behavioral Health Capitation rates and eliminated the need to classify and track them separately.

  The Goebel Lawsuit Settlement line item was created in FY 2003-04 to fund specialized and enhanced behavioral health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 2003-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Behavioral Health Community Programs payments.

  On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined an actuarially certified payment would become part of the Behavioral Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 2006-07 capitations.

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.

- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designated funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program were appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; and b) for FY 2009-10 through FY 2013-14, 50% of State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.

- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund, effective until FY

2011-12. Beginning FY 2012-13, State funding for the Breast and Cervical Cancer Program was shifted back to 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund.

- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates above the actuarial midpoint of the rate setting range. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from CMS, the Department has gradually put more weight on the encounter data per-member per-month (PMPM). FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found estimated service expenditures to be generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes there are two primary reasons for this discrepancy. First, the non-traditional, federally waivered (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices caused some difficulties in the encounter pricing methodology. To offset the discrepancy, the Department paid its behavioral health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.

- HB 09-1293, the "Colorado Health Care Affordability Act," provided health care coverage for more than 100,000 uninsured Coloradans. The bill was implemented in April 2010 when the Department began collecting the hospital provider fee. Behavioral health services were subsequently expanded to parents up to 100% of the federal poverty level using the Hospital Provider Fee cash fund to cover the additional expenses. Behavioral health services were expanded further in FY 2011-12 to adults without dependent children with income up to 100% of the federal poverty level and disabled individuals with income up to 450% of the federal poverty level. For more detail, please see Exhibit J in the Medical Services Premiums Request.

- The June 22, 2009 General Revenue forecast indicated additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department's behavioral health programs in the following ways:

  1. As a part of FY 2010-11 ES-2 "Medicaid Program Reductions," the Department reduced the reimbursement rate for the behavioral health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years' behavioral health capitation payments.

  2. As a part of NP-ES-5 "Close Beds at the Mental Health Institutes," the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients available for the capitated behavioral health program. While

treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the "payer of last resort." Displacing these clients allowed them to be eligible to receive Medicaid funded benefits and increased expenditure for mental health services.

- Effective January 1, 2010, the Department calculated a new set of behavioral health rates and set them below the actuarial midpoint. Three of the Behavioral Health Organizations (BHOs) were paid 2.5% below the actuarially set midpoint of the new set of rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). These rates remained in effect through CY 2010. See the description of Exhibit GG for additional information.

- Effective January 1, 2011, the Department calculated a new set of behavioral health rates for calendar year 2011. The new rates implicitly included the 2.5% reductions taken by the BHOs, as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of $2,170,355. The Department worked with the BHOs in order to ensure they were able to certify the rates and continue to provide quality services to their clients, even while their rates were being reduced. The result of that negotiation process was to begin a series of rate reforms, the first of which was to include a new component in the rate called a "case rate" adjustment that was applied to the CY 2011 rates. The case rate is the BHO statewide average cost by diagnosis category. The case rate allows the Department to comply with CMS's direction by increasing the weight of the encounter data in the rate-setting process. The BHOs can accept the increased weight of encounter data because the case rate allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department's goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients.

- The Department requested to continue to apply the 1.71% reduction to the BHO rates in the current and request years in FY 2011-12 BRI-5 "Medicaid Reductions." The reduction was appropriated in the FY 2011-12 Long Bill.

- The FY 2011-12 Long Bill transferred $616,044 from the Division of Youth Corrections appropriation, which is administered by the Department of Human Services, to the appropriation for Behavioral Health Community Programs to fund behavioral health services provided to children living at the Ridge View Youth Services Center. In FY 2009-10, the Ridge View Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridge View to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children.

Prior to FY 2011-12, the expenditure for behavioral health services provided to Ridge View clients was transferred from the appropriation for Behavioral Health Community Programs and into the appropriation for the Division of Youth Corrections. Its appropriation was transferred to the behavioral health long bill line to streamline the process and avoid manually transferring expenditure. Since the Ridge View clients have been incorporated in the caseload data since FY 2009-10, the Department assumes that the impact of these clients on behavioral health expenditures will be captured in the caseload forecasts and does not need to be added as a bottom line impact to Exhibit BB.

- SB 11-008, "Aligning Medicaid Eligibility for Children," will expand Medicaid eligibility from 100% to up to 133% of the federal poverty level for children ages six through 18. The bill shifts impacted children from the Children's Basic Health Plan (CHP+) to Medicaid beginning January 1, 2013. The Department assumes the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. SB 11-250, "Eligibility for Pregnant Women in Medicaid," will expand Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65% federal match rate.

- SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL for parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

- Beginning January 1, 2014, the Medicaid benefit for the Behavioral Health Community Programs will also include a substance use disorder benefit. This expands the range of services that will be covered under Medicaid for disorders relating to substance use for currently enrolled members.

Program Administration

In FY 2005-06, SB 05-112 transferred all of Behavioral Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The current year and out-year requests for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item; the costs for these drugs were and are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds behavioral health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06 and incorporated into the Behavioral Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

The behavioral health organizations are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

The Medicaid populations that are eligible for behavioral health services covered by capitation rates are combined into seven categories, as indicated below. Partial dual-eligible clients and non-citizens are ineligible for behavioral health services.

The eligible behavioral health populations are:

- Adults 65 and Older (OAP-A)
- Disabled Individuals Through 64 (AND/AB, OAP-B)
- Low Income Adults
- Adults without Dependent Children
- Eligible Children (AFDC-C/BC)
- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System (MMIS). Monthly payments were paid based on eligibility categories. The MMIS provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System (COFRS). The drawback was the COFRS provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the COFRS. This calculation estimated actual COFRS expenditures across each eligibility category. Variance between the two systems was less than 0.67%

Description of Transition to New Methodology

Member month methodology was used prior to 2005 when the administration of Behavioral Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each behavioral health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Behavioral health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact

of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

From February 2005 until the present Request, the Department had been transitioning towards a per-capita methodology. Previous year actual amounts were trended forward by eligibility category, generating an estimated per capita. Prior to this Request, the Joint Budget Committee had asked the Department to explore the possibility of projecting budgets by behavioral health organization as well as by eligibility category. The Department has determined that such a projection is not yet possible due to the following: a) the recent (FY 2005-06) consolidation of eight behavioral health assessment and service agencies into five behavioral health organizations, b) the disproportionate impact of Goebel driven expenditures into one behavioral health organization's capitation rate, and c) the volatile nature of specific capitation rates as compared to the overall trend of capitation rate increases within respective eligibility categories. However, the Department will continue to explore this methodology as new data becomes available.

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department moved to a capitation trend forecast model for the FY 2008-09 Estimate and FY 2009-10 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per-capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed-upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g., Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some behavioral health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year requests for Behavioral Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Behavioral Health Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from Exhibit BB. The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Behavioral Health Community Programs budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% State funds and 50% federal funds. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately below. Capitation expenditures are split between traditional clients and expansion clients funded from Hospital Provider Fee funds. Finally, the recoupments from prior years for behavioral health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and the Substance Use Disorder benefit are also presented (see Exhibit II for recoupment calculations).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Expansion clients funded through HB 09-1293 receive State share funding from the Hospital Provider Fee Cash Fund. These clients also receive a 50% federal match.

Medicaid Mental Health Fee-for-Service Payments also receive 50% General Fund and 50% federal funds. The sum of the capitations and the fee-for-service payments comprise the Department's request.

Behavioral Health Services for Breast and Cervical Cancer Program Adults

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer patients into the appropriation for Behavioral Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Behavioral health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the behavioral health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(8), (9), and (10) C.R.S. (2012). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the clients already enrolled in the program, called "traditional clients," is 17.5% General Fund, 17.5% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds in FY 2012-13 and FY 2013-14. In FY 2014-15, the funding for traditional clients is 35% General Fund and 65% federal funds. In addition, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the "expansion clients," are funded by the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients was 35% reappropriated funds and 65% federal funds.

Behavioral Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients are funded through the Hospital Provider Fee cash fund. These clients are assumed to be similar to other adult clients and expenditure for these clients is therefore calculated using the same per capita rate as other adult clients (see Exhibit JJ). Starting in FY 2011-12, additional expansion populations also received funding through the Hospital Provider Fee cash fund. These include disabled individuals with income limits up to 450% of the federal poverty level and adults without dependent children, both of which received services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients is therefore calculated using the same per-capita rate as other disabled clients (see exhibit JJ). For the adults without dependent children, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for adults without dependent children and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

Behavioral Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the federal poverty level (FPL) for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

Behavioral Health Services for Expansion populations in SB 13-200

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

EXHIBIT CC - BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of behavioral health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Behavioral Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 1.7%, as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - BEHAVIORAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit DD contains the caseload, per-capita, and expenditure history for each of the 11 eligibility categories. Each of the tables that comprise Exhibit DD is described below.

Behavioral Health Community Programs Caseload

Behavioral Health Community Programs caseload is displayed in two tables. The first table shows total caseload for the combined disabled categories as well as the combined adult categories. The second table displays caseload by all behavioral health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The behavioral health caseload excludes the caseload for partial dual eligible clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Behavioral Health Community Programs exhibits and narrative.

Behavioral Health Community Programs Per Capita Historical Summary

As with caseload, Behavioral Health Community Programs per capita is displayed in two tables. The first table sets forth total per capita for the combined disabled categories as well as the combined adult categories. The second table displays per capita by all behavioral health eligibility categories. However, since the actual per capita from the first table is the same for both disabled categories, and the four adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates.

Behavioral Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Financial Reporting System (COFRS). Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the COFRS. The Medicaid Management Information System (MMIS) does provide expenditures by eligibility category but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the COFRS as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the COFRS across eligibility categories.

A ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures by the total MMIS expenditures. The ratio is multiplied by the total expenditures from the COFRS. This calculation estimates actual COFRS expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the

calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit EE provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits FF through HH and will be presented in more detail below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting partial dual eligible clients and non-citizens, as discussed above).

The Department has broken down the current fiscal year and the request year into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate rate from the previous two quarters (the first two quarters of the calendar year). For the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for the current year and the first half of the request year are known and only the final two quarters of the request year are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page EE-3.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in

retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a 10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline, as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

SB 13-200 Adjusted Rates

In order to properly account for SB 13-200 and how it affects the weighted capitation rates for FY 2013-14, FY 2014-15, and FY 2015-16, the Department averaged weighted capitation rate for the base population with the weighted capitation rate for the SB 13-200 expansion population. The estimated weighted capitation rates for the SB 13-200 populations were based on assumptions utilized in the bill's fiscal note. The SB 13-200 adjusted rates are used in calculating the capitation expenditure for the current and request years.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages F.EE-4 through F.EE-5 presents the percentage of claims paid in a six-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except disabled individuals through 64, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the disabled individuals, it takes a full 18 months for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exist for this category of clients.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to

pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and, should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

The IBNR factor for the adults without dependent children eligibility category cannot be calculated with the methodology which is used in all other eligibility categories because of insufficient periods of observation. Instead the Department chooses 98% for FY 2012-13 Q1 and Q2 and onward because the population is capped below its natural level due to financial constraints, and the turnaround between disenrollment and enrollment is rapid, which suggests the IBNR factor should be high. In future requests, the Department will use actual cost data available for this new population to determine the true, population-specific IBNR factor and rate adjustments that should be applied.
On pages F.EE-9 through F.EE-11, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages F.EE-1, F.EE-2, and F.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - BEHAVIORAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends

are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Behavioral Health Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories except for disabled individuals. For this reason, the Department assumes the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last five years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations from eight, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future comparisons to claims paid.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for runout of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - BEHAVIORAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

Beginning in January of 2009, the Department switched its rate-setting cycle from a state fiscal-year cycle to a calendar-year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates in six-month blocks to account for the rate change occurring in the middle of a state fiscal year.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

Based on the Department's calculations and rate-setting process and input from the behavioral health organizations, the Department's actuaries certify a capitation rate range for each BHO and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Behavioral Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit GG presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit GG in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

From January 1, 2009, to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to a new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below

the actuarial midpoint. New rates were established for the 2010 calendar year and set 2.5% below their certified midpoint rates. However, the Department's rate-setting process and federal regulation require that both the Department and the BHOs actuarially certify they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates. These two BHOs continued to be paid their September 1, 2009 rates through CY 2010. The 2.5% reductions to the BHOs' rates will continue to be in effect through future fiscal years, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates were reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011 and appropriated it as a savings of $2,170,355 to be achieved in FY 2010-11. The Department determined it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%. This rate reduction will continue to be built into the rates in the current and request years, as requested in FY 2011-12 BRI-5.

The Department added a new rate cell in FY 2011-12 for the adults without dependent children expansion population, which will be funded through the Hospital Provider Fee Cash Fund. The rates for CY 2012 and CY 2013 for the adults without dependent children are actuarially certified at $100.81 and $101.87 respectively. The rates are based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumed a large reconciliation component to be paid retroactively; this was, in part, due to the fact there were a great number of unknowns related to the rate setting process. Based on the current expenditure projections, however, the Department has removed the reconciliation component from its expenditure calculations.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages F.HH-1 and F.HH-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page F.HH-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages F.HH-1 and F.HH-2. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-3 (see below). For Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to

the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

For Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described below.

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. For Q3 and Q4 of FY 2010-11, the Department reduced rates by an additional 1.71%. The Department requested this reduction in FY 2010-11 BRI-6, "Medicaid Reductions," for the full year but will be implemented for only two quarters of FY 2010-11, per instructions from the Office of State Planning and Budgeting. The 1.71% reduction will continue to be in effect in the current and request years.

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep behavioral health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-3 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the behavioral health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	**CY 2014 Trend Selection**	**CY 2015 Trend Selection**	**CY 2016 Trend Selection**	**Justification**
Adults 65 and Older (OAP-A)	1.46%	1.46%	1.46%	Historical capitation rates for Adults 65 and Older have increased slowly over time. The percentage change for the most recent calendar year was negative. It is anticipated that the rate will not continue to decline in future years, but grow at a modest rate. The Department chose the two-period average growth rate from FY
	Average Growth from FY 2011-12 to FY 2012-13	Average Growth from FY 2011-12 to FY 2012-13	Average Growth from FY 2011-12 to FY 2012-13	

				2011-12 to FY 2012-13 to trend the CY 2014, CY 2015, and CY 2016 rates.
Disabled Individuals Through 64 (AND/AB, OAP-B)	4.82%	4.82%	4.82%	The rate for the Disabled populations has increased along a linear trend since the incorporation of the Goebel settlement into the rate methodology, except for the last calendar year -- the percentage change was negative. The Department expects that the rate will not continue to decline but will grow slowly in future years due to rate reform initiatives that reward BHOs for cost-savings efforts. Therefore, the percentage change in weighted fiscal year rates from FY 2007-08 to FY 2012-13 was selected to trend the CY 2014, CY 2015, and CY 2016 rates.
	Average Rate Change from FY 2007-08 to FY 2012-13	Average Rate Change from FY 2007-08 to FY 2012-13	Average Rate Change from FY 2007-08 to FY 2012-13	
Low Income Adults	3.85%	3.85%	3.85%	The Low Income Adults category has also seen steady increases in its rate, and that growth has followed closely to a linear trend since FY 2002-03. The percentage change for the most recent calendar year was negative. As with the Adults 65 and Older and Disabled Individuals Through 64 rates, the Department anticipates that the rate for this category will increase rather than decrease, but at a moderate rate. The most recent percentage change in weighted fiscal year rates was selected to trend the CY 2014, CY 2015, and CY 2016 rates.
	Rate change from FY 2010-11 to FY 2011-12	Rate change from FY 2010-11 to FY 2011-12	Rate change from FY 2010-11 to FY 2011-12	
	4.34%	4.34%	4.34%	The Adults without Dependent Children rate was set assuming expenditure would reflect 50% of the disabled

Adults without Dependent Children	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults	individuals through 64 (AND/AB, OAP-B) behavioral health expenditure and 50% of low income adults behavioral health expenditure. Therefore, the Department assumes that the trend for this rate will be an average of the trends of the two categories.
Eligible Children (AFDC-C/BC)	4.30%	4.30%	4.30%	The rate for the Children category has been steadily increasing over recent years. The Department expects it to increase again to a similar degree in CY 2014 and CY 2015. The Department chose the average growth over the last six fiscal years to trend the CY 2012 rate forward.
	Average Rate Change from FY 2007-08 to FY 2012-13	Average Rate Change from FY 2007-08 to FY 2012-13	Average Rate Change from FY 2007-08 to FY 2012-13	
Foster Care	1.00%	3.00%	3.00%	Despite a consistent history of decreases in the foster care rate, the CY 2013 rate experienced an increase. This is consistent with the Department's expectation that rates would eventually stabilize for this population. The Department believes rates will continue to increase at a marginal rate over the forecast period.
	Approximately 3x the growth rate from CY 2012 to CY 2013	Expecting a marginal increase to rates after experiencing consistent decline in past years.	Expecting a marginal increase to rates after experiencing consistent decline in past years.	

The selected point estimates of the capitation rates are adjusted on pages F.HH-1 and F.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - RECOUPMENTS AND RECONCILIATIONS

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. Exhibit II summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community behavioral health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 were set for collection in FY 2012-13, but due to timely filling, requirements from CMS were collected in FY 2011-12. Recoupments for FY 2009-10 are altered by the enhanced federal match from the year the claims were processed. Due to timely filing issues raised by federal authorities, the Department will not be processing reconciliations for FY 2010-11. As a result, the Department estimates that reconciliations will be lower in FY 2012-13 that previously estimated. Reconciliations are anticipated to return to previous levels in subsequent years. Recoupments from FY 2011-12 will be collected in FY 2012-13, and those from FY 2012-13 as well as future recoupments will no longer be made by the Department due to issues related to timely filing; instead, capitation rates will be adjusted accordingly.

The most recent recoupment made by the Department was for FY 2009-10 ineligibles. The methodology used to calculate the recoupment for that year differs slightly from previous years. The data for that fiscal year is also more reliable than past fiscal years due to data standardization and verification efforts undertaken by the BHOs and the Department. For those reasons, the Department

estimated future recoupments using the FY 2009-10 actual amount as a base and inflating it by the growth rate in caseload for that fiscal year. Beginning in FY 2012-13, the Department will no longer request recoupments for ineligibles.

EXHIBIT JJ - EXPANSION POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293) and other bills to the Behavioral Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Tobacco Tax Bill:

HB 05-1262 established a number of funds, two of which provide funding to the Behavioral Health Community Programs line: the Health Care Expansion Fund administered by the Department; and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provided capitated behavioral health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, optional legal immigrants eligible for services as a result of HB 05-1086, and foster care clients eligible for services up to the age of 21 as a result of beginning SB 07-002. The Health Care Expansion Fund became insolvent in FY 2010-11. Any additional revenue that comes into the fund will be used to offset General Fund expenditure in Medical Services Premiums; effective in FY 2011-12, there are no longer any behavioral health services funded by the Health Care Expansion Fund.

The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program, and historically 30% of the Breast and Cervical Cancer Program caseload is paid for out of this fund. The Department requested a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program was $1,215,340. The Department requested $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Behavioral Health Community Programs Long Bill Group from the Breast and Cervical Cancer Prevention and Treatment Fund and General Fund.

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided funding to provide health care coverage for uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

The first expansion population to be affected by HB 09-1293 was the expansion adult population with income limits up to 100% of the federal poverty level (FPL). The Department assumed that the costs for this population was the same as for the traditional population, as the vast majority of behavioral health services payments are made via capitation and do not change based on client utilization. An additional population has been added in FY 2011-12 consisting of working disabled adults with income up to 450% of the federal poverty level and disabled children with income up to 300% of the federal poverty level. As with adults, the Department assumes that the costs for this population will be the same as for the traditional population.

The Department also expanded eligibility to cover adults without dependent children in FY 2011-12. The program is initially limited to 10,000 clients. This population received the full range of behavioral health services provided by the BHOs, and the BHOs were paid at a different capitation rate for these members than any of its other eligibility categories. The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the FPL for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumed the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. As with most of the Hospital Provider Fee populations, the Department assumed the per-capita costs for this expansion population would be the same as for the traditional population since the majority of behavioral health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65% federal match rate and that the per-capita costs will be the same as for the traditional population.

Expanding Medicaid Eligibility in Colorado

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

EXHIBIT KK - MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in Behavioral Health Community Programs. Expenditures for this line are shown in Exhibit KK. The data from Exhibit KK also appears in Exhibits AA, BB, and CC as well as the Schedule 13.

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and behavioral health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Behavioral Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee-for-Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home- and Community-Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Mental Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004, for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures made year to date, trended forward based upon the expected change in caseload from the first half of the year to the second half of the year. The request year estimate is the result of a forward trend of the current-year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out-year estimate.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Mental health fee-for-service expenditure has increased drastically over previous years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. In the process, the Department discovered there was an error in the MMIS in which certain services billed as fee-for-service claims for BHO-enrolled clients are paying when they should be denied by the MMIS and billed to the appropriate BHO. This error was corrected through a system change effective November 2011. Initial data analysis since November shows there was a decline in the expenditure paid as mental health fee-for-service due to the system change. The Department

will continue to monitor its impact as more data becomes available over time and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between behavioral health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2013-14 appropriation is 26.38% higher than FY 2012-13 actual expenditures, primarily due to caseload growth. The FY 2013-14 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 25.82% increase from FY 2012-13 actual expenditures and a -0.45% decrease from the current appropriation. The FY 2014-15 estimate is built on the FY 2013-14 estimate and presents a 28.10% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) projected increases in capitation rates from CY 2012 to CY 2014. The FY 2014-15 request represents a 27.53% increase over the current FY 2013-14 appropriation. The FY 2015-16 Budget Request is built on the FY 2014-15 estimate and represents a 9.67% expenditure increase over the FY 2014-15 request and a 39.87% increase over the FY 2013-14 appropriation.

Schedule 13
Funding Request for the 2014-15 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: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2014-15
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	200,601,356	-	211,777,563	(38,043,495)	(21,134,424)
	FTE	-	-	-	-	-
	GF	22,825,770	-	26,649,625	(9,403,169)	(27,407,746)
	GFE	438,300	-	438,300	(3,300)	(438,300)
	CF	48,432,911	-	48,598,700	(3,709,744)	(10,251,597)
	RF	-	-	-	-	-
	FF	128,904,375	-	136,090,938	(24,927,282)	16,963,219
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**Total**	196,282,277	-	207,458,484	(38,043,495)	(21,134,424)
	FTE	-	-	-	-	-
	GF	22,825,770	-	26,649,625	(9,403,169)	(27,407,746)
	GFE	438,300	-	438,300	(3,300)	(438,300)
	CF	46,413,329	-	46,579,118	(3,709,744)	(10,251,597)
	RF	-	-	-	-	-
	FF	126,604,878	-	133,791,441	(24,927,282)	16,963,219
(4) Indigent Care Program; Children's Basic Health Plan Administration	**Total**	4,319,079	-	4,319,079	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	2,019,582	-	2,019,582	-	-
	RF	-	-	-	-	-
	FF	2,299,497	-	2,299,497	-	-

Letternote Text Revision Required? Yes: [x] No: [ ] **If yes, describe the Letternote Text Revision:** See Exhibit C2

Cash or Federal Fund Name and COFRS Fund Number: See exhibit C2

Reappropriated Funds Source, by Department and Line Item Name: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests a decrease of $38,043,495 total funds, $9,406,469 General Fund, in FY 2014-15.

Link to Operations

- Children's Basic Health Plan is an entitlement program that ensures that qualified children in Colorado receive medical and dental care.

Problem or Opportunity

- Caseload has decreased and per capita costs have changed, putting the Department at risk for expenditure under the Department's FY 2014-15 spending authority for the Children's Basic Health Plan program.

Consequences of Problem

- This problem creates a high risk for under-expenditure due to changes in actual program usage and costs compared to those previously expected.

Proposed Solution

- The Department requests a decrease in funding from the current FY 2014-15 spending authority to lessen the risk of under-expenditure.

Department of Health Care Policy and Financing
Children's Basic Health Plan

FY 2013-14, FY 2014-15, and FY 2015-16 Budget Request

November 1, 2013

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CHILDREN'S BASIC HEALTH PLAN

The following is a description of the budget projection for the Children's Basic Health Plan.

History and Background Information

CHP+ 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. CHP+ offers 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. CHP+ 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 CHP+ receive services through the State's self-funded network.

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration. The Department will submit a separate supplemental request to true up its most recent estimates for FY 2013-14 in January 2014.

Points of Interest

- Beginning in January 2013, Medicaid eligibility expanded to include children ages 6 to 18 up to 133% Federal Poverty Level (FPL) per SB 11-008 and prenatal clients up to 185% FPL per SB 11-250. Senate bills 11-008 and 11-250 led to a significant decrease in caseload for CHP+ and is seen as a bottom line adjustment in caseload. These adjustments are discussed in further detail on pages R-3.17, R-3.18, and R-3.28.
- The Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) begins in January 2014. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in Health Care Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household

size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with reported household incomes within the official Medicaid eligibility range are actually eligible for CHP+. The anticipated changes from the implementation of MAGI are reported as bottom line adjustments. These adjustments are discussed in further detail on pages R-3.17, R-3.18, and R-3.28.

- A significant amount of claims accrued in June were shifted to be paid in July. This can be seen as a bottom line adjustment in the FY 2013-14 budget in the amount of $13,123,436 in exhibit C3.
- The Department a faced potential disallowance due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-250% FPL range. In order to be compliant with Federal regulation, the Department continued to provide coverage for these clients despite the expiration of the applicable waiver.
- Upon review of historical rates, actuaries determined that the rates for the State Managed Care Network were set too high. The State Managed Care Network, Colorado Access, holds a no-risk contract with the Department and as such will reimburse the Department for the artificially high rate. The analysis is not yet complete, but the Department believes that the reimbursement will be significant.

CBHP CAPITATION PAYMENTS

The CBHP Capitation Payments line item reflects the appropriation that funds CBHP services throughout Colorado through managed care providers contracted by the Department. 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. 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.

The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor. 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.

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.

The eligible CBHP populations are:

- Children to 200% FPL (Medical and Dental)
- Children 201%-205% FPL (Medical and Dental)
- Children 206%-250% FPL (Medical and Dental)
- Prenatal to 200% FPL
- Prenatal 201%-205% FPL
- Prenatal 206%-250% FPL

Analysis of Historical Expenditure Allocations across Eligibility Categories

Historical expenditure allocations across eligibility categories reflects the expenditures reported in the Colorado Financial Reporting System (COFRS).

Description of Transition to New Methodology

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department is moving to a capitation trend forecast model for the FY 2013-14 Estimate and FY 2014-15 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends for each eligibility category, rather than a weighted rate for all categories, future expenditures are forecasted per the characteristics of a specific eligibility category: the actuarially agreed-upon capitation rate and caseload for the 9 categories rather than the previous 3 (children's medical, children's dental, and prenatal). By tying forecasted capitation rates directly to each eligibility category, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the

forecasting process by presenting a clear link between total expenditure and the rates being paid to health maintenance organizations and the state managed care network.

In estimating the future per capitas, the Department has also started incorporating partial month and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C5 (page R-3.8)

Additionally, the Department has incorporated an incurred but not reported methodology similar to the Medicaid Mental Health Program Request submitted by the Department. The Department is adjusting its request to capture the reality that some CBHP claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year for Medicaid Children's Basic Health Plan. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT C1 - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 1, 2013 Budget Request, the Department will include Exhibit C1 which presents a concise summary of spending authority affecting Children's Basic Health Plan. In this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit C2. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from page Exhibit C2. The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT C2 - CALCULATION OF FUND SPLITS

Exhibit C2 details fund splits for all Children's Basic Health Plan budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments less enrollment fees, the funding is 35% State funds and 65% federal funds. Capitation expenditures are split between traditional clients which are funded from the CBHP Trust fund and expansion clients which are funded from Hospital Provider Fee funds. Finally, the recoupments from prior years for CBHP capitation overpayments are also presented (see Exhibit C4 for recoupment estimates).

In the capitation base for both years, most clients are paid for with 35% General Fund and 65% federal funds. Expansion clients (clients with income 206%-250% FPL) funded through HB 09-1293 receive State share funding from the Hospital Provider Fee Cash Fund. These clients also receive a 65% federal match.

CBHP Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The set of expansion clients that are funded through the bill are children and prenatal clients with income 206%-250% of the Federal Poverty Limit (FPL). Services for these clients are funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other clients, and expenditure for these clients are therefore calculated using the same per capita rate as other clients.

EXHIBIT C3 - MEDICAID CHILDREN'S BASIC HEALTH PLAN SUMMARY

Exhibit C3 presents a summary of CBHP caseload and capitation expenditures itemized by eligibility category as well as a summary of the bottom line adjustments of the Children's Basic Health Plan. The net capitation payments include the impacts of actions with perpetual effect as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. Exhibit C4 illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT C4 - CBHP CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit C4 contains the caseload, per-capita, and expenditure history for each of the 6 eligibility categories. Each of the tables that comprise Exhibit C4 is described below.

Children's Basic Health Plan Caseload

Children's Basic Health Plan caseload is displayed in one table showing caseload by all CBHP eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are used in numerous exhibits throughout the Children's Basic Health Plan Exhibits and narrative. Caseload numbers for children are used twice, once for medical and once for dental.

Children's Basic Health Plan Per Capita Historical Summary

Medicaid Children's Basic Health Plan per capita is displayed in one table. The table displays per capita by all CBHP eligibility categories, children categories are displayed twice to show medical and dental per capitas. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates. Calculated per capitas in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all adjustments for the given fiscal year, per capitas without bottom line adjustments can be found in Exhibit C4. Projected per capitas without bottom line adjustments are listed below, calculations are described in Exhibits C5 through C6 (pages R-3.9-12).

	Children to 200% FPL Medical	**Children 201%-205% FPL Medical**	**Children 206%-250% FPL Medical**	**Children to 200% FPL Dental**	**Children 201%-205% FPL Dental**	**Children 206%-250% FPL Dental**	**Prenatal to 200% FPL**	**Prenatal 201%-205% FPL**	**Prenatal 206%-250% FPL**
Projected FY 2013-14	$2,189.87	$2,161.05	$2,388.70	$192.52	$188.37	$209.95	$12,481.52	$11,724.39	$11,820.51
Projected FY 2014-15	$2,284.95	$2,284.74	$2,202.78	$185.15	$185.15	$185.15	$13,066.73	$12,254.37	$12,475.90
Projected FY 2015-16	$2,352.05	$2,371.26	$2,204.25	$190.60	$189.79	$189.79	$12,275.58	$12,345.34	$13,087.74

Children's Basic Health Plan Expenditures Historical Summary

The history of expenditures shows total capitation expenditures for all CBHP eligibility categories. Medical and dental expenditures are listed separately. Actual expenditures by eligibility category are available from the Colorado Financial Reporting System (COFRS) and are reported in Exhibit C4-Expenditure Summary.

EXHIBIT C5 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit C5 provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits C6 through C8 and will be presented in more detail below. The caseload is the same as displayed in Exhibit C4.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page EE-3.

After calculating total expenditure, the anticipated recoupments for each fiscal year are estimated and added to total expenditure for the per capita estimate that is used in final expenditure calculations seen in Exhibit C3.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims

incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages F.EE-4 through F.EE-5 present the percentage of claims paid in a six-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Actuarially Certified Capitation Rates

Capitated rates for the health maintenance organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit C5. The methodology for determining the forecasted capitation rate is the subject of Exhibits C6 through C8.

EXHIBIT C6 - CBHP RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the CBHP Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories except for disabled individuals. For this reason, the Department assumes the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last five years of data were examined.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual health maintenance organization or state managed care network) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for runout of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT C7 - CBHP RECONCILIATION ADJUSTMENT CALCULATION

The projected per capitas from the February 15, 2013 request incorporated predicted reconciliations while the projected per capitas for the November 15, 2013 request do not. The Department assumes that the difference between the inflated former projected per capita and the more recent projected per capita will reflect the approximate reconciliation payment per client.

EXHIBIT C8 - CBHP CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual health maintenance organization or state managed care network) was examined. Exhibit C6 presents historical data as well as the forecasted weighted rates.

The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit C8.

Based on the Department's calculations and rate-setting process and input from the health maintenance organizations, the Department's actuaries certify a capitation rate range for each HMO, SMCN, and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the health maintenance organizations' and state managed care network's proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted CBHP Total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit C6 presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit C6 in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

EXHIBIT C9 - FORECAST MODEL COMPARISONS

Exhibit C8 produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit C4. Pages R-3.C9-1 and R-3.C9-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit C5.

On page R-3.C9-2, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages R-3.C8-1. Based on the point estimates, the adjustments presented in Exhibit C5 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit C4.

Final Forecasts

Page R-3.C9-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page R-3.C9-2 (see below).

The forecasted rate is then adjusted by the partial month adjustment multiplier, calculated on page R-3.C6-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From Exhibit C6, page R-3.C6-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit C6, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in Exhibit C5. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page R-3.C9-2 and historical midpoint rates are presented in Exhibit C9.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is

applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the CBHP capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

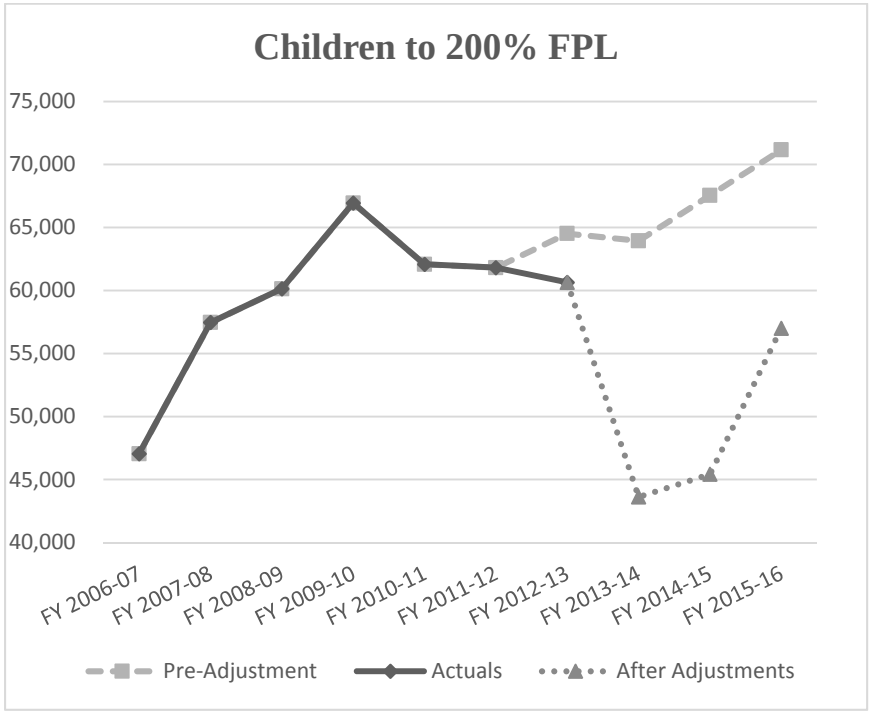
Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Children to 200% FPL Medical	3.80% Average Growth from FY 2013-14 to FY 2014-15	3.80% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Children to 200% (Medical) have increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.
Children 201%-205% FPL Medical	3.79% Average Growth from FY 2013-14 to FY 2014-15	3.79% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Children 201% to 205% (Medical) have increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.

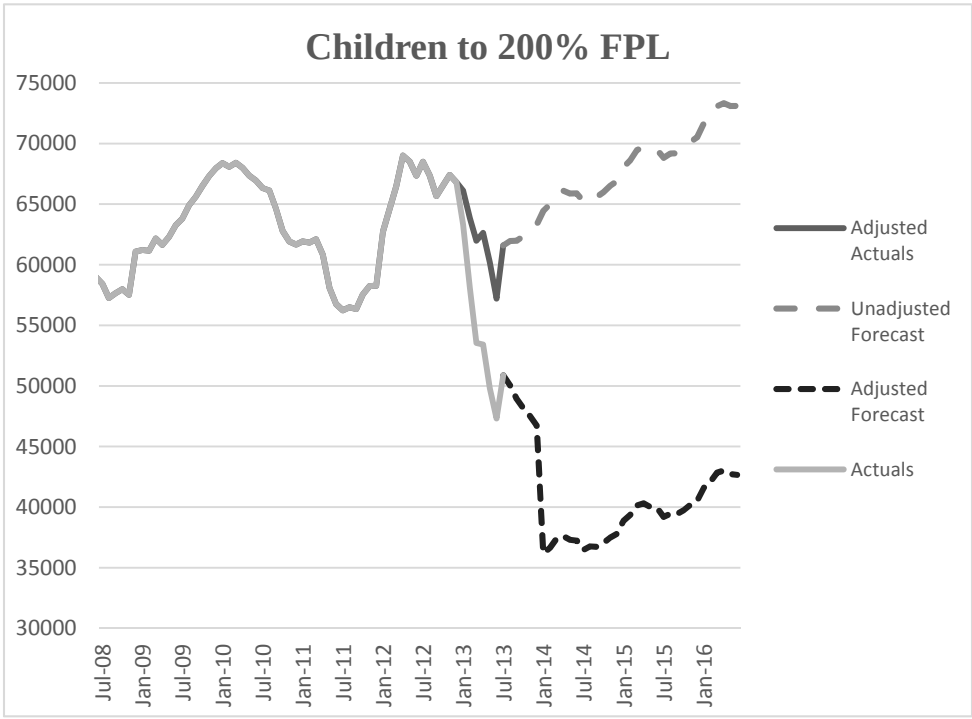
Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Children 206%-250% FPL Medical	0.07% Average Growth from FY 2013-14 to FY 2014-15	0.07% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Children 206% to 250% (Medical) have slightly decreased over time. The Department assumes that this trend will not continue and rates will begin to trend up, comparable to other eligibility categories. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.
Children to 200% FPL Dental	2.48% Average Growth from FY 2013-14 to FY 2014-15	2.48% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Children to 200% (Dental) have increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.
Children 201%-205% FPL Dental	2.48% Average Growth from FY 2013-14 to FY 2014-15	2.48% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Children 201% to 205% (Dental) have increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.
Children 206%-250% FPL Dental	2.48% Average Growth from FY 2013-14 to FY 2014-15	2.48% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Children 206% to 250% (Dental) have increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.
Prenatal to 200% FPL	3.32% Average Growth from FY 2013-14 to FY 2014-15	3.32% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Prenatal to 200% have slowly increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	Justification
Prenatal 201%-205% FPL	3.17% Average Growth from FY 2013-14 to FY 2014-15	3.17% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Prenatal 201% to 205% have slowly increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates
Prenatal 206%-250% FPL	5.84% Average Growth from FY 2013-14 to FY 2014-15	5.84% Average Growth from FY 2014-15 to FY 2015-16	Historical capitation rates for Prenatal 206% to 250% have slowly increased over time. The Department chose the average growth rate from FY 2008-09 through FY 2013-14 to trend the FY 2014-15 and FY 2015-16 rates

The selected point estimates of the capitation rates are adjusted on pages R-3.C9-1 and R-3.C9-2, as described above, for use in the expenditure calculations presented in Exhibit C5.

Children's Caseload Projections (Exhibit C4)





- Adjusted growth in children to 200% FPL in FY 2012-13 was lower than the Department's February 2013 forecast, in which annual caseload was projected to be 68,022 and average monthly growth was projected to be 258. The estimated base caseload for FY 2012-13 decreased by an average of 442 children per month. Monthly caseload changes during FY 2012-13 were greater than the long-term average. The Department believes this may be related to the implementation of the federally required Income Eligibility Verification System (IEVS) in August 2011. Per Section 1137 of the Social Security Act, States must use IEVS to request information from other Federal and State agencies to verify applicants' income and resources. IEVS extracts wage information reported by employers to the Colorado Department of Labor and Employment each month to update family incomes for the previous quarter. Since individual and family incomes may vary frequently, even from month to month, the implementation of IEVS has resulted in an increased number of children in low-income FPL categories moving between Medicaid

and CHP+ each month. The increase in CHP+ caseload in this category during the first part of calendar year 2012 suggests that the incomes of low-income families may have increased during that time period.

- The selected trend for FY 2013-14 for Children to 200% FPL is lower than the Department's February 2013 forecast and would result in average growth of 373 per month. This lower forecast is reflective of the average monthly decreases over FY 2012-13. The Department believes that base caseload will not continue to decrease in future months. Growth is forecasted to average 1.2% per month in FY 2013-14.
- The Department's existing Section 1115 waiver, which covers the Premium Assistance Program and pregnant women in CHP+, will expire on December 31, 2012. Any eligible CHP+ at Work clients will transition to direct coverage in the CHP+ program beginning in January 2013.
- There are three bottom-line adjustments to the Children to 200% FPL caseload. The first is from SB 11-008, which increases Medicaid eligibility for children from six through 18 years of age to 133% FPL beginning in January 2013. This has had a negative impact on caseload for the second half of FY 2012-13 and is expected to have a negative impact on caseload for the first half of FY 2013-14. 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.
- The second bottom line adjustment to the Children to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of a new income definition, the Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) beginning in January 2014. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in Health Care Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with reported household incomes within the official Medicaid eligibility range are actually eligible for CHP+. In FY 2011-12, 22.8% of children in the Children to 200% FPL category reported family incomes under 100% FPL and 51.8% reported family incomes under 133% FPL. Due to the number of children under existing Medicaid income limits, the Department believes the potential impact of MAGI is significant. The Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+, thus negatively impacting the caseload for children whose incomes are currently documented at or below 133% FPL in CHP+. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has included a negative adjustment to its caseload forecast for FY 2013-14 forward.
- The third adjustment accounts for clients that are eligible but not enrolled (EBNE) pursuant to the Affordable Care Act (ACA) in January 2014, which accounts for those clients who were eligible for Medicaid benefits but did not seek out the insurance package until the mandate to obtain health care coverage under the ACA and increased awareness due to the Medicaid expansions.

Children to 200% FPL			
	Actuals	**Monthly Change**	**% Change**
Dec-10	61,662	-	-
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%
Jul-11	56,237	(517)	-0.91%
Aug-11	56,495	258	0.46%
Sep-11	56,349	(146)	-0.26%
Oct-11	57,549	1,200	2.13%
Nov-11	58,238	689	1.20%
Dec-11	58,258	20	0.03%
Jan-12	62,736	4,478	7.69%
Feb-12	64,579	1,843	2.94%
Mar-12	66,466	1,887	2.92%
Apr-12	69,001	2,535	3.81%
May-12	68,520	(481)	-0.70%
Jun-12	67,346	(1,174)	-1.71%
Jul-12	68,486	1,140	1.69%
Aug-12	67,368	(1,118)	-1.63%
Sep-12	65,667	(1,701)	-2.52%
Oct-12	66,552	885	1.35%
Nov-12	67,410	858	1.29%
Dec-12	66,797	(613)	-0.91%
Jan-13	63,305	(3,492)	-5.23%
Feb-13	58,114	(5,191)	-8.20%
Mar-13	53,539	(4,575)	-7.87%
Apr-13	53,416	(123)	-0.23%
May-13	49,793	(3,623)	-6.78%
Jun-13	47,308	(2,485)	-4.99%

Base trend from June 2013 level			
FY 2013-14	47,308	-26.68%	(17,212)

February 2013 Forecast	
Forecasted June 2013 Level	70,447

	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	61,815	-0.43%	(265)
FY 2012-13*	64,520	4.38%	2,705
FY 2013-14	63,942	-0.90%	(578)
FY 2014-15	67,553	5.65%	3,611
FY 2015-16	71,164	5.35%	3,611

*Caseload has been adjusted to include clients that moved from CHP to Medicaid per SB 11-008.

SB 11-008 Adjustment	
FY 2012-13	(3,874)
FY 2013-14	(15,495)
FY 2014-15	(16,558)
FY 2015-16	(16,558)

MAGI Adjustment	
FY 2013-14	(5,952)
FY 2014-15	(12,579)
FY 2015-16	(13,479)

SB 13-200 Medicaid Expansion	
FY 2013-14	1,124
FY 2014-15	7,002
FY 2015-16	15,871

Projections After Adjustments			
FY 2012-13*	60,646	-1.89%	(1,169)
FY 2013-14	43,619	-32.39%	(20,901)
FY 2014-15	45,418	4.12%	1,799
FY 2015-16	56,998	25.50%	11,580

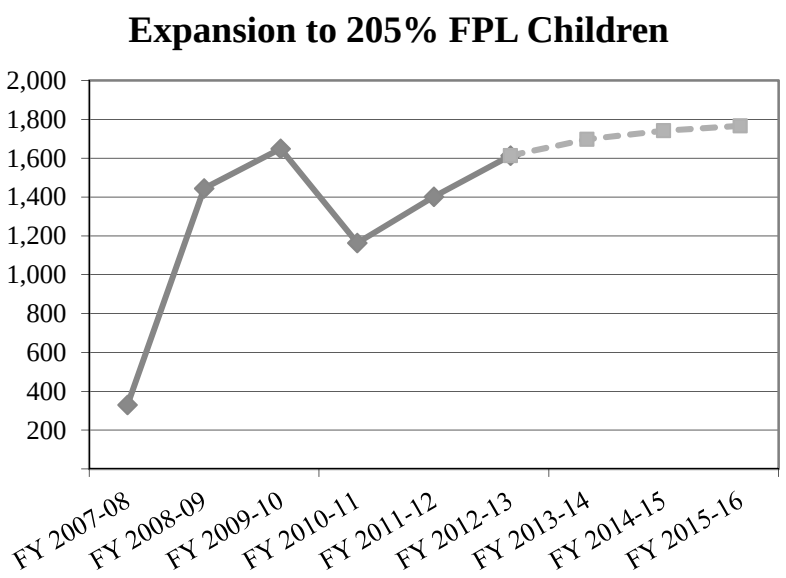
* Value reported for FY 2012-13 was actual caseload

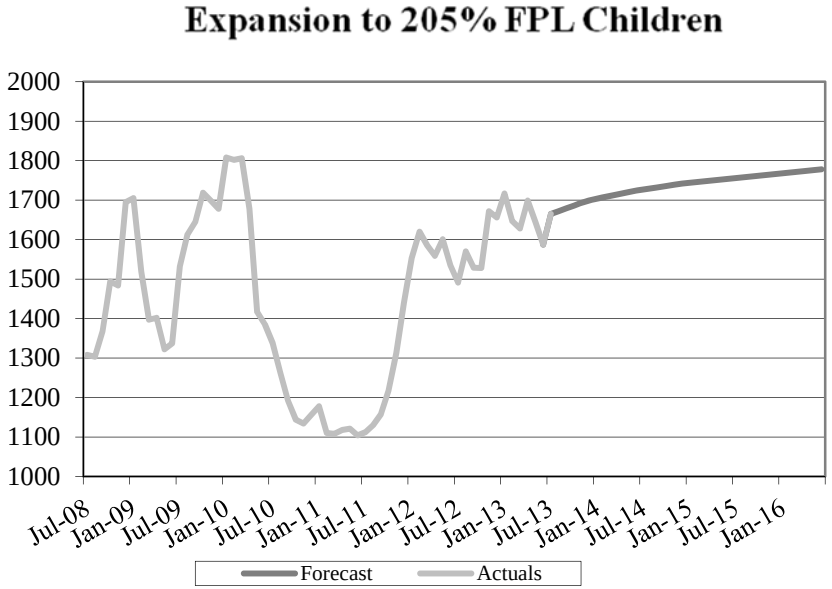
Actuals		
	Monthly Change	**% Change**
First 6-month average	(92)	-0.12%
Last 6-month average	(3,248)	-5.55%
12-month average	(1,670)	-2.84%
18-month average	(608)	-1.06%
24-month average	(394)	-0.69%

Adjusted Monthly Average Growth Comparisons		
February 2013 Forecast	258	0.38%
FY 2012-13 Actuals	(442)	-0.63%
FY 2012-13 1st Half	(92)	-0.12%
FY 2012-13 2nd Half	(743)	-1.07%
FY 2013-14 Forecast	656	-0.11%
February 2013 Forecast	406	0.47%
FY 2014-15 Forecast	301	0.45%

February 2013 Trend Selections Before Adjustments			
FY 2012-13	68,022	10.04%	6,207
FY 2013-14	73,378	7.87%	5,356
FY 2014-15	77,272	5.31%	3,894

February 2013 Trend Selections After Adjustments			
FY 2012-13	65,392	5.79%	3,577
FY 2013-14	51,721	-20.91%	(13,671)
FY 2014-15	44,324	-14.30%	(7,398)





- This population was created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201 and 205% FPL.
- Growth in Expansion to 205% FPL children in FY 2012-13 was lower than the Department's February 2013 forecast, in which annual caseload was projected to be 1,640 and average monthly growth was projected to be 17.
- The selected trend for FY 2013-14 for Expansion to 205% FPL children is lower than the Department's February 2013 forecast, and would result in average growth of 11 per month. The Department does not believe the caseload will continue to decrease as it did in the second half of FY 2012-13 as the first half of the fiscal year showed strong growth. Growth is forecasted to average 0.70% per month in FY 2013-14. The forecast for the expansion to 205% FPL assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth in forecast years.

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Expansion to 205% FPL Children			
	Actuals	**Monthly Change**	**% Change**
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%
Jul-11	1,112	8	0.72%
Aug-11	1,130	18	1.62%
Sep-11	1,157	27	2.39%
Oct-11	1,217	60	5.19%
Nov-11	1,313	96	7.89%
Dec-11	1,441	128	9.75%
Jan-12	1,553	112	7.77%
Feb-12	1,620	67	4.31%
Mar-12	1,585	(35)	-2.16%
Apr-12	1,559	(26)	-1.64%
May-12	1,601	42	2.69%
Jun-12	1,535	(66)	-4.12%
Jul-12	1,491	(44)	-2.87%
Aug-12	1,570	79	5.30%
Sep-12	1,529	(41)	-2.61%
Oct-12	1,528	(1)	-0.07%
Nov-12	1,672	144	9.42%
Dec-12	1,656	(16)	-0.96%
Jan-13	1,717	61	3.68%
Feb-13	1,647	(70)	-4.08%
Mar-13	1,628	(19)	-1.15%
Apr-13	1,699	71	4.36%
May-13	1,645	(54)	-3.18%
Jun-13	1,587	(58)	-3.53%

	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	1,402	20.45%	238
FY 2012-13	1,614	15.12%	212
FY 2013-14	1,698	5.20%	84
FY 2014-15	1,742	2.59%	44
FY 2015-16	1,767	1.44%	25

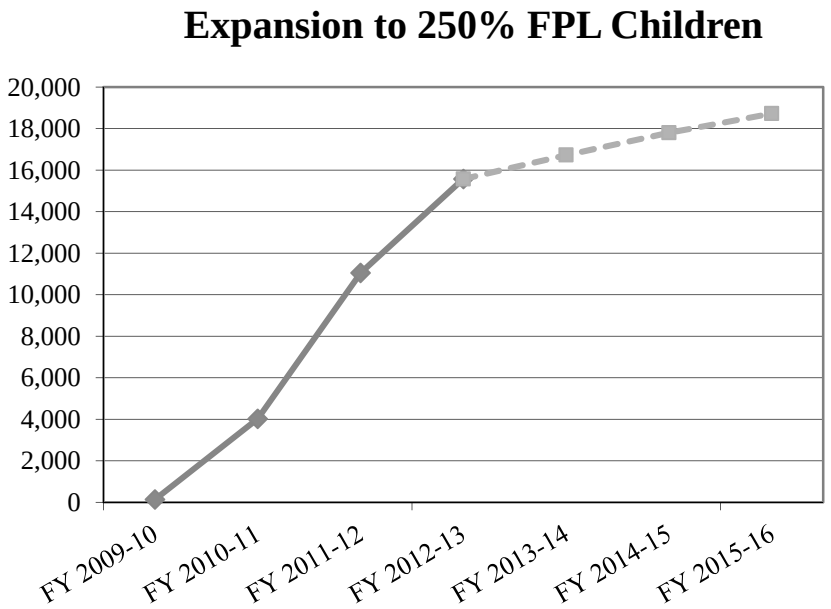
February 2013 Trend Selections			
FY 2012-13	1,640	16.98%	238
FY 2013-14	1,780	8.54%	140
FY 2014-15	1,822	2.36%	42

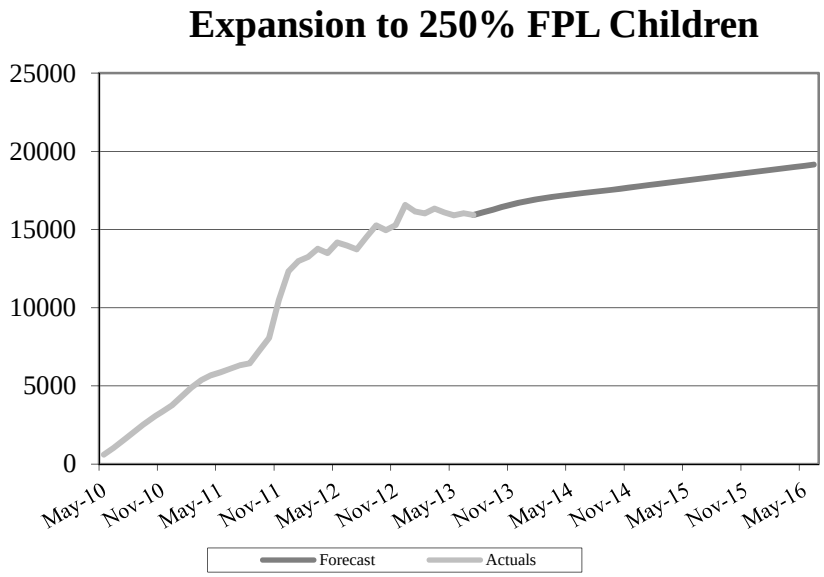
Actuals		
	Monthly Change	**% Change**
6-month average	(12)	-0.65%
12-month average	4	0.36%
18-month average	8	0.62%
24-month average	20	1.61%

Monthly Average Growth Comparisons		
February 2013 Forecast	17	1.10%
FY 2012-13 Actuals	4	0.36%
FY 2012-13 1st Half	20	1.37%
FY 2012-13 2nd Half	(12)	-0.65%
FY 2013-14 Forecast	11	0.70%
February 2013 Forecast	6	0.31%
FY 2014-15 Forecast	3	0.14%

Base trend from June 2013 level			
FY 2013-14	1,587	-1.67%	(27)

February 2013 Forecast	
Forecasted June 2013 Level	1,740





- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206% and 250% of the federal poverty level.
- Growth in FY 2012-13 was lower than the Department's February 2013 estimates in which annual caseload was projected to be 16,284 and average monthly growth was projected to be 351. Actual FY 2012-13 caseload was 15,575 and average monthly growth was 173. The selected trend for FY 2013-14 for Expansion to 250% FPL children is 0.63% per month, and would result in average growth of 105 per month.
- The Department assumes that the slow improvement in economic conditions will continue, resulting in moderate caseload growth for the forecast years.

Expansion to 250% Children			
	Actuals	**Monthly Change**	**% Change**
Dec-10	3,759	-	-
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%
Jul-11	6,320	222	3.64%
Aug-11	6,444	124	1.96%
Sep-11	7,275	831	12.90%
Oct-11	8,075	800	11.00%
Nov-11	10,493	2,418	29.94%
Dec-11	12,338	1,845	17.58%
Jan-12	12,985	647	5.24%
Feb-12	13,250	265	2.04%
Mar-12	13,774	524	3.95%
Apr-12	13,492	(282)	-2.05%
May-12	14,169	677	5.02%
Jun-12	13,975	(194)	-1.37%
Jul-12	13,731	(244)	-1.75%
Aug-12	14,509	778	5.67%
Sep-12	15,267	758	5.22%
Oct-12	14,955	(312)	-2.04%
Nov-12	15,289	334	2.23%
Dec-12	16,575	1,286	8.41%
Jan-13	16,159	(416)	-2.51%
Feb-13	16,028	(131)	-0.81%
Mar-13	16,337	309	1.93%
Apr-13	16,091	(246)	-1.51%
May-13	15,914	(177)	-1.10%
Jun-13	16,047	133	0.84%

	Caseload	**% Change**	**Level Change**
FY 2009-10	136	-	-
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	15,575	40.96%	4,526
FY 2013-14	16,730	7.42%	1,155
FY 2014-15	17,804	6.42%	1,074
FY 2015-16	18,728	5.19%	924

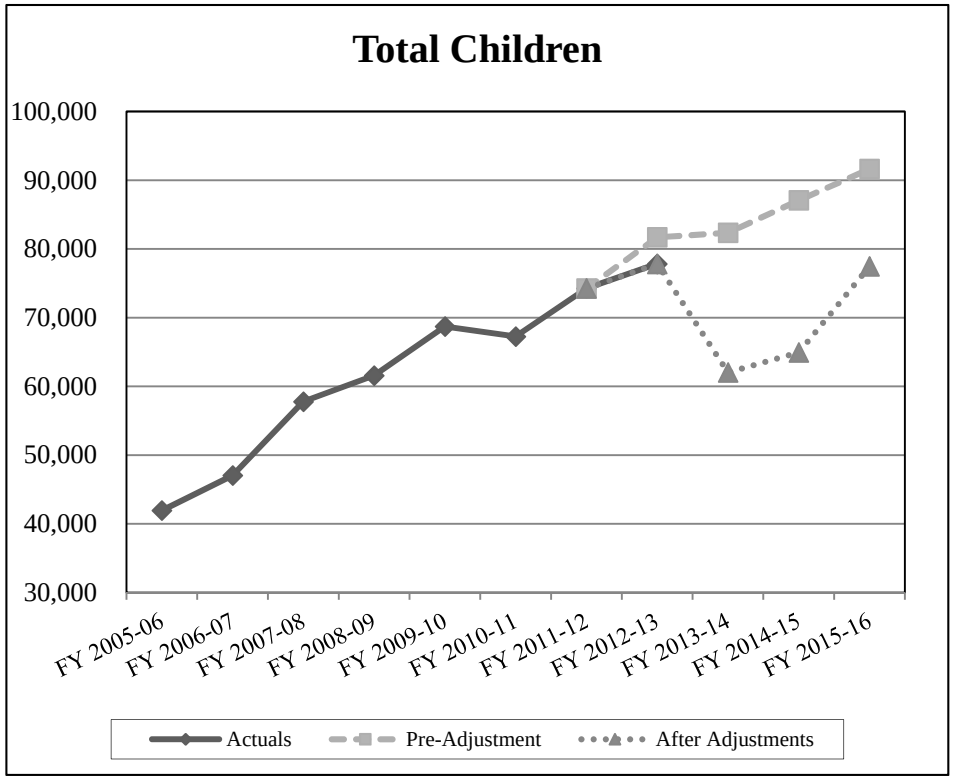
February 2013 Trend Selections			
FY 2012-13	16,284	47.38%	5,235
FY 2013-14	19,148	17.59%	2,864
FY 2014-15	20,222	5.61%	1,074

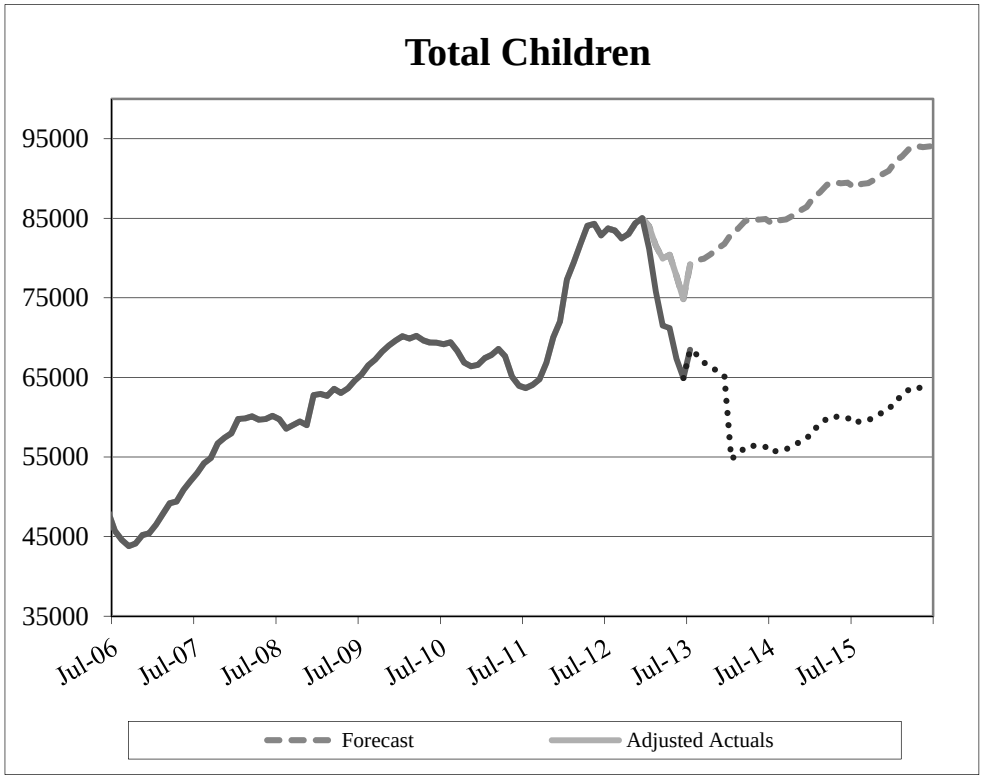
Actuals		
	Monthly Change	**% Change**
6-month average	(88)	-0.53%
12-month average	173	1.22%
18-month average	206	1.52%
24-month average	415	4.35%

Monthly Average Growth Comparisons		
February 2013 Forecast	351	2.26%
FY 2012-13 Actuals	173	1.22%
FY 2012-13 1st Half	433	2.96%
FY 2012-13 2nd Half	(88)	-0.53%
FY 2013-14 Forecast	105	0.63%
February 2013 Forecast	128	0.68%
FY 2014-15 Forecast	77	0.43%

Base trend from June 2013 level			
FY 2013-14	16,047	3.03%	472

February 2013 Forecast	
Forecasted June 2013 Level	18,183





- The FY 2013-14 children's caseload forecast is 62,047, a 20.28% decrease over the FY 2012-13 caseload of 77,836 after adjustments. This forecast of the base caseload results in average increases of 772 (1.04%) per month in FY 2013-14. Average monthly growth for base caseload in FY 2013-14 is higher than previously forecasted (540 per month) due to July actuals. Because of the unusual growth seen in July, the Department incorporated the July actual in the forecast in order to derive a more accurate result.
- The Department estimates that the slow improvement in economic conditions will continue, resulting in lower growth in the CHP+ children caseload compared to FY 2012-13. The annual FY 2013-14 base caseload is projected to increase by 0.81% to 82,370,

and the FY 2014-15 base caseload is forecasted to grow 5.74% to 87,098. Total children's base caseload is projected to increase by 1.04% (772 clients) per month in FY 2013-14 and 0.44% (380 clients) per month in FY 2014-15.

- Beginning in January 2013, the Department allowed the children of State employees eligible for CHP+ to enroll in the program. Although this policy change is anticipated to have a positive impact on children's caseload, the effects are difficult to anticipate. Per state statute at 25.5-8-109 (1) C.R.S. (2012), the newly eligible children must still comply with a waiting period that requires that they are not insured by a comparable health plan during the three months prior to enrolling in CHP+. The Department believes that the growth rates it has incorporated into the forecast will account for any increases due to this policy change.
- As described in the CHP+ Children to 200% FPL section, there are three bottom-line adjustment to the CHP+ children's caseload. The first is from SB 11-008, which increases Medicaid eligibility for children from six through 18 years of age to 133% FPL beginning in January 2013. This has had a negative impact on caseload for the second half of FY 2012-13 and is expected to have a negative impact on caseload for the first half of FY 2013-14. The second bottom line adjustment to the Children to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of a new income definition, the Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) beginning in January 2014. The third adjustment accounts for clients that are eligible but not enrolled (EBNE) pursuant to the Affordable Care Act (ACA) in January 2014, which accounts for those clients who were eligible for Medicaid benefits but did not seek out the insurance package till the mandate to obtain health care coverage under the ACA and increased awareness due to the Medicaid expansions.
- The bottom line adjustments decrease the projected FY 2013-14 to 62,047, which is a 20.28% decrease over the FY 2012-13 caseload. The projected FY 2014-15 caseload with adjustments decreases to 64,963, which is a 4.7% increase over the projected FY 2013-14 caseload. The projected FY 2015-16 caseload with adjustments decreases to 77,492, which is a 19.29% increase over the projected FY 2014-15 caseload.

Total Children			
	Actuals	**Monthly Change**	**% Change**
Dec-10	66,577	-	-
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%
Jul-11	63,669	(287)	-0.45%
Aug-11	64,069	400	0.63%
Sep-11	64,781	712	1.11%
Oct-11	66,841	2,060	3.18%
Nov-11	70,044	3,203	4.79%
Dec-11	72,037	1,993	2.85%
Jan-12	77,274	5,237	7.27%
Feb-12	79,449	2,175	2.81%
Mar-12	81,825	2,376	2.99%
Apr-12	84,052	2,227	2.72%
May-12	84,290	238	0.28%
Jun-12	82,856	(1,434)	-1.70%
Jul-12	83,708	852	1.03%
Aug-12	83,447	(261)	-0.31%
Sep-12	82,463	(984)	-1.18%
Oct-12	83,035	572	0.69%
Nov-12	84,371	1,336	1.61%
Dec-12	85,028	657	0.78%
Jan-13	81,181	(3,847)	-4.52%
Feb-13	75,789	(5,392)	-6.64%
Mar-13	71,504	(4,285)	-5.65%
Apr-13	71,206	(298)	-0.42%
May-13	67,352	(3,854)	-5.41%
Jun-13	64,942	(2,410)	-3.58%

Base trend from June 2013 level			
FY 2013-14	64,942	-20.52%	(16,767)

November 2012 Forecast	
Forecasted December 2012 Level	83,622

	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	41,945	17.16%	6,145
FY 2006-07	47,047	12.16%	5,102
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%	7,143
FY 2010-11	67,267	-2.12%	(1,458)
FY 2011-12	74,266	10.40%	6,999
FY 2012-13*	81,709	10.02%	7,443
FY 2013-14	82,370	0.81%	661
FY 2014-15	87,098	5.74%	4,728
FY 2015-16	91,658	5.24%	4,560

*Value reported for FY 2012-13 has been adjusted to include clients that moved from CHP+ to Medicaid per SB 11-008

SB 11-008 Adjustments	
FY 2012-13	(3,874)
FY 2013-14	(15,495)
FY 2014-15	(16,558)
FY 2015-16	(16,558)

MAGI Adjustments	
FY 2013-14	(5,952)
FY 2014-15	(12,579)
FY 2015-16	(13,479)

SB 13-200 Medicaid Expansion	
FY 2013-14	1,124
FY 2014-15	7,002
FY 2015-16	15,871

Projections After Adjustments			
FY 2012-13*	77,836	4.81%	3,570
FY 2013-14	62,047	-20.28%	(15,789)
FY 2014-15	64,963	4.70%	2,916
FY 2015-16	77,492	19.29%	12,529

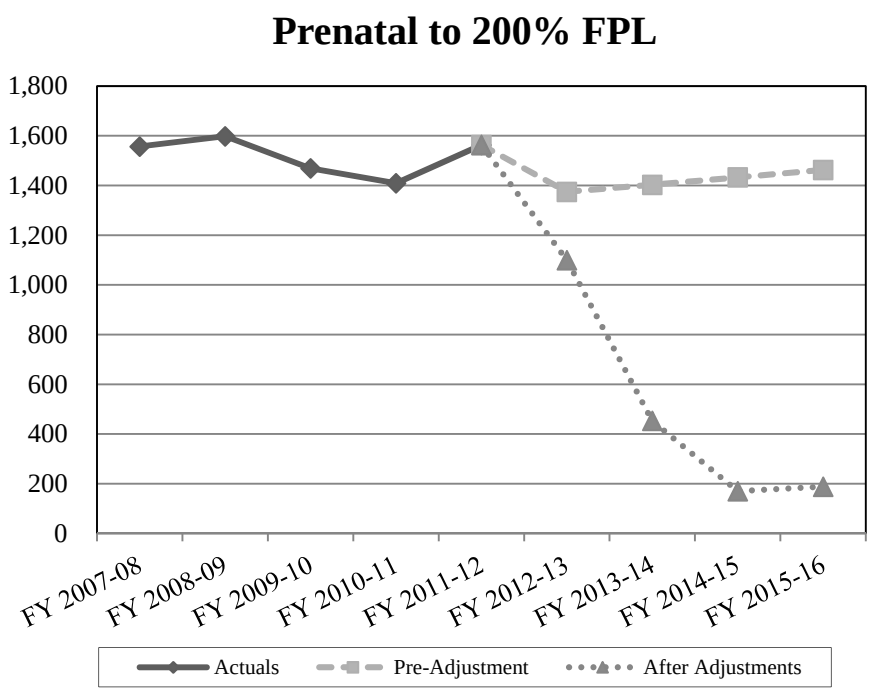
*Value reported for FY 2012-13 was actual caseload

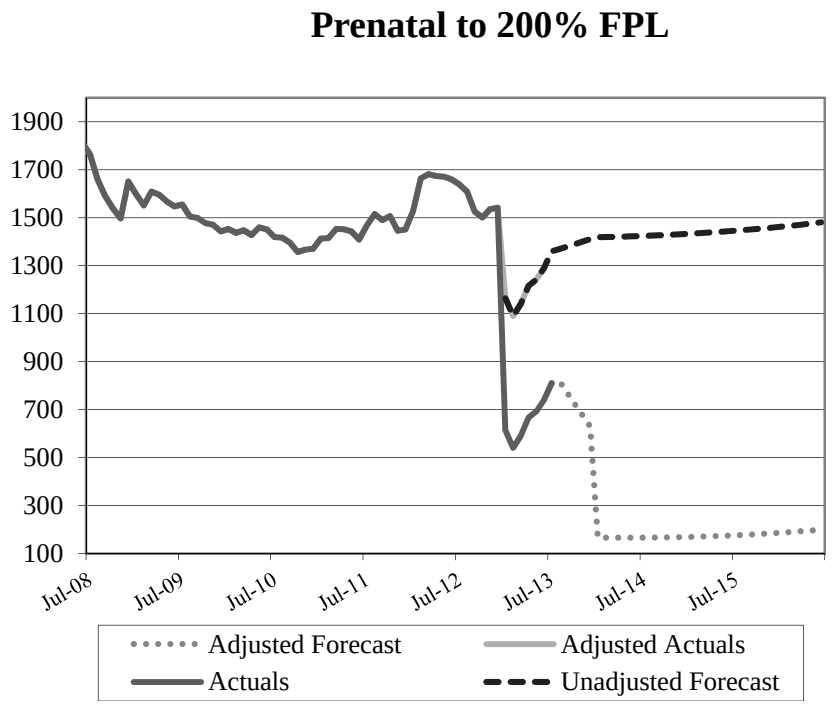
Actuals		
	Monthly Change	**% Change**
First 6-month average	362	0.44%
Last 6-month average	(3,348)	0.44%
12-month average	(1,493)	1.42%
18-month average	(394)	1.62%
24-month average	41	1.05%

Adjusted Monthly Average Growth Comparisons		
February 2013 Forecast	626	0.75%
FY 2012-13 Actuals	(668)	-0.83%
FY 2012-13 1st Half	362	0.44%
FY 2012-13 2nd Half	(1,698)	-2.09%
FY 2013-14 Forecast	772	1.04%
February 2013 Forecast	540	0.58%
FY 2014-15 Forecast	380	0.44%

February 2013 Trend Selections Before Adjustments			
FY 2012-13	85,946	15.73%	11,680
FY 2013-14	94,306	9.73%	8,360
FY 2014-15	99,316	5.31%	5,010

February 2013 Trend Selections After Adjustments			
FY 2012-13	83,316	12.19%	9,050
FY 2013-14	72,649	-12.80%	(10,667)
FY 2014-15	66,368	-8.65%	(6,282)





- Caseload growth in Prenatal to 200% FPL in FY 2012-13 was lower than the Department's February 2013 forecast, in which annual caseload was projected to be 1,224 and average monthly growth was projected to be a decrease of 9 per month. The Prenatal to 200% FPL base caseload for FY 2012-13 decreased by an average of 3.87% per month.
- The Department does not believe that the strong negative trend in FY 2012-13 will continue at similar magnitudes. The Department's forecast assumes that the FY 2013-14 base caseload will have an average monthly decrease of 48, compared to the FY 2012-13 average monthly decrease of 77. By FY 2014-15, the forecast shows the average monthly growth leveling out with average monthly growth of 1, 0.43%.
- There are two bottom-line adjustments to the CHP+ prenatal caseload. The first adjustment is from SB 11-250, which increases Medicaid eligibility for pregnant women from 133% FPL to 185% FPL beginning in January 2013 to comply with federal mandate. This has had a negative impact on CHP+ caseload as pregnant women who would otherwise be in CHP+ become

eligible for Medicaid for the last half of FY 2012-13 and is expected to continue to have a negative impact for the first half of FY 2013-14. This adjustment has been updated from the SB 11-250 estimate to account for the revised caseload forecasts and recent guidance from CMS. CMS has directed the Department to move all pregnant women who meet this income requirement in January 2013 into Medicaid immediately upon implementation, including the women who are enrolled in CHP+ at that time. This can be seen in the substantial decrease observed in January 2013.

- Similar to the Children's caseload, the second bottom-line adjustment to the Prenatal to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in health Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with household incomes within the official Medicaid eligibility range are actually eligible for CHP+. In FY 2011-12, for example, 39.0% of clients in the Prenatal to 200% caseload reported family incomes within the existing Medicaid eligibility limit of 133% FPL and 88.7% reported family incomes under 185% FPL. The Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for pregnant women whose incomes are documented at or below 185% FPL in CHP+ prior to the change. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has included an adjustment to its caseload forecast for FY 2013-14 forward.

Prenatal to 200% FPL

	Actuals	Monthly Change	% Change
Dec-10	1,370	-	-
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%
Jul-11	1,468	59	4.19%
Aug-11	1,516	48	3.27%
Sep-11	1,490	(26)	-1.72%
Oct-11	1,507	17	1.14%
Nov-11	1,446	(61)	-4.05%
Dec-11	1,451	5	0.35%
Jan-12	1,528	77	5.31%
Feb-12	1,664	136	8.90%
Mar-12	1,682	18	1.08%
Apr-12	1,674	(8)	-0.48%
May-12	1,671	(3)	-0.18%
Jun-12	1,660	(11)	-0.66%
Jul-12	1,639	(21)	-1.27%
Aug-12	1,610	(29)	-1.77%
Sep-12	1,526	(84)	-5.22%
Oct-12	1,501	(25)	-1.64%
Nov-12	1,536	35	2.33%
Dec-12	1,542	6	0.39%
Jan-13	614	(928)	-60.18%
Feb-13	541	(73)	-11.89%
Mar-13	591	50	9.24%
Apr-13	666	75	12.69%
May-13	692	26	3.90%
Jun-13	740	48	6.94%

	Caseload	% Change	Level Change
FY 2002-03	372	-	-
FY 2003-04	101	-72.85%	(271)
FY 2004-05	472	367.33%	371
FY 2005-06	963	104.03%	491
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	1,563	10.93%	154
FY 2012-13*	1,375	-12.04%	(188)
FY 2013-14	1,403	2.05%	28
FY 2014-15	1,433	2.14%	30
FY 2015-16	1,463	2.09%	30

* Value for FY 2012-13 reflects caseload including those clients now eligible for Medicaid due to SB 11-250

SB 11-250 Adjustment	
FY 2012-13	(275)
FY 2013-14	(713)
FY 2014-15	(780)
FY 2015-16	(780)

MAGI Adjustment	
FY 2012-13	0
FY 2013-14	(237)
FY 2014-15	(483)
FY 2015-16	(495)

Projections After Adjustments			
FY 2012-13*	1,100	-29.63%	(463)
FY 2013-14	453	-58.81%	(647)
FY 2014-15	170	-62.45%	(283)
FY 2015-16	188	10.58%	18

* Value reported for FY 2012-13 was actual caseload

Actuals	Monthly Change	% Change
First 6-month average	(20)	-1.19%
Last 6-month average	(134)	-6.55%
12-month average	(77)	-3.87%
18-month average	(40)	-1.80%
24-month average	(28)	-1.22%

Adjusted Monthly Average Growth Comparisons		
February 2013 Forecast	(9)	-0.52%
FY 2012-13 Actuals	(77)	-3.87%
FY 2012-13 1st Half	(20)	-1.19%
FY 2012-13 2nd Half	(134)	-6.55%
FY 2013-14 Forecast	(48)	-7.37%
February 2013 Forecast	1	0.04%
FY 2014-15 Forecast	1	0.43%

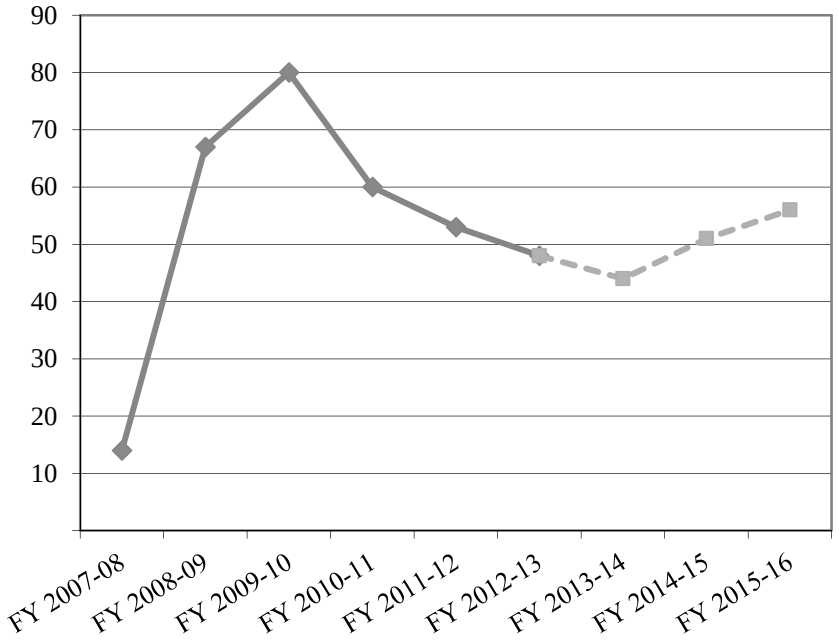
Base trend from June 2013 level			
FY 2013-14	740	-46.18%	(635)

February 2013 Forecast	
Forecasted June 2013 Level	1,557

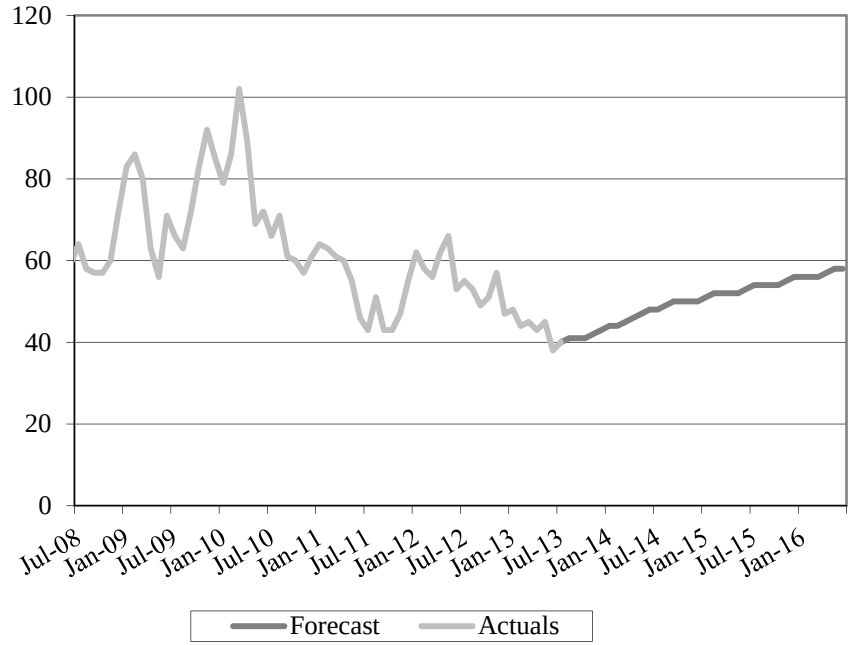
February 2013 Trend Selections Before Adjustments			
FY 2012-13	1,555	-0.51%	(8)
FY 2013-14	1,562	0.45%	7
FY 2014-15	1,568	0.38%	6

February 2013 Trend Selections After Adjustments			
FY 2012-13	1,224	-21.72%	(340)
FY 2013-14	708	-42.17%	(516)
FY 2014-15	387	-45.30%	(321)

Expansion to 205% FPL Prenatal



Expansion to 205% FPL Prenatal



- Along with the children's expansion to 205% FPL, this population was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this population have family incomes between 201 and 205% of the federal poverty level.
- Growth in the Expansion to 205% FPL Prenatal in FY 2012-13 was lower than the Department's February 2013 forecast, in which annual caseload was projected to be 52 and average monthly growth was forecasted to be 0. The selected trend for FY 2013-14 for Expansion to 205% FPL Prenatal is lower than the Department's February 2013 forecast with projected annual caseload at 44, and would result in average growth of 1 per month.

Expansion to 205% FPL Prenatal			
	Actuals	**Monthly Change**	**% Change**
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%
Jul-11	43	(3)	-6.52%
Aug-11	51	8	18.60%
Sep-11	43	(8)	-15.69%
Oct-11	43	0	0.00%
Nov-11	47	4	9.30%
Dec-11	55	8	17.02%
Jan-12	62	7	12.73%
Feb-12	58	(4)	-6.45%
Mar-12	56	(2)	-3.45%
Apr-12	62	6	10.71%
May-12	66	4	6.45%
Jun-12	53	(13)	-19.70%
Jul-12	55	2	3.77%
Aug-12	53	(2)	-3.64%
Sep-12	49	(4)	-7.55%
Oct-12	51	2	4.08%
Nov-12	57	6	11.76%
Dec-12	47	(10)	-17.54%
Jan-13	48	1	2.13%
Feb-13	44	(4)	-8.33%
Mar-13	45	1	2.27%
Apr-13	43	(2)	-4.44%
May-13	45	2	4.65%
Jun-13	38	(7)	-15.56%

Base trend from June 2013 level			
FY 2013-14	38	-20.83%	(10)

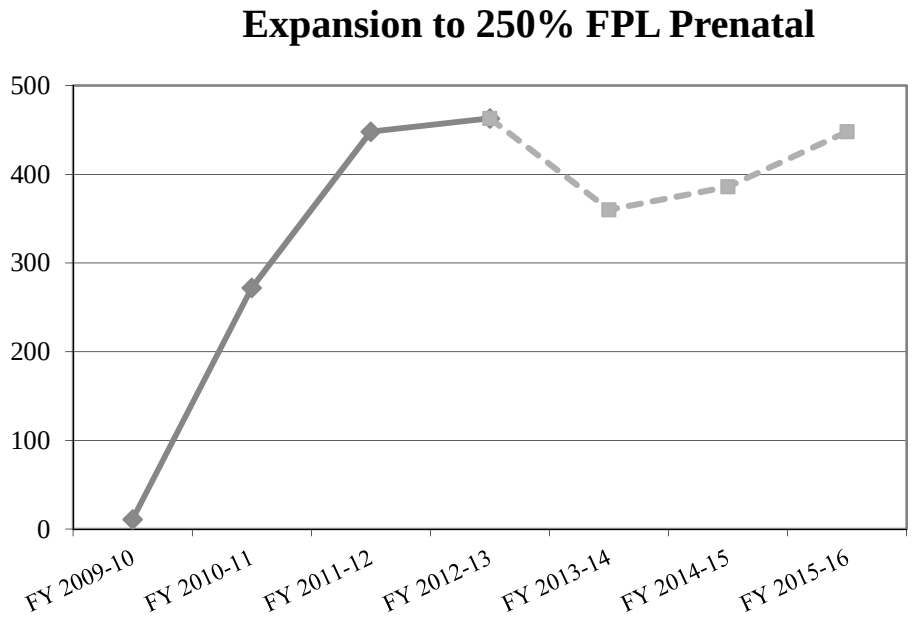
	Caseload	**% Change**	**Level Change**
FY 2007-08	14	-	-
FY 2008-09	67	378.57%	53
FY 2009-10	80	19.40%	13
FY 2010-11	60	-25.00%	(20)
FY 2011-12	53	-11.67%	(7)
FY 2012-13	48	-9.43%	(5)
FY 2013-14	44	-8.33%	(4)
FY 2014-15	51	15.91%	7
FY 2015-16	56	9.80%	5

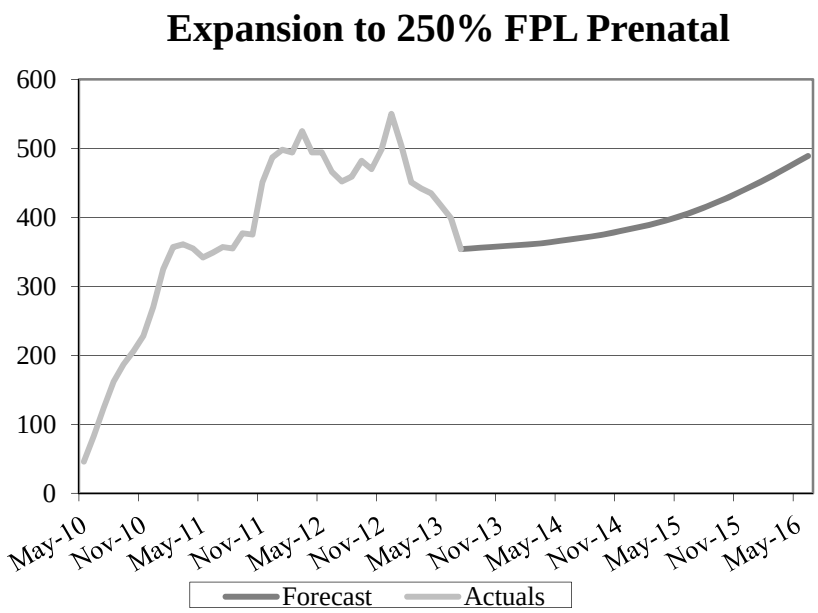
February 2013 Trend Selections			
FY 2012-13	52	-1.89%	(1)
FY 2013-14	53	1.92%	1
FY 2014-15	53	0.00%	0

Actuals		
	Monthly Change	**% Change**
6-month average	(2)	-3.21%
12-month average	(1)	-2.37%
18-month average	(1)	-1.56%
24-month average	0	-0.22%

Monthly Average Growth Comparisons		
February 2013 Forecast	0	0.27%
FY 2012-13 Actuals	(1)	-2.37%
FY 2012-13 1st Half	(1)	-1.52%
FY 2012-13 2nd Half	(2)	-3.21%
FY 2013-14 Forecast	1	1.98%
February 2013 Forecast	0	0.00%
FY 2014-15 Forecast	0	0.83%

February 2013 Forecast	
Forecasted June 2013 Level	53





- 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 and 250% of the federal poverty level.
- Growth in FY 2012-13 was lower than the Department's February 2013 estimates in which annual caseload was projected to be 536 and average monthly growth was projected to be 12. The Department has decreased its caseload growth forecast to account for this lower growth.
- The selected trend for FY 2013-14 for Expansion to 250% FPL Prenatal is lower than the Department's February 2013 forecast, and would result in average decreases of 3 per month. This is based on the average monthly growth between July 2012 and June 2013 which had average decreases of 1.12% per month in FY 2012-13.
- The FY 2014-15 forecast for the Expansion to 250% FPL Prenatal assumes that the decreases will not continue in out years. The forecast predicts that positive growth will resume in FY 2014-15 under the assumption that as the economy improves people are more likely to become pregnant.

Expansion to 250% Prenatal			
	Actuals	**Monthly Change**	**% Change**
Dec-10	270	-	-
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%
Jul-11	357	8	2.29%
Aug-11	355	(2)	-0.56%
Sep-11	377	22	6.20%
Oct-11	375	(2)	-0.53%
Nov-11	451	76	20.27%
Dec-11	487	36	7.98%
Jan-12	498	11	2.26%
Feb-12	494	(4)	-0.80%
Mar-12	525	31	6.28%
Apr-12	494	(31)	-5.90%
May-12	494	0	0.00%
Jun-12	466	(28)	-5.67%
Jul-12	452	(14)	-3.00%
Aug-12	459	7	1.55%
Sep-12	482	23	5.01%
Oct-12	470	(12)	-2.49%
Nov-12	498	28	5.96%
Dec-12	550	52	10.44%
Jan-13	504	(46)	-8.36%
Feb-13	451	(53)	-10.52%
Mar-13	442	(9)	-2.00%
Apr-13	435	(7)	-1.58%
May-13	417	(18)	-4.14%
Jun-13	399	(18)	-4.32%

	Caseload	**% Change**	**Level Change**
FY 2009-10	11	-	-
FY 2010-11	272	2372.73%	261
FY 2011-12	448	64.71%	176
FY 2012-13	463	3.35%	15
FY 2013-14	360	-22.25%	(103)
FY 2014-15	386	7.22%	26
FY 2015-16	448	16.06%	62

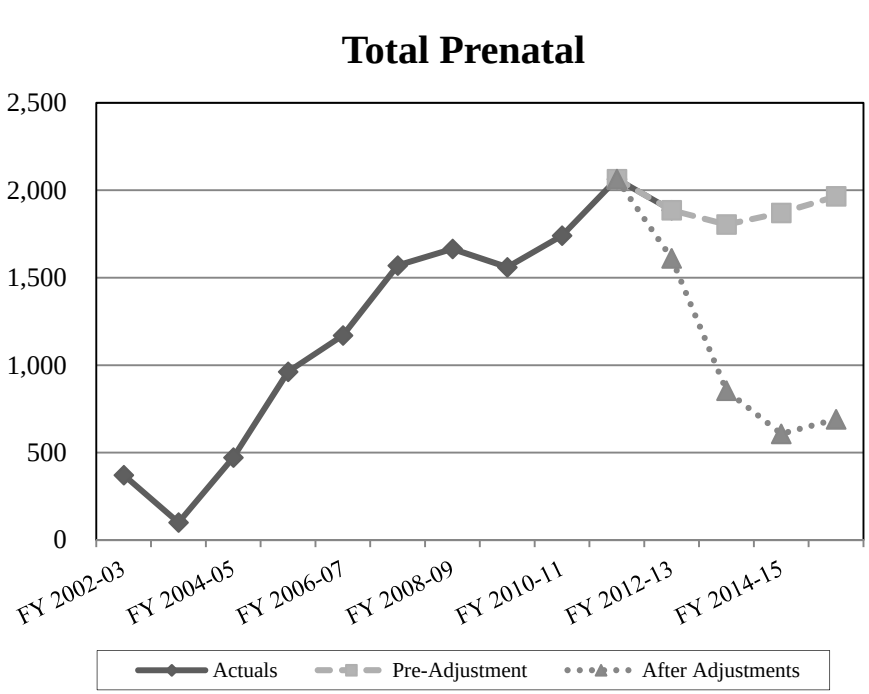
February 2013 Trend Selections			
FY 2012-13	536	19.64%	88
FY 2013-14	637	18.84%	101
FY 2014-15	692	8.63%	55

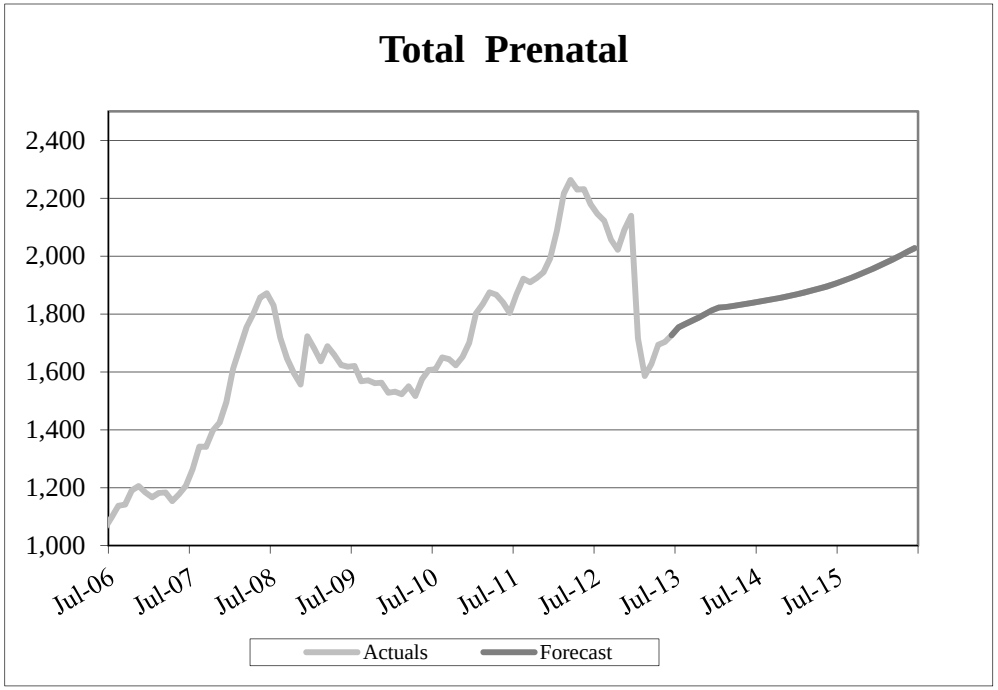
Actuals		
	Monthly Change	**% Change**
6-month average	(25)	2.91%
12-month average	(6)	1.14%
18-month average	(5)	2.74%
24-month average	2	3.22%

Monthly Average Growth Comparisons		
February 2013 Forecast	12	2.28%
FY 2012-13 Actuals	(6)	-1.12%
FY 2012-13 1st Half	14	2.91%
FY 2012-13 2nd Half	(25)	-5.15%
FY 2013-14 Forecast	(3)	-0.62%
February 2013 Forecast	5	0.73%
FY 2014-15 Forecast	3	0.82%

Base trend from June 2013 level			
FY 2013-14	399	-13.82%	(64)

February 2013 Forecast	
Forecasted June 2013 Level	607





- The FY 2013-14 total prenatal caseload forecast is 855, a 58.57% decrease over the FY 2012-13 caseload of 1,611. This forecast includes average increases of 55 (4.48%) per month before bottom line adjustments.
- The FY 2013-14 base caseload is projected to decrease 4.29% to 1,805, and FY 2014-15 caseload is forecasted to grow 3.66% to 1,871. Total prenatal base caseload is projected to increase by 4.48% (55 clients) per month in FY 2013-14 and 0.28% (5 clients) per month in FY 2014-15. The strong monthly growth in FY 2013-14 is due to the unusual decreases in the second half of FY 2012-13 seen in the base caseload, excluding those clients that were moved from CHP+ to Medicaid due to SB 11-250. The department does not assume these decreases will continue and the base caseload will return to a positive trend.
- As described in the CHP+ Prenatal to 200% FPL section, there are two bottom-line adjustments to the CHP+ prenatal caseload. The first adjustment is from SB 11-250, which increases Medicaid eligibility for pregnant women from 133% FPL to 185% FPL beginning in January 2013 to comply with federal mandate. This has had a negative impact on CHP+ caseload as pregnant women who would otherwise be in CHP+ become eligible for Medicaid for the last half of FY 2012-13 and is expected to continue to have

a negative impact for the first half of FY 2013-14. The second bottom-line adjustment to the Prenatal to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in health Exchanges, as well as Medicaid and federal CHIP programs.

- The SB 11-250 and MAGI adjustments decrease the FY 2013-14 caseload projection to 855, which is a 58.57% decrease from the adjusted FY 2012-13 actuals. Both adjustments also decrease the FY 2014-15 caseload projection to 608, which is a 28.88% decrease from the adjusted FY 2013-14 projection. FY 2015-16 returns to a positive growth trend with caseload projection at 691, a 13.65% increase from the adjusted FY 2014-15 projection.

Total Prenatal

	Actuals	Monthly Change	% Change
Dec-10	1,701	-	-
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%
Jul-11	1,868	64	3.55%
Aug-11	1,922	54	2.89%
Sep-11	1,910	(12)	-0.62%
Oct-11	1,925	15	0.79%
Nov-11	1,944	19	0.99%
Dec-11	1,993	49	2.52%
Jan-12	2,088	95	4.77%
Feb-12	2,216	128	6.13%
Mar-12	2,263	47	2.12%
Apr-12	2,230	(33)	-1.46%
May-12	2,231	1	0.04%
Jun-12	2,179	(52)	-2.33%
Jul-12	2,146	(33)	-1.51%
Aug-12	2,122	(24)	-1.12%
Sep-12	2,057	(65)	-3.06%
Oct-12	2,022	(35)	-1.70%
Nov-12	2,091	69	3.41%
Dec-12	2,139	48	2.30%
Jan-13	1,166	(973)	-45.49%
Feb-13	1,036	(130)	-11.15%
Mar-13	1,078	42	4.05%
Apr-13	1,144	66	6.12%
May-13	1,154	10	0.87%
Jun-13	1,177	23	1.99%

	Caseload	% Change	Level Change
FY 2002-03	372	-	-
FY 2003-04	101	-72.85%	(271)
FY 2004-05	472	367.33%	371
FY 2005-06	963	104.03%	491
FY 2006-07	1,170	21.50%	207
FY 2007-08	1,570	34.19%	400
FY 2008-09	1,665	6.05%	95
FY 2009-10	1,560	-6.31%	(105)
FY 2010-11	1,741	11.60%	181
FY 2011-12	2,064	18.55%	323
FY 2012-13	1,886	-8.62%	(178)
FY 2013-14	1,805	-4.29%	(81)
FY 2014-15	1,871	3.66%	66
FY 2015-16	1,966	5.08%	95

SB 11-250 Adjustments	
FY 2012-13	(275)
FY 2013-14	(713)
FY 2014-15	(780)
FY 2015-16	(780)

MAGI Adjustments	
FY 2013-14	(237)
FY 2014-15	(483)
FY 2015-16	(495)

Projections After Adjustments			
FY 2012-13	1,611	-21.95%	(453)
FY 2013-14	855	-58.57%	(1,209)
FY 2014-15	608	-28.88%	(247)
FY 2015-16	691	13.65%	83

Actuals		
	Monthly Change	% Change
First 6-month average	(7)	-0.28%
Last 6-month average	(160)	-7.27%
12-month average	(84)	-3.77%
18-month average	(45)	-2.00%
24-month average	(26)	-1.08%

Adjusted Monthly Average Growth Comparisons		
February 2013 Forecast	3	0.16%
FY 2012-13 Actuals	(38)	-1.70%
FY 2012-13 1st Half	(7)	-0.28%
FY 2012-13 2nd Half	(69)	-3.12%
FY 2013-14 Forecast	55	4.48%
February 2013 Forecast	5	0.22%
FY 2014-15 Forecast	5	0.28%

Base trend from June 2013 level			
FY 2013-14	1,177	-37.59%	(709)

February 2013 Forecast	
Forecasted June 2013 Level	1,552

February 2013 Trend Selections Before Adjustments			
FY 2012-13	2,143	3.83%	79
FY 2013-14	2,252	5.09%	109
FY 2014-15	2,313	2.71%	61

February 2013 Trend Selections After Adjustments			
FY 2012-13	1,812	-12.23%	(253)
FY 2013-14	1,398	-22.85%	(414)
FY 2014-15	1,132	-19.00%	(266)

Exhibit	Title of Exhibit
Exhibit C1	Calculation of Current Total Long Bill Group Impact
Exhibit C2	Calculation of Fund Splits
Exhibit C2	Cash Fund Report
Exhibit C3	CBHP Expenditure Summary
Exhibit C4	CBHP Caseload by Fiscal Year
Exhibit C4	CBHP Caseload by Month
Exhibit C4	CBHP Capitation Payments Per Capita Historical Summary
Exhibit C4	CBHP Historical Expenditure Summary
Exhibit C5	Expenditure Calculations by Eligibility Category
Exhibit C5	Incurred But Not Reported Runout by Fiscal Period
Exhibit C5	Incurred But Not Reported Expenditures by Fiscal Period
Exhibit C6	CBHP Retroactivity Adjustment
Exhibit C6	CBHP Partial Month Adjustment Multiplier
Exhibit C7	CBHP Reconciliation Adjustment Calculation
Exhibit C8	CBHP Capitation Rate Trends and Forecasts
Exhibit C9	Forecast Model Comparisons - Capitation Trend Models - Final Forecasts

Exhibit C1 - Calculation of Current Total Long Bill Group Impact

FY 2013-14 Children's Basic Health Plan Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Chilldren's Basic Health Plan Capitation Appropriation						
FY 2013-14 Long Bill Appropriation (SB 13-230)	$194,274,465	$22,131,064	$438,300	$46,390,391	$0	$125,314,710
Bill Annualizations						
SB 13-200 "Expand Medicaid Eligibility"	$2,007,812	$694,706	$0	$22,938	$0	$1,290,168
FY 2013-14 Total Children's Basic Heath Plan Capitation Spending Authority	**$196,282,277**	**$22,825,770**	**$438,300**	**$46,413,329**	**$0**	**$126,604,878**
Projected Total FY 2013-14 CBHP Capitation Expenditure	**$178,896,554**	**$19,516,349**	**$438,300**	**$43,844,144**	**$0**	**$115,097,761**
FY 2013-14 Children's Basic Health Plan Capitation Estimated Change from Appropriation	**($17,385,723)**	**($3,309,421)**	**$0**	**($2,569,185)**	**$0**	**($11,507,117)**
Percent Change from Spending Authority	-8.86%	-14.50%	0.00%	-5.54%	0.00%	-9.09%

FY 2013-14 CBHP External Admin

FY 2013-14 CBHP External Admin Appropriation						
FY 2013-14 Long Bill Appropriation (SB 13-230)	$4,319,079	$0	$0	$2,019,582	$0	$2,299,497
FY 2013-14 Total CBHP External Admin Spending Authority	**$4,319,079**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
Projected Total FY 2013-14 CBHP External Admin Expenditure	**$4,319,079**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
Total FY 2013-14 CBHP External Admin Change from Appropriation	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from Spending Authority	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact

FY 2014-15 Children's Basic Health Plan Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 CBHP Capitation Appropriation Plus Special Bills	**$196,282,277**	**$22,825,770**	**$438,300**	**$46,413,329**	**$0**	**$126,604,878**
SB 13-079 "Rule Review Bill"	$307,832	$61,909	$0	$45,832	$0	$200,091
SB 13-200 Annualization "Expand Medicaid Eligibility"	$10,868,375	$3,761,946	$0	$119,957	$0	$6,986,472
Total Annualizations	**$11,176,207**	**$3,823,855**	**$0**	**$165,789**	**$0**	**$7,186,563**
FY 2014-15 CBHP Capitation Base Amount	**$207,458,484**	**$26,649,625**	**$438,300**	**$46,579,118**	**$0**	**$133,791,441**
Projected Total FY 2014-15 CBHP Capitation Expenditure	**$169,414,990**	**$17,246,456**	**$435,000**	**$42,869,374**	**$0**	**$108,864,159**
Total FY 2014-15 CBHP Capitation Request	**($38,043,494)**	**($9,403,169)**	**($3,300)**	**($3,709,744)**	**$0**	**($24,927,282)**
Percent Change from FY 2014-15 CBHP Capitation Base	-18.34%	-35.28%	-0.75%	-7.96%	0.00%	-18.63%
Percent Change from FY 2013-14 Estimated CBHP Capitation Expenditure	-5.30%	-11.63%	-0.75%	-2.22%	0.00%	-5.42%

FY 2014-15 CBHP External Admin

FY 2013-14 CBHP External Admin Appropriation Plus Special Bills	**$4,319,079**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
FY 2014-15 CBHP External Admin Base Amount	**$4,319,079**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
Projected Total FY 2014-15 CBHP External Admin Expenditure	**$4,319,079**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
Total FY 2013-14 CBHP External Admin Request	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2013-14 CBHP External Admin Base	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Percent Change from FY 2012-13 Estimated CBHP External Admin Expenditure	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 2015-16 Children's Basic Health Plan Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2014-15 CBHP Capitation Appropriation Plus Special Bills	**$207,458,484**	**$26,649,625**	**$438,300**	**$46,579,118**	**$0**	**$133,791,441**
Bill Annualizations						
SB 13-200 Annualization "Expand Medicaid Eligibility"	$16,826,706	$758,121	$0	$180,997		$15,887,588
FY 2015-16 CBHP Capitation Base Amount	**$224,285,190**	**$27,407,746**	**$438,300**	**$46,760,115**	**$0**	**$149,679,029**
Projected Total FY 2015-16 CBHP Capitation Expenditure	**$203,150,766**	**$0**	**$0**	**$36,508,518**	**$0**	**$166,642,248**
Total FY 2015-16 CBHP Capitation Continuation Amount	**($21,134,424)**	**($27,407,746)**	**($438,300)**	**($10,251,597)**	**$0**	**$16,963,219**
Percent Change from FY 2015-16 CBHP Capitation Base	-9.42%	-100.00%	-100.00%	-21.92%	0.00%	11.33%
Percent Change from FY 2014-15 Estimated CBHP Capitation Expenditure	19.91%	-100.00%	-100.00%	-14.84%	0.00%	53.07%
FY 2015-16 CBHP External Admin						
FY 2014-15 CBHP External Admin Base Amount	**$4,319,079**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
FY 2014-15 R#10 Administrative Contract Reprocurements	$1,690,563	$0	$0	$794,518	$0	$896,045
SB 13-200 Annualization "Expand Medicaid Eligibility"	$714,195	$0	$0	$344,242	$0	$369,953
FY 2015-16 CBHP External Admin Base Amount	**$6,723,837**	**$0**	**$0**	**$3,158,342**	**$0**	**$3,565,495**
Projected Total FY 2015-16 CBHP External Admin Expenditure	**$6,723,837**	**$0**	**$0**	**$3,158,342**	**$0**	**$3,565,495**
Total FY 2015-16 CBHP External Admin Continuation Amount	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2014-15 CBHP External Admin Base	55.68%	0.00%	0.00%	56.39%	0.00%	55.06%
Percent Change from FY 2014-15 CBHP External Admin Expenditure	55.68%	0.00%	0.00%	56.39%	0.00%	55.06%

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2013-14 CBHP Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
CBHP Expenditure to be matched	$177,073,478	$61,975,717	$0	$0	$115,097,761	65.00%
Enrollment Fees CBHP Trust Fund	$309,888		$309,888	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,513,188		$1,513,188	$0	$0	0.00%
Total CBHP Expenditure	**$178,896,554**	**$61,975,717**	**$1,823,076**	**$0**	**$115,097,761**	
Cash Fund Financing						
CBHP Trust Fund	$0	($24,235,114)	$24,235,114	$0	$0	
CO Immunization Fund	$0	($216,871)	$216,871	$0	$0	
Health Care Expansion Fund	$0	($1)	$1	$0	$0	
Hospital Provider Fee Fund	$0	($17,569,081)	$17,569,081	$0	$0	
Estimated FY 2013-14 Capitation Expenditure	**$178,896,554**	**$19,954,649**	**$43,844,144**	**$0**	**$115,097,761**	
CBHP Admin Payments	**$4,319,079**	**$0**	**$2,019,582**	**$0**	**$2,299,497**	53.24%
Final Estimated FY 2013-14 CBHP Expenditure	**$183,215,633**	**$19,954,649**	**$45,863,726**	**$0**	**$117,397,258**	

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Split - FY 2014-15 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
CBHP Expenditure to be matched	$167,483,322	$58,619,163	$0	$0	$108,864,159	65.00%
Enrollment Fees CBHP Trust Fund	$321,339	$0	$321,339	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,610,329	$0	$1,610,329	$0	$0	0.00%
Total CBHP Expenditure	**$169,414,990**	**$58,619,163**	**$1,931,668**	**$0**	**$108,864,159**	
Cash Fund Financing						
CBHP Trust Fund	$0	($24,434,927)	$24,434,927	$0	$0	
CO Immunization Fund	$0	($234,000)	$234,000	$0	$0	
Health Care Expansion Fund	$0	($1)	$1	$0	$0	
Hospital Provider Fee Fund	$0	($16,268,778)	$16,268,778	$0	$0	
Final Estimated FY 2014-15 Capitation Expenditure	**$169,414,990**	**$17,681,456**	**$42,869,374**	**$0**	**$108,864,159**	
CBHP Admin Payments	**$4,319,079**	**$0**	**$2,019,582**	**$0**	**$2,299,497**	53.24%
Final Estimated FY 2014-15 CBHP Expenditure	**$173,734,069**	**$17,681,456**	**$44,888,956**	**$0**	**$111,163,656**	

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Split - FY 2015-16 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate
CBHP Expenditure to be matched Q1& Q2*	$89,597,919	$21,055,511	$0	$0	$68,542,408	76.50%
CBHP Expenditure to be matched Q3& Q4	$111,477,091	$13,377,251	$0	$0	$98,099,840	88.00%
Enrollment Fees CBHP Trust Fund Q1 & Q2	$175,629	$0	$175,629	$0	$0	0.00%
Enrollment Fees CBHP Trust Fund Q3 & Q4	$206,224	$0	$206,224	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee Q1 & Q2	$683,920	$0	$683,920	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee Q3 & Q4	$1,009,983	$0	$1,009,983	$0	$0	0.00%
Total CBHP Expenditure Q1 & Q2	**$90,457,467**	**$21,055,511**	**$859,548**	**$0**	**$68,542,408**	
Total CBHP Expenditure Q3 & Q4	**$112,693,299**	**$13,377,251**	**$1,216,208**	**$0**	**$98,099,840**	
Total CBHP Expenditure	**$203,150,766**	**$34,432,762**	**$2,075,756**	**$0**	**$166,642,248**	
Cash Fund Financing						
CBHP Trust Fund	$0	($25,951,357)	$25,951,357	$0	$0	
CO Immunization Fund	$0	($234,000)	$234,000	$0	$0	
Health Care Expansion Fund	$0	($1)	$1	$0	$0	
Hospital Provider Fee Fund	$0	($8,247,404)	$8,247,404	$0	$0	
Final Estimated FY 2014-15 Capitation Expenditure	**$203,150,766**	**$0**	**$36,508,518**	**$0**	**$166,642,248**	
CBHP Admin Payments	**$6,723,837**	**$0**	**$3,158,342**	**$0**	**$3,565,495**	53.03%
Final Estimated FY 2015-16 CBHP Expenditure	**$209,874,603**	**$0**	**$39,666,860**	**$0**	**$170,207,743**	

*Starting October 1, 2015, CBHP programs will receive a federal match of 88% instead of the historical 65%. The first half of the fiscal year has an FFP rate of 76.50%, the average of 65% and 88%. The second half of the fiscal year is 88%

Exhibit C2 - Cash Funds Report for Children's Basic Health Plan Capitation Payments

Cash Fund	FY 2013-14			FY 2014-15			FY 2015-16*		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund**	$26,763,427	$24,545,002	($2,218,425)	$26,883,384	$24,756,266	($2,127,118)	$26,918,265	$26,333,210	($585,055)
CO Immunization Fund	$216,871	$216,871	$0	$216,871	$234,000	$17,129	$216,871	$234,000	$17,129
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Hospital Provider Fee Fund	$19,433,030	$19,082,270	($350,760)	$19,478,862	$17,879,107	($1,599,755)	$19,478,862	$9,941,307	($9,537,555)
Total Cash Funds	**$46,413,329**	**$43,844,144**	**($2,569,185)**	**$46,579,118**	**$42,869,374**	**($3,709,744)**	**$46,613,999**	**$36,508,518**	**($10,105,481)**

*Starting October 1, 2015, CBHP programs will receive a federal match of 88% instead of the historical 65%. Due to this subtantial change, cash funds are estimated as the expenditure in each half of FY 2015-16 for populations to 205% FPL (CBHP Trust Fund) and populations 206%-250% FPL (Hospital Provider Fee). The Colorado Immunization Fund and Health Care Expansion Fund are then applied as offsets to the CBHP Trust Fund expenditure.

**Estimated revenues to the CBHP Trust Fund are based on the 2013 Tobacco MSA Payment Forecast.

Exhibit C2 - Cash Funds Report for Children's Basic Health Plan Admin Payments

Cash Fund	FY 2013-14			FY 2014-15			FY 2015-16		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund*	$2,010,221	$2,010,221	$0	$2,010,221	$2,010,221	$0	$3,148,981	$3,148,981	$0
CO Immunization Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Expansion Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hospital Provider Fee Fund	$9,361	$9,361	$0	$9,361	$9,361	$0	$9,361	$9,361	$0
Total Cash Funds	**$2,019,582**	**$2,019,582**	**$0**	**$2,019,582**	**$2,019,582**	**$0**	**$3,158,342**	**$3,158,342**	**$0**

*Estimated revenues to the CBHP Trust Fund are based on the 2013 Tobacco MSA Payment Forecast.

Exhibit C3 - Children's Basic Health Plan Programs Expenditure Summary

Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2012-13 Actual		FY 2013-14 Appropriated		FY 2013-14 Estimate		FY 2013-14 Change from Appropriation		FY 2014-15 Estimate		FY 2014-15 Change from FY 2013-14 Estimate		FY 2014-15 Change from FY 2013-14 Appropriation		FY 2015-16 Estimate		FY 2015-16 Change from FY 2014-15 Estimate	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
CBHP Capitation Payments																		
Children to 200% FPL Medical	60,646	$125,142,253	51,721	$113,853,437	43,619	$95,519,972	(8,102)	($18,333,465)	45,418	$103,777,684	1,799	$8,257,712	(6,303)	($10,075,753)	56,998	$134,062,412	11,580	$30,284,729
Children 201%-205% FPL Medical	1,614	$3,278,065	1,780	$3,918,314	1,698	$3,669,462	(82)	($248,852)	1,742	$3,980,020	44	$310,558	(38)	$61,706	1,767	$4,190,021	25	$210,001
Children 206%-250% FPL Medical	15,575	$28,314,344	19,148	$42,150,492	16,730	$39,962,954	(2,418)	($2,187,539)	17,804	$39,218,219	1,074	($744,735)	(1,344)	($2,932,274)	18,728	$41,281,220	924	$2,063,002
Children to 200% FPL Dental	60,646	$10,750,133	51,721	$9,342,364	43,619	$8,397,563	(8,102)	($944,801)	45,418	$8,409,335	1,799	$11,771	(6,303)	($933,029)	56,998	$10,863,649	11,580	$2,454,314
Children 201%-205% FPL Dental	1,614	$258,132	1,780	$321,521	1,698	$319,858	(82)	($1,663)	1,742	$322,539	44	$2,680	(38)	$1,017	1,767	$335,362	25	$12,823
Children 206%-250% FPL Dental	15,575	$2,326,813	19,148	$3,458,703	16,730	$3,512,502	(2,418)	$53,799	17,804	$3,296,486	1,074	($216,016)	(1,344)	($162,217)	18,728	$3,554,417	924	$257,931
Prenatal to 200% FPL	1,100	$15,738,589	708	$9,435,963	453	$5,654,754	(254)	($3,781,209)	170	$2,222,651	(283)	($3,432,103)	(537)	($7,213,312)	188	$2,309,037	18	$86,386
Prenatal 201%-205% FPL	48	$631,596	53	$706,864	44	$515,873	(9)	($190,991)	51	$624,973	7	$109,100	(2)	($81,891)	56	$691,339	5	$66,366
Prenatal 206%-250% FPL	463	$5,063,773	637	$8,495,701	360	$4,255,383	(277)	($4,240,318)	386	$4,815,699	26	$560,316	(251)	($3,680,002)	448	$5,863,309	62	$1,047,610
Adjustments																		
Estimated cost of CBHP PPS Implementation				*$2,591,104*		*$3,964,797*				*$2,747,385*								
Retroactive payments for June 2013 [1]						*$13,123,436*												
Sub-total CBHP Capitation Payments	**79,446**	**$191,503,697**	**74,047**	**$194,274,465**	**62,904**	**$178,896,554**	**(11,142)**	**($15,377,911)**	**65,571**	**$169,414,990**	**2,667**	**($9,481,564)**	**(8,475)**	**($24,859,475)**	**78,185**	**$203,150,766**	**12,614**	**$33,735,776**
Enrollment Fees		$1,801,418				$1,823,076		$1,823,076		$1,931,668		$108,592		$1,931,668		$2,075,756		$144,088
Children to 200%	*$5.12*	*$310,231*			*$5.12*	*$223,130*		*$5.12*	*$5.12*	*$232,333*	*$0*	*$9,203*		*$5*	*$5.12*	*$291,570*	*$5*	*$59,237*
Children 201%-205%	*$51.09*	*$82,466*			*$51.09*	*$86,757*		*$51.09*	*$51.09*	*$89,006*	*$0*	*$2,248*			*$51.09*	*$90,283*	*$51*	*$1,277*
Children 206%-250%	*$90.45*	*$1,408,721*			*$90.45*	*$1,513,188*		*$90.45*	*$90.45*	*$1,610,329*	*$0*	*$97,141*		*$90*	*$90.45*	*$1,693,903*	*$90*	*$83,574*
Total CBHP Capitation Payments	**79,446**	**$191,503,697**	**74,047**	**$194,274,465**	**62,904**	**$178,896,554**	**(11,142)**	**($15,377,911)**	**65,571**	**$169,414,990**	**2,667**	**($9,481,564)**	**(8,475)**	**($24,859,475)**	**78,185**	**$203,150,766**	**12,614**	**$33,735,776**
Incremental Percent Change							-15.05%	-7.92%			4.24%	-5.30%	-11.45%	-12.80%			19.24%	19.91%
CBHP Admin Payments																		
External Admin		$4,245,129		$4,319,079		$4,319,079		$0		$4,319,079		$0		$0		$6,723,837		$2,404,758
Internal Admin		$0		$1,845,172		$0		($1,845,172)		$0		$0		($1,845,172)		$0		$0
Total CBHP Admin Payments		**$4,245,129**		**$6,164,251**		**$4,319,079**		**($1,845,172)**		**$4,319,079**		**$0**		**($1,845,172)**		**$6,723,837**		**$2,404,758**
Total CBHP Programs		**$195,748,826**		**$198,593,544**		**$183,215,633**		**($15,377,911)**		**$173,734,069**		**($9,481,564)**		**($24,859,475)**		**$209,874,603**		**$36,140,534**
Incremental Percent Change								-7.74%				-5.18%		-12.52%				20.80%

[1] Adjustment is made for July 2013 due to amount of claims paid in June.

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Average Caseload By Fiscal Year

Item	Children to 200% FPL	Children 201%-205% FPL	Children 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	CBHP TOTAL
FY 2006-07 Actuals	52,199	-	-	-	-	-	52,199
FY 2007-08 Actuals	57,466	330	-	1,557	14	-	59,367
% Change from FY 2006-07	10.09%	-	-	-	-	-	13.73%
FY 2008-09 Actuals	60,137	1,445	-	1,598	67	-	63,247
% Change from FY 2007-08	4.65%	337.88%	-	2.63%	378.57%	-	6.54%
FY 2009-10 Actuals	66,940	1,649	136	1,469	80	11	70,285
% Change from FY 2008-09	11.31%	14.12%	-	-8.07%	19.40%	-	11.13%
FY 2010-11 Actuals	62,080	1,164	4,023	1,409	60	272	69,008
% Change from FY 2009-10	-7.26%	-29.41%	2858.09%	-4.08%	-25.00%	2372.73%	-1.82%
FY 2011-12 Actuals	61,815	1,402	11,049	1,563	53	448	76,330
% Change from FY 2010-11	-0.43%	20.45%	174.65%	10.93%	-11.67%	64.71%	10.61%
FY 2012-13 Actuals	60,646	1,614	15,575	1,100	48	463	79,446
% Change from FY 2011-12	-1.89%	15.12%	40.96%	-29.62%	-9.43%	3.35%	4.08%
FY 2013-14 Projection	43,619	1,698	16,730	453	44	360	62,904
% Change from FY 2012-13	-28.08%	5.20%	7.42%	-58.81%	-8.33%	-22.25%	-20.82%
FY 2014-15 Projection	45,418	1,742	17,804	170	51	386	65,571
% Change from FY 2013-14	4.12%	2.59%	6.42%	-62.45%	15.91%	7.22%	4.24%
FY 2015-16 Projection	56,998	1,767	18,728	188	56	448	78,185
% Change from FY 2014-15	25.50%	1.44%	5.19%	10.58%	9.80%	16.06%	19.24%
FY 2013-14 Appropriation	51,721	1,780	19,148	708	53	637	74,047
Difference between the FY 2013-14 Appropriation and the FY 2013-14 Projection	8,925	(166)	(3,573)	393	(5)	(174)	5,400

Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary

CBHP CASELOAD FY 2011-12

FY 2011-12	Children to 200% FPL	Children 201%-205% FPL	Children 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201% 205% FPL	Prenatal 206% 250% FPL	TOTAL[(1)]	Monthly Growth	Monthly Growth Rate
July 2011	56,237	1,112	6,320	1,468	43	357	65,537	(223)	-0.34%
August 2011	56,495	1,130	6,444	1,516	51	355	65,991	454	0.69%
September 2011	56,349	1,157	7,275	1,490	43	377	66,691	700	1.06%
October 2011	57,549	1,217	8,075	1,507	43	375	68,766	2,075	3.11%
November 2011	58,238	1,313	10,493	1,446	47	451	71,988	3,222	4.69%
December 2011	58,258	1,441	12,338	1,451	55	487	74,030	2,042	2.84%
January 2012	62,736	1,553	12,985	1,528	62	498	79,362	5,332	7.20%
February 2012	64,579	1,620	13,250	1,664	58	494	81,665	2,303	2.90%
March 2012	66,466	1,585	13,774	1,682	56	525	84,088	2,423	2.97%
April 2012	69,001	1,559	13,492	1,674	62	494	86,282	2,194	2.61%
May 2012	68,520	1,601	14,169	1,671	66	494	86,521	239	0.28%
June 2012	67,346	1,535	13,975	1,660	53	466	85,035	(1,486)	-1.72%
Year-to-Date Average	**61,815**	**1,402**	**11,049**	**1,563**	**53**	**448**	**76,330**	**1,606**	**2.19%**

Effective November 3, 2008, the Department has restated caseload for fiscal years FY 2002-03 through FY 2007-08. For complete information on the restatement, please see the Department's caseload narrative accompanying this Request. The number of days captured in the monthly figure is equal to the number of days in the report month.

(1) Due to rounding, the average monthly totals may differ slightly from annual totals reported elsewhere.

CBHP CASELOAD FY 2012-13

FY 2012-13	Children to 200% FPL	Children 201%-205% FPL	Children 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201% 205% FPL	Prenatal 206% 250% FPL	TOTAL	Monthly Growth	Monthly Growth Rate
July 2012	68,486	1,491	13,731	1,639	55	452	85,854	819	0.96%
August 2012	67,368	1,570	14,509	1,610	53	459	85,569	(285)	-0.33%
September 2012	65,667	1,529	15,267	1,526	49	482	84,520	(1,049)	-1.23%
October 2012	66,552	1,528	14,955	1,501	51	470	85,057	537	0.64%
November 2012	67,410	1,672	15,289	1,536	57	498	86,462	1,405	1.65%
December 2012	66,797	1,656	16,575	1,542	47	550	87,167	705	0.82%
January 2013	63,305	1,717	16,159	614	48	504	82,347	(4,820)	-5.53%
February 2013	58,114	1,647	16,028	541	44	451	76,825	(5,522)	-6.71%
March 2013	53,539	1,628	16,337	591	45	442	72,582	(4,243)	-5.52%
April 2013	53,416	1,699	16,091	666	43	435	72,350	(232)	-0.32%
May 2013	49,793	1,645	15,914	692	45	417	68,506	(3,844)	-5.31%
June 2013	47,308	1,587	16,047	740	38	399	66,119	(2,387)	-3.48%
Year-to-Date Average	**60,646**	**1,614**	**15,575**	**1,100**	**48**	**463**	**79,447**	**(1,576)**	**-2.03%**

Effective November 3, 2008, the Department has restated caseload for fiscal years FY 2002-03 through FY 2007-08. For complete information on the restatement, please see the Department's caseload narrative accompanying this Request. The number of days captured in the monthly figure is equal to the number of days in the report month.

Exhibit C4 - Children's Basic Health Plan Capitation Payments Per Capita Historical Summary

Children's Basic Health Plan Capitation Payments Per Capita History

Item	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	TOTAL PER CAPITA
FY 2007-08 Actuals	$1,511.25	$1,437.26	-	$150.90	$143.57	-	$11,065.13	$9,541.29	-	$1,910.16
FY 2008-09 Actuals	$1,625.53	$1,671.91	-	$160.30	$163.88	-	$12,394.55	$12,427.40	-	$2,066.29
% Change from FY 2007-08	7.56%	16.33%	-	6.23%	14.15%	-	12.01%	30.25%	-	8.17%
FY 2009-10 Actuals	$2,169.08	$2,146.83	$1,185.39	$157.33	$153.67	$27.23	$12,115.01	$12,060.26	$4,086.11	$2,539.59
% Change from FY 2008-09	33.44%	28.41%	-	-1.85%	-6.23%	-	-2.26%	-2.95%	-	22.91%
FY 2010-11 Actuals	$2,050.19	$2,249.91	$2,431.25	$159.07	$158.68	$150.31	$15,205.14	$16,304.20	$16,695.74	$2,569.03
% Change from FY 2009-10	-5.48%	4.80%	105.10%	1.11%	3.26%	452.00%	25.51%	35.19%	308.60%	1.16%
FY 2011-12 Actuals	$1,992.16	$1,999.11	$1,746.70	$170.65	$167.16	$147.66	$12,042.02	$12,085.37	$10,473.06	$2,381.98
% Change from FY 2010-11	-2.83%	-11.15%	-28.16%	7.28%	5.34%	-1.76%	-20.80%	-25.88%	-37.27%	-7.28%
FY 2012-13 Actuals	$2,063.49	$2,031.02	$1,817.94	$177.26	$159.93	$149.39	$14,307.81	$13,158.25	$10,936.88	$2,410.49
% Change from FY 2011-12	3.58%	1.60%	4.08%	3.87%	-4.33%	1.17%	18.82%	8.88%	4.43%	1.20%
FY 2013-14 Projection	$2,449.98	$2,401.73	$2,599.88	$207.32	$200.45	$221.49	$13,963.39	$12,096.08	$12,524.87	$2,843.96
% Change from FY 2012-13	18.73%	18.25%	43.01%	16.96%	25.33%	48.27%	-2.41%	-8.07%	14.52%	17.98%
FY 2014-15 Projection	$2,326.85	$2,326.64	$2,244.68	$185.15	$185.15	$185.15	$13,108.63	$12,296.27	$12,517.80	$2,583.68
% Change from FY 2013-14	-5.03%	-3.13%	-13.66%	-10.70%	-7.63%	-16.41%	-6.12%	1.65%	-0.06%	-9.15%
FY 2015-16 Projection	$2,352.05	$2,371.26	$2,204.25	$190.60	$189.79	$189.79	$12,275.58	$12,345.34	$13,087.74	$2,598.33
% Change from FY 2014-15	1.08%	1.92%	-1.80%	2.94%	2.51%	2.51%	-6.35%	0.40%	4.55%	0.57%

Exhibit C4 - Children's Basic Health Plan Program, Expenditures Historical Summary								
Annual Total Expenditures								
Item		Children to 200% FPL	Children 201%-205% FPL	Children 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	CBHP TOTAL
FY 2007-08	*Medical Per Capita*	$1,511.25	$1,437.26	-	$11,065.13	$9,541.29	-	
	Dental Per Capita	$150.90	$143.57	-	-	-	-	
	Caseload	57,466	330	-	1,557	14	-	59,367
	Medical Expenditure	$86,845,298	$474,297	$0	$17,228,408	$133,578	$0	$104,681,581
	Dental Expenditure	$8,671,584	$47,378	$0	-	-	-	$8,718,962
	Total FY 2007-08 Expenditures	**$95,516,882**	**$521,675**	**$0**	**$17,228,408**	**$133,578**	**$0**	**$113,400,543**
FY 2008-09	*Medical Per Capita*	$1,625.53	$1,671.91	-	$12,394.55	$12,427.40	-	
	Dental Per Capita	$160.30	$163.88	-	-	-	-	
	Caseload	60,137	1,445	-	1,598	67	-	63,247
	Medical Expenditure	$97,754,566	$2,415,911	$0	$19,806,492	$832,636	$0	$120,809,604
	Dental Expenditure	$9,639,952	$236,802	$0	-	-	-	$9,876,754
	Total FY 2008-09 Expenditures	**$107,394,518**	**$2,652,712**	**$0**	**$19,806,492**	**$832,636**	**$0**	**$130,686,358**
	% Change from FY 2007-08	**12.44%**	**408.50%**	**-**	**14.96%**	**523.33%**	**-**	**15.24%**
FY 2009-10	*Medical Per Capita*	$2,169.08	$2,146.83	$1,185.39	$12,115.01	$12,060.26	$4,086.11	
	Dental Per Capita	$157.33	$153.67	$27.23	-	-	-	
	Caseload	66,940	1,649	136	1,469	80	11	70,285
	Medical Expenditure	$145,198,143	$3,540,117	$161,213	$17,796,945	$964,820	$44,947	$167,706,185
	Dental Expenditure	$10,531,735	$253,397	$3,704	-	-	-	$10,788,836
	Total FY 2009-10 Expenditures	**$155,729,878**	**$3,793,514**	**$164,916**	**$17,796,945**	**$964,820**	**$44,947**	**$178,495,021**
	% Change from FY 2008-09	**45.01%**	**43.01%**	**-**	**-10.15%**	**15.88%**	**-**	**36.58%**
FY 2010-11	*Medical Per Capita*	$2,050.19	$2,249.91	$2,431.25	$15,205.14	$16,304.20	$16,695.74	
	Dental Per Capita	$159.07	$158.68	$150.31	-	-	-	
	Caseload	62,080	1,164	4,023	1,409	60	272	69,008
	Medical Expenditure	$127,276,088	$2,618,896	$9,780,907	$21,424,039	$978,252	$4,541,242	$166,619,422
	Dental Expenditure	$9,875,071	$184,709	$604,697	-	-	-	$10,664,477
	Total FY 2010-11 Expenditures	**$137,151,159**	**$2,803,605**	**$10,385,604**	**$21,424,039**	**$978,252**	**$4,541,242**	**$177,283,899**
	% Change from FY 2009-10	**-11.93%**	**-26.09%**	**6197.49%**	**20.38%**	**1.39%**	**10003.49%**	**-0.68%**
FY 2011-12	*Medical Per Capita*	$1,992.16	$1,999.11	$1,746.70	$12,042.02	$12,085.37	$10,473.06	
	Dental Per Capita	$170.65	$167.16	$147.66	-	-	-	
	Caseload	61,815	1,402	11,049	1,563	53	448	76,330
	Medical Expenditure	$123,145,656	$2,802,756	$19,299,265	$18,821,679	$640,525	$4,691,931	$169,401,811
	Dental Expenditure	$10,548,485	$234,363	$1,631,528	-	-	-	$12,414,377
	Total FY 2011-12 Expenditures	**$133,694,141**	**$3,037,119**	**$20,930,793**	**$18,821,679**	**$640,525**	**$4,691,931**	**$181,816,188**
	% Change from FY 2010-11	**-2.52%**	**8.33%**	**101.54%**	**-12.15%**	**-34.52%**	**3.32%**	**2.56%**
FY 2012-13	*Medical Per Capita*	$2,063.49	$2,031.02	$1,817.94	$14,307.81	$13,158.25	$10,936.88	
	Dental Per Capita	$177.26	$159.93	$149.39	-	-	-	
	Caseload	60,646	1,614	15,575	1,100	48	463	79,446
	Medical Expenditure	$125,142,253	$3,278,065	$28,314,344	$15,738,589	$631,596	$5,063,773	$178,168,619
	Dental Expenditure	$10,750,133	$258,132	$2,326,813	-	-	-	$13,335,077
	Total FY 2012-13 Expenditures	**$135,892,385**	**$3,536,197**	**$30,641,156**	**$15,738,589**	**$631,596**	**$5,063,773**	**$191,503,697**
	% Change from FY 2011-12	**1.64%**	**16.43%**	**46.39%**	**-16.38%**	**-1.39%**	**7.93%**	**5.33%**
FY 2013-14 Projection	*Medical Per Capita*	$2,449.98	$2,401.73	$2,599.88	$13,963.39	$12,096.08	$12,524.87	
	Dental Per Capita	$207.32	$200.45	$221.49	-	-	-	
	Caseload	43,619	1,698	16,730	453	44	360	62,904
	Medical Expenditure	$106,865,847	$4,078,139	$43,496,016	$6,326,114	$532,227	$4,508,953	$165,807,297
	Dental Expenditure	$9,043,303	$340,359	$3,705,596	-	-	-	$13,089,257
	Total FY 2013-14 Expenditures	**$115,909,150**	**$4,418,499**	**$47,201,611**	**$6,326,114**	**$532,227**	**$4,508,953**	**$178,896,554**
	% Change from FY 2012-13	**-14.71%**	**24.95%**	**54.05%**	**-59.81%**	**-15.73%**	**-10.96%**	**-6.58%**
FY 2014-15 Projection	*Medical Per Capita*	$2,326.85	$2,326.64	$2,244.68	$13,108.63	$12,296.27	$12,517.80	
	Dental Per Capita	$185.15	$185.15	$185.15	-	-	-	
	Caseload	45,418	1,742	17,804	170	51	386	65,571
	Medical Expenditure	$105,680,668	$4,053,008	$39,964,194	$2,229,778	$627,110	$4,831,872	$157,386,630
	Dental Expenditure	$8,409,335	$322,539	$3,296,486	-	-	-	$12,028,360
	Total FY 2014-15 Expenditures	**$114,090,003**	**$4,375,547**	**$43,260,680**	**$2,229,778**	**$627,110**	**$4,831,872**	**$169,414,990**
	% Change from FY 2013-14	**-1.57%**	**-0.97%**	**-8.35%**	**-64.75%**	**17.83%**	**7.16%**	**-5.30%**
FY 2015-16 Projection	*Medical Per Capita*	$2,352.05	$2,371.26	$2,204.25	$12,275.58	$12,345.34	$13,087.74	
	Dental Per Capita	$190.60	$189.79	$189.79	-	-	-	
	Caseload	56,998	1,767	18,728	188	56	448	78,185
	Medical Expenditure	$134,062,412	$4,190,021	$41,281,220	$2,309,037	$691,339	$5,863,309	$188,397,338
	Dental Expenditure	$10,863,649	$335,362	$3,554,417	-	-	-	$14,753,427
	Total FY 2015-16 Expenditures	**$144,926,061**	**$4,525,382**	**$44,835,637**	**$2,309,037**	**$691,339**	**$5,863,309**	**$203,150,766**
	% Change from FY 2014-15	**27.03%**	**3.42%**	**3.64%**	**3.55%**	**10.24%**	**21.35%**	**19.91%**

Exhibit C5 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2013-14

FY 2013-14 Q1 & Q2 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	Totals
Weighted Capitation Rate	$153.45	$154.91	$153.94	$14.05	$14.05	$14.05	$991.57	$992.29	$983.47	
Estimated Monthly Caseload [1]	38,043	1,545	12,052	38,043	1,545	12,052	520	34	335	104,169
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	6	
Total Costs for FY 2013-14 Q1 & Q2 Capitated Payments	$35,026,190	$1,436,016	$11,131,709	$3,207,025	$130,244	$1,015,984	$3,093,698	$202,427	$1,976,775	$57,220,068
Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	90.31%	95.27%	92.13%	98.78%	98.69%	98.57%	91.40%	91.06%	92.48%	
Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$31,632,152	$1,368,092	$10,255,644	$3,167,899	$128,538	$1,001,455	$2,827,640	$184,330	$1,828,122	$52,393,872
Expenditure for Prior Period Dates of Service	$6,655,839	$93,795	$1,401,417	$50,084	$15,040	$2,456	$462,077	$20,686	$177,633	$8,879,027
Total Expenditure in FY 2013-14 Q1 & Q2	**$38,287,991**	**$1,461,887**	**$11,657,061**	**$3,217,983**	**$143,578**	**$1,003,911**	**$3,289,717**	**$205,016**	**$2,005,755**	**$61,272,899**

FY 2013-14 Q3 and Q4 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	Totals
Estimated Weighted Capitation Rate	$153.45	$154.91	$153.94	$14.05	$14.05	$14.05	$991.57	$992.29	$983.47	
Estimated Monthly Caseload [1]	49,194	1,850	21,408	49,194	1,850	21,408	386	54	385	145,729
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2013-14 Q3 and Q4 Capitated Payments	$45,292,916	$1,719,501	$19,773,285	$4,147,054	$155,955	$1,804,694	$2,296,476	$321,502	$2,271,816	$77,783,199
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	90.31%	95.27%	92.13%	98.78%	98.69%	98.57%	91.40%	91.06%	92.48%	
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$40,904,032	$1,638,169	$18,217,127	$4,096,460	$153,912	$1,778,887	$2,098,979	$292,760	$2,100,975	$71,281,301
Estimated Expenditure for Prior Period Dates of Service	$3,394,038	$67,924	$876,065	$39,126	$11,644	$14,529	$266,058	$18,097	$148,653	$4,836,134
Total Estimated Expenditure in FY 2013-14 Q3 and Q4	**$44,298,070**	**$1,706,093**	**$19,093,192**	**$4,135,586**	**$165,556**	**$1,793,416**	**$2,365,037**	**$310,857**	**$2,249,628**	**$76,117,435**
Total Estimated FY 2013-14 Expenditure	**$82,586,061**	**$3,167,980**	**$30,750,253**	**$7,353,569**	**$309,134**	**$2,797,327**	**$5,654,754**	**$515,873**	**$4,255,383**	**$137,390,334**
Estimated Reconciliations	$12,933,911	$501,482	$9,212,701	$1,043,994	$10,724	$715,175	$0	$0	$0	$24,417,987
Total Estimated FY 2013-14 Expenditure Including Reconciliations	**$95,519,972**	**$3,669,462**	**$39,962,954**	**$8,397,563**	**$319,858**	**$3,512,502**	**$5,654,754**	**$515,873**	**$4,255,383**	**$161,808,320**
June 2013 Adjustment	$8,596,602	$301,654	$2,478,582	$645,739	$20,501	$193,094	$642,805	$13,581	$230,879	$13,123,436
CBHP PPS Adjustment	$2,749,274	$107,024	$1,054,480				$28,555	$2,773	$22,691	$3,964,797
Total Estimated FY 2013-14 Expenditure Including Adjustments	**$106,865,847**	**$4,078,139**	**$43,496,016**	**$9,043,303**	**$340,359**	**$3,705,596**	**$6,326,114**	**$532,227**	**$4,508,953**	**$178,896,554**
Estimated FY 2013-14 Monthly Caseload	43,619	1,698	16,730	43,619	1,698	16,730	453	44	360	62,904
Estimated FY 2013-14 Per Capita Expenditure	**$2,189.87**	**$2,161.05**	**$2,388.70**	**$192.52**	**$188.37**	**$209.95**	**$12,481.52**	**$11,724.39**	**$11,820.51**	**$2,843.96**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

2 Exhibit C5, pages 4, 5, and 6 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit C5 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2014-15

FY 2014-15 Q1 & Q2 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	Totals
Estimated Weighted Capitation Rate	$159.28	$160.79	$154.05	$14.40	$14.40	$14.40	$1,024.50	$1,023.75	$1,040.90	
Estimated Monthly Caseload [1]	46,632	1,861	21,349	46,632	1,861	21,349	228	57	396	140,365
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2014-15 Q1 & Q2 Capitated Payments	$44,565,270	$1,795,381	$19,732,881	$4,029,005	$160,790	$1,844,554	$1,401,516	$350,123	$2,473,178	$76,352,698
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	90.31%	95.27%	92.13%	98.78%	98.69%	98.57%	91.40%	91.06%	92.48%	
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$40,246,895	$1,710,459	$18,179,903	$3,979,851	$158,684	$1,818,177	$1,280,986	$318,822	$2,287,195	$69,980,972
Estimated Expenditure for Prior Period Dates of Service	$4,388,884	$81,332	$1,556,158	$50,594	$13,942	$25,807	$197,497	$28,742	$170,841	$6,513,797
Total Estimated Expenditure in FY 2014-15 Q1 & Q2	**$44,635,779**	**$1,791,791**	**$19,736,061**	**$4,030,445**	**$172,626**	**$1,843,984**	**$1,478,483**	**$347,564**	**$2,458,036**	**$76,494,769**

FY 2014-15 Q3 and Q4 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	Totals
Estimated Weighted Capitation Rate	$159.28	$160.79	$154.05	$14.40	$14.40	$14.40	$1,024.50	$1,023.75	$1,040.90	
Estimated Monthly Caseload [1]	44,203	1,623	14,258	44,203	1,623	14,258	111	44	376	120,699
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2014-15 Q3 and Q4 Capitated Payments	$42,243,923	$1,565,773	$13,178,669	$3,819,139	$140,227	$1,231,891	$682,317	$270,270	$2,348,270	$65,480,479
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	90.31%	95.27%	92.13%	98.78%	98.69%	98.57%	91.40%	91.06%	92.48%	
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$38,150,487	$1,491,712	$12,141,508	$3,772,546	$138,390	$1,214,275	$623,638	$246,108	$2,171,680	$59,950,344
Estimated Expenditure for Prior Period Dates of Service	$4,318,375	$84,922	$1,552,978	$49,154	$14,375	$26,377	$120,530	$31,301	$185,983	$6,383,995
Total Estimated Expenditure in FY 2014-15 Q3 and Q4	**$42,468,862**	**$1,576,634**	**$13,694,486**	**$3,821,700**	**$152,765**	**$1,240,652**	**$744,168**	**$277,409**	**$2,357,663**	**$66,334,339**
Total Estimated FY 2014-15 Expenditure	**$87,104,641**	**$3,368,425**	**$33,430,547**	**$7,852,145**	**$325,391**	**$3,084,636**	**$2,222,651**	**$624,973**	**$4,815,699**	**$142,829,108**
Estimated Reconciliations	$16,673,043	$611,595	$5,787,672	$557,190	($2,852)	$211,850	$0	$0	$0	$23,838,497
Total Estimated FY 2014-15 Expenditure Including Reconciliations	**$103,777,684**	**$3,980,020**	**$39,218,219**	**$8,409,335**	**$322,539**	**$3,296,486**	**$2,222,651**	**$624,973**	**$4,815,699**	**$166,667,605**
CBHP PPS Adjustment	$1,902,984	$72,989	$745,976	$0	$0	$0	$7,127	$2,137	$16,173	$2,747,385
Total Estimated FY 2014-15 Expenditure Including Adjustments	**$105,680,668**	**$4,053,008**	**$39,964,194**	**$8,409,335**	**$322,539**	**$3,296,486**	**$2,229,778**	**$627,110**	**$4,831,872**	**$169,414,990**
Estimated FY 2014-15 Monthly Caseload	45,418	1,742	17,804	45,418	1,742	17,804	170	51	386	65,571
Estimated FY 2014-15 Per Capita Expenditure	**$2,284.95**	**$2,284.74**	**$2,202.78**	**$185.15**	**$185.15**	**$185.15**	**$13,066.73**	**$12,254.37**	**$12,475.90**	**$2,583.68**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

2 Exhibit C5, pages 4, 5, and 6 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit C5 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2015-16

FY 2015-16 Q1 & Q2 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	Totals
Estimated Weighted Capitation Rate	$165.33	$166.87	$154.15	$14.76	$14.76	$14.76	$1,058.51	$1,056.21	$1,101.69	
Estimated Monthly Caseload [1]	52,245	1,644	15,123	52,245	1,644	15,123	124	47	409	69,592
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2015-16 Q1 & Q2 Capitated Payments	$51,825,995	$1,646,006	$13,987,263	$4,626,817	$145,593	$1,339,293	$787,531	$297,851	$2,703,547	$77,359,896
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	90.31%	95.27%	92.13%	98.78%	98.69%	98.57%	91.40%	91.06%	92.48%	
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$46,804,056	$1,568,150	$12,886,465	$4,570,370	$143,686	$1,320,141	$719,803	$271,223	$2,500,240	$70,784,134
Estimated Expenditure for Prior Period Dates of Service	$4,093,436	$74,061	$1,037,161	$46,593	$12,536	$17,616	$58,679	$24,162	$176,590	$5,540,834
Total Estimated Expenditure in FY 2015-16 Q1 & Q2	**$50,897,492**	**$1,642,211**	**$13,923,626**	**$4,616,963**	**$156,222**	**$1,337,757**	**$778,482**	**$295,385**	**$2,676,830**	**$76,324,968**

FY 2015-16 Q3 and Q4 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-250% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-250% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL	Totals
Estimated Weighted Capitation Rate	$165.33	$166.87	$154.15	$14.76	$14.76	$14.76	$1,058.51	$1,056.21	$1,101.69	
Estimated Monthly Caseload [1]	61,750	1,890	22,333	61,750	1,890	22,333	252	64	488	86,777
Number of Months Rate is Effective	6	6	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2015-16 Q3 and Q4 Capitated Payments	$61,254,765	$1,892,306	$20,655,792	$5,468,580	$167,378	$1,977,810	$1,600,467	$405,585	$3,225,748	$96,648,431
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	90.31%	95.27%	92.13%	98.78%	98.69%	98.57%	91.40%	91.06%	92.48%	
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$55,319,178	$1,802,800	$19,030,181	$5,401,863	$165,185	$1,949,527	$1,462,827	$369,326	$2,983,172	$88,484,059
Estimated Expenditure for Prior Period Dates of Service	$5,021,939	$77,856	$1,100,798	$56,447	$13,016	$19,152	$67,728	$26,628	$203,307	$6,586,871
Total Estimated Expenditure in FY 2015-16 Q3 and Q4	**$60,341,117**	**$1,880,656**	**$20,130,979**	**$5,458,310**	**$178,201**	**$1,968,679**	**$1,530,555**	**$395,954**	**$3,186,479**	**$95,070,930**
Total Estimated FY 2015-16 Expenditure	**$111,238,609**	**$3,522,867**	**$34,054,605**	**$10,075,273**	**$334,423**	**$3,306,436**	**$2,309,037**	**$691,339**	**$5,863,309**	**$171,395,898**
Estimated Reconciliations	$22,823,803	$667,154	$7,226,615	$788,376	$939	$247,981	$0	$0	$0	$31,754,868
Total Estimated FY 2015-16 Expenditure Including Reconciliations	**$134,062,412**	**$4,190,021**	**$41,281,220**	**$10,863,649**	**$335,362**	**$3,554,417**	**$2,309,037**	**$691,339**	**$5,863,309**	**$203,150,766**
Estimated FY 2015-16 Monthly Caseload	56,998	1,767	18,728	56,998	1,767	18,728	188	56	448	78,185
Estimated FY 2015-16 Per Capita Expenditure	**$2,352.05**	**$2,371.26**	**$2,204.25**	**$190.60**	**$189.79**	**$189.79**	**$12,275.58**	**$12,345.34**	**$13,087.74**	**$2,598.33**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

2 Exhibit C5, pages 4, 5, and 6 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit C5 - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Medical to 200% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*9.69%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*90.31%*	9.69%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	90.31%	9.69%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	90.31%	9.69%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	90.31%	9.69%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	90.31%	9.69%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	90.31%

Incurred But Not Reported (IBNR) Estimate for Children Medical 201%-205% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*		-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*4.73%*	0.00%		-	-	-
Incurred in FY 2013-14 Q1 & Q2	*95.27%*	4.73%	0.00%		-	-
Incurred in FY 2013-14 Q3 & Q4	-	95.27%	4.73%	0.00%		-
Incurred in FY 2014-15 Q1 & Q2	-	-	95.27%	4.73%	0.00%	
Incurred in FY 2014-15 Q3 & Q4	-	-	-	95.27%	4.73%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	95.27%	4.73%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	95.27%

Incurred But Not Reported (IBNR) Estimate for Children Medical 206%-250% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*7.87%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*92.13%*	7.87%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	92.13%	7.87%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	92.13%	7.87%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	92.13%	7.87%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	92.13%	7.87%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	92.13%

Exhibit C5 - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Dental to 200% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*1.22%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*98.78%*	1.22%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	98.78%	1.22%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	98.78%	1.22%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	98.78%	1.22%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	98.78%	1.22%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	98.78%

Incurred But Not Reported (IBNR) Estimate for Children Dental 201%-205% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*		-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*1.31%*	0.00%		-	-	-
Incurred in FY 2013-14 Q1 & Q2	*98.69%*	1.31%	0.00%		-	-
Incurred in FY 2013-14 Q3 & Q4	-	98.69%	1.31%	0.00%		-
Incurred in FY 2014-15 Q1 & Q2	-	-	98.69%	1.31%	0.00%	
Incurred in FY 2014-15 Q3 & Q4	-	-	-	98.69%	1.31%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	98.69%	1.31%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	98.69%

Incurred But Not Reported (IBNR) Estimate for Children Dental 206%-250% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*1.43%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*98.57%*	1.43%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	98.57%	1.43%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	98.57%	1.43%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	98.57%	1.43%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	98.57%	1.43%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	98.57%

Exhibit C5 - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Prenatal to 200% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*8.60%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*91.40%*	8.60%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	91.40%	8.60%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	91.40%	8.60%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	91.40%	8.60%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	91.40%	8.60%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	91.40%

Incurred But Not Reported (IBNR) Estimate for Prenatal 201%-205% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*8.94%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*91.06%*	8.94%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	91.06%	8.94%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	91.06%	8.94%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	91.06%	8.94%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	91.06%	8.94%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	91.06%

Incurred But Not Reported (IBNR) Estimate for Prenatal 206%-250% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	*7.52%*	0.00%	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	*92.48%*	7.52%	0.00%	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	92.48%	7.52%	0.00%	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	92.48%	7.52%	0.00%	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	92.48%	7.52%	0.00%
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	92.48%	7.52%
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	92.48%

Exhibit C5 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Medical to 200% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$6,655,839	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$31,632,152	$3,394,038	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$40,904,032	$4,388,884	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$40,246,895	$4,318,375	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$38,150,487	$4,093,436	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$46,804,056	$5,021,939
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$55,319,178
Total Paid in Current Period	$31,632,152	$40,904,032	$40,246,895	$38,150,487	$46,804,056	$55,319,178
Total IBNR Amount	$6,655,839	$3,394,038	$4,388,884	$4,318,375	$4,093,436	$5,021,939
Total Paid for All Incurred Dates	$38,287,991	$44,298,070	$44,635,779	$42,468,862	$50,897,492	$60,341,117

Incurred But Not Reported (IBNR) Estimate for Children Medical 201%-205% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	$0	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$93,795	$0	$0	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$1,368,092	$67,924	$0	$0	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$1,638,169	$81,332	$0	$0	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$1,710,459	$84,922	$0	$0
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$1,491,712	$74,061	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$1,568,150	$77,856
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$1,802,800
Total Paid in Current Period	$1,368,092	$1,638,169	$1,710,459	$1,491,712	$1,568,150	$1,802,800
Total IBNR Amount	$93,795	$67,924	$81,332	$84,922	$74,061	$77,856
Total Paid for All Incurred Dates	$1,461,887	$1,706,093	$1,791,791	$1,576,634	$1,642,211	$1,880,656

Incurred But Not Reported (IBNR) Estimate for Children Medical 206%-250% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$1,401,417	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$10,255,644	$876,065	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$18,217,127	$1,556,158	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$18,179,903	$1,552,978	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$12,141,508	$1,037,161	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$12,886,465	$1,100,798
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$19,030,181
Total Paid in Current Period	$10,255,644	$18,217,127	$18,179,903	$12,141,508	$12,886,465	$19,030,181
Total IBNR Amount	$1,401,417	$876,065	$1,556,158	$1,552,978	$1,037,161	$1,100,798
Total Paid for All Incurred Dates	$11,657,061	$19,093,192	$19,736,061	$13,694,486	$13,923,626	$20,130,979

Exhibit C5 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Dental to 200% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$50,084	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$3,167,899	$39,126	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$4,096,460	$50,594	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$3,979,851	$49,154	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$3,772,546	$46,593	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$4,570,370	$56,447
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$5,401,863
Total Paid in Current Period	$3,167,899	$4,096,460	$3,979,851	$3,772,546	$4,570,370	$5,401,863
Total IBNR Amount	$50,084	$39,126	$50,594	$49,154	$46,593	$56,447
Total Paid for All Incurred Dates	$3,217,983	$4,135,586	$4,030,445	$3,821,700	$4,616,963	$5,458,310

Incurred But Not Reported (IBNR) Estimate for Children Dental 201%-205% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	$0	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$15,040	$0	$0	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$118,600	$11,644	$0	$0	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$142,013	$13,942	$0	$0	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$146,415	$14,375	$0	$0
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$127,691	$12,536	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$132,577	$13,016
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$152,414
Total Paid in Current Period	$118,600	$142,013	$146,415	$127,691	$132,577	$152,414
Total IBNR Amount	$15,040	$11,644	$13,942	$14,375	$12,536	$13,016
Total Paid for All Incurred Dates	$133,640	$153,657	$160,357	$142,066	$145,113	$165,430

Incurred But Not Reported (IBNR) Estimate for Children Dental 206%-250% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$2,456	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$1,001,455	$14,529	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$1,778,887	$25,807	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$1,818,177	$26,377	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$1,214,275	$17,616	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$1,320,141	$19,152
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$1,949,527
Total Paid in Current Period	$1,001,455	$1,778,887	$1,818,177	$1,214,275	$1,320,141	$1,949,527
Total IBNR Amount	$2,456	$14,529	$25,807	$26,377	$17,616	$19,152
Total Paid for All Incurred Dates	$1,003,911	$1,793,416	$1,843,984	$1,240,652	$1,337,757	$1,968,679

Exhibit C5 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Prenatal to 200% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$462,077	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$2,827,640	$266,058	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$2,098,979	$197,497	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$1,280,986	$120,530	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$623,638	$58,679	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$719,803	$67,728
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$1,462,827
Total Paid in Current Period	$2,827,640	$2,098,979	$1,280,986	$623,638	$719,803	$1,462,827
Total IBNR Amount	$462,077	$266,058	$197,497	$120,530	$58,679	$67,728
Total Paid for All Incurred Dates	$3,289,717	$2,365,037	$1,478,483	$744,168	$778,482	$1,530,555

Incurred But Not Reported (IBNR) Estimate for Prenatal 201%-205% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$20,686	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$184,330	$18,097	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$292,760	$28,742	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$318,822	$31,301	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$246,108	$24,162	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$271,223	$26,628
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$369,326
Total Paid in Current Period	$184,330	$292,760	$318,822	$246,108	$271,223	$369,326
Total IBNR Amount	$20,686	$18,097	$28,742	$31,301	$24,162	$26,628
Total Paid for All Incurred Dates	$205,016	$310,857	$347,564	$277,409	$295,385	$395,954

Incurred But Not Reported (IBNR) Estimate for Prenatal 206%-250% FPL

	Paid in FY 2013-14 Q1 & Q2	Paid in FY 2013-14 Q3 & Q4	Paid in FY 2014-15 Q1 & Q2	Paid in FY 2014-15 Q3 & Q4	Paid in FY 2015-16 Q1 & Q2	Paid in FY 2015-16 Q3 & Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2012-13 Q3 & Q4	$177,633	$0	-	-	-	-
Incurred in FY 2013-14 Q1 & Q2	$1,828,122	$148,653	$0	-	-	-
Incurred in FY 2013-14 Q3 & Q4	-	$2,100,975	$170,841	$0	-	-
Incurred in FY 2014-15 Q1 & Q2	-	-	$2,287,195	$185,983	$0	-
Incurred in FY 2014-15 Q3 & Q4	-	-	-	$2,171,680	$176,590	$0
Incurred in FY 2015-16 Q1 & Q2	-	-	-	-	$2,500,240	$203,307
Incurred in FY 2015-16 Q3 & Q4	-	-	-	-	-	$2,983,172
Total Paid in Current Period	$1,828,122	$2,100,975	$2,287,195	$2,171,680	$2,500,240	$2,983,172
Total IBNR Amount	$177,633	$148,653	$170,841	$185,983	$176,590	$203,307
Total Paid for All Incurred Dates	$2,005,755	$2,249,628	$2,458,036	$2,357,663	$2,676,830	$3,186,479

Exhibit C6 - Children's Basic Health Plan Retroactivity Adjustment

Fiscal Year		Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL
FY 2007-08	Average Monthly Claims	62,837	1,150	-	52,719	715	-	1,695	50	-
	Average Caseload	57,466	330	-	57,466	330	-	1,557	14	-
	Claims as a Percentage of Caseload	109.35%	348.41%	-	91.74%	216.61%	-	108.88%	355.36%	-
FY 2008-09	Average Monthly Claims	62,881	1,603	-	54,774	1,347	-	1,703	75	-
	Average Caseload	60,137	1,445	-	60,137	1,445	-	1,598	67	-
	Claims as a Percentage of Caseload	104.56%	110.92%	-	91.08%	93.25%	-	106.60%	112.56%	-
FY 2009-10	Average Monthly Claims	68,814	1,676	1,116	59,738	1,435	815	1,511	79	169
	Average Caseload	66,940	1,649	136	66,940	1,649	136	1,469	80	11
	Claims as a Percentage of Caseload	102.80%	101.66%	820.22%	89.24%	87.03%	599.26%	102.86%	98.85%	1536.36%
FY 2010-11	Average Monthly Claims	64,399	1,272	4,812	55,102	1,103	3,656	1,451	64	297
	Average Caseload	62,080	1,164	4,023	62,080	1,164	4,023	1,409	60	272
	Claims as a Percentage of Caseload	103.74%	109.30%	119.60%	88.76%	94.77%	90.87%	102.97%	106.81%	109.13%
FY 2011-12	Estimated Average Monthly Claims	51,742	1,120	8,144	55,046	1,288	9,448	1,405	48	354
	Average Caseload	61,815	1,402	11,049	61,815	1,402	11,049	1,563	53	448
	Claims as a Percentage of Caseload	83.70%	79.89%	73.71%	89.05%	91.88%	85.51%	89.90%	90.88%	79.09%
FY 2012-13	Estimated Average Monthly Claims	87,841	2,526	22,996	52,638	1,327	12,203	1,448	58	511
	Average Caseload	60,646	1,614	15,575	60,646	1,614	15,575	1,100	48	463
	Claims as a Percentage of Caseload	144.84%	156.52%	147.64%	86.80%	82.20%	78.35%	131.61%	121.53%	110.46%
Weighted Average Claims as a Percentage of Caseload		103.70%	103.70%	103.70%	89.69%	89.69%	89.69%	104.14%	104.14%	104.14%
Retroactivity Adjustment Factor		3.70%	3.70%	3.70%	-10.31%	-10.31%	-10.31%	4.14%	4.14%	4.14%

[1] The retroactivity adjustment captures the difference in total claims paid versus caseload due to retroactive eligibility. After analyzing the data and historical trends, the Department determined that the average of FY 2008-09, FY 2009-10, and FY 2010-11 for populations to 200% FPL most accurately represents the relationship between average monthly claims and average caseload for all eligibility categories.

Exhibit C6 - Children's Basic Health Plan Partial Month Adjustment Multiplier

Fiscal Year		Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL
FY 2008-09	Weighted Claims-Based Rate	$118.81	$114.73	-	$14.55	$14.52	$0.00	$883.05	$845.83	-
	Weighted Capitation Rate	$125.25	$125.86	-	$14.66	$14.66	$14.66	$915.80	$913.97	-
	Claims as a Percentage of Capitation	94.86%	91.15%	-	99.26%	99.03%	0.00%	96.42%	92.54%	-
FY 2009-10	Weighted Claims-Based Rate	$146.50	$145.53	$157.52	$14.72	$14.68	$14.08	$813.49	$820.28	$797.28
	Weighted Capitation Rate	$140.72	$140.80	$149.28	$14.81	$14.81	$14.81	$821.35	$821.35	$821.35
	Claims as a Percentage of Capitation	104.11%	103.36%	105.52%	99.38%	99.14%	95.07%	99.04%	99.87%	97.07%
FY 2010-11	Weighted Claims-Based Rate	$151.50	$156.62	$157.99	$14.40	$13.48	$13.50	$1,157.24	$1,180.47	$1,168.40
	Weighted Capitation Rate	$154.57	$153.54	$156.92	$14.40	$14.40	$14.40	$1,092.92	$1,092.92	$1,092.92
	Claims as a Percentage of Capitation	98.01%	102.00%	100.68%	100.01%	93.60%	93.76%	105.88%	108.01%	106.91%
FY 2011-12	Weighted Claims-Based Rate	$157.13	$159.69	$159.57	$14.98	$14.18	$14.11	$1,114.06	$1,123.94	$1,113.94
	Weighted Capitation Rate	$157.88	$156.97	$157.12	$15.27	$15.27	$15.27	$1,144.27	$1,144.27	$1,144.27
	Claims as a Percentage of Capitation	99.52%	101.73%	101.56%	98.10%	92.86%	92.39%	97.36%	98.22%	97.35%
FY 2012-13	Weighted Claims-Based Rate	$135.79	$128.56	$127.28	$15.64	$14.90	$14.89	$864.14	$860.48	$808.50
	Weighted Capitation Rate	$147.73	$146.73	$147.33	$16.15	$16.15	$16.15	$928.30	$929.21	$929.21
	Claims as a Percentage of Capitation	91.92%	87.62%	86.39%	96.87%	92.27%	92.19%	93.09%	92.60%	87.01%
Average Claims as a Percentage of Capitation [(1)]		99.52%	99.52%	99.52%	98.10%	98.10%	98.10%	97.36%	98.22%	97.35%
Partial Month Adjustment Multiplier		-0.48%	-0.48%	-0.48%	-1.90%	-1.90%	-1.90%	-2.64%	-1.78%	-2.65%

[1] The partial month adjustment captures the difference in the amount paid per claim versus the capitation rate due to paying an adjusted rate for clients enrolled for only part of a month. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2011-12 for populations to 200% FPL, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

Exhibit C7 - Reconciliation Adjustment Calculation

Estimated FY 2013-14 Reconciliations*

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Average Total
FY 2012-13 Projected Per Capita February 15, 2013 Request	$1,962.55	$1,962.55	$1,962.55	$175.37	$175.37	$175.37	$1,068.96
FY 2013-14 Projected Rate Inflation November 1, 2013 Request	0.65%	2.30%	1.25%	-1.11%	-1.11%	-1.11%	
Per Capita from Rate Trend	$1,975.30	$2,007.76	$1,987.06	$173.42	$173.42	$173.42	$1,076.39
FY 2013-14 Projected Per Capita November 1, 2013 Request	$1,678.78	$1,712.42	$1,436.39	$149.48	$167.10	$130.67	$879.62
Difference	$296.52	$295.34	$550.67	$23.93	$6.32	$42.75	$196.77
Projected Caseload	43,619	1,698	16,730	43,619	1,698	16,730	124,094
Estimated FY 2013-14 Reconciliations	**$12,933,911**	**$501,482**	**$9,212,701**	**$1,043,994**	**$10,724**	**$715,175**	**$24,417,987**

*The projected per capitas from the February 15, 2013 request incorporated predicted reconciliations and the projected per capitas for this request do not. The Department assumes that the difference between the inflated former projected per capita and the more recent projected per capita will reflect the approximate reconciliation payment per client.

Estimated FY 2014-15 Reconciliations*

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Total
FY 2013-14 Projected Per Capita February 15, 2013 Request	$2,201.30	$2,201.30	$2,201.30	$180.63	$180.63	$180.63	$1,190.97
FY 2014-15 Projected Rate Inflation November 1, 2013 Request	3.80%	3.79%	0.07%	2.50%	2.50%	2.50%	
Per Capita from Rate Trend	$2,284.95	$2,284.74	$2,202.78	$185.15	$185.15	$185.15	$1,223.79
FY 2014-15 Projected Per Capita November 1, 2013 Request	$1,917.84	$1,933.65	$1,877.70	$172.89	$186.79	$173.26	$1,040.31
Difference	$367.10	$351.09	$325.08	$12.27	($1.64)	$11.90	$183.47
Projected Caseload	45,418	1,742	17,804	45,418	1,742	17,804	129,928
Estimated FY 2014-15 Reconciliations	**$16,673,043**	**$611,595**	**$5,787,672**	**$557,190**	**($2,852)**	**$211,850**	**$23,838,497**

*The projected per capitas from the February 15, 2013 request incorporated predicted reconciliations and the projected per capitas for this request do not. The Department assumes that the difference between the inflated former projected per capita and the more recent projected per capita will reflect the approximate reconciliation payment per client.

Estimated FY 2015-16 Reconciliations*

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Total
FY 2014-15 Projected Per Capita February 15, 2013 Request	$2,266.02	$2,284.74	$2,202.78	$185.94	$185.15	$185.15	$1,218.45
FY 2015-16 Projected Rate Inflation November 1, 2013 Request	3.80%	3.79%	0.07%	2.50%	2.50%	2.50%	
Per Capita from Rate Trend	$2,352.05	$2,371.26	$2,204.25	$190.60	$189.79	$189.79	$1,253.58
FY 2015-16 Projected Per Capita November 1, 2013 Request	$1,951.62	$1,993.70	$1,818.38	$176.77	$189.26	$176.55	$1,048.69
Difference	$400.43	$377.56	$385.87	$13.83	$0.53	$13.24	$204.89
Projected Caseload	56,998	1,767	18,728	56,998	1,767	18,728	154,986
Estimated FY 2015-16 Reconciliations	**$22,823,803**	**$667,154**	**$7,226,615**	**$788,376**	**$939**	**$247,981**	**$31,754,868**

*The projected per capitas from the February 15, 2013 request incorporated predicted reconciliations and the projected per capitas for this request do not. The Department assumes that the difference between the inflated former projected per capita and the more recent projected per capita will reflect the approximate reconciliation payment per client.

Exhibit C8 - Children's Basic Health Plan Capitation Rate Trends and Forecasts										
Capitation Rate Trends										
Fiscal Year	**Children Medical to 200% FPL**	**Children Medical 201%-205% FPL**	**Children Medical 206%-250% FPL**	**Children Dental to 200% FPL**	**Children Dental 201%-205% FPL**	**Children Dental 206%-250% FPL**	**Prenatal to 200% FPL**	**Prenatal 201%-205% FPL**	**Prenatal 206%-250% FPL**	**Weighted CBHP Total**
FY 2007-08 Actuals	**$120.12**	**$121.39**	-	**$13.84**	**$13.84**	**$13.84**	**$864.09**	**$864.09**	-	**$153.29**
FY 2008-09 Actuals	**$125.25**	**$125.86**	-	**$14.66**	**$14.66**	**$14.66**	**$915.80**	**$913.97**	-	**$160.35**
% Change from FY 2007-08	4.27%	3.68%	-	5.92%	5.92%	5.92%	5.98%	5.77%	-	4.61%
FY 2009-10 Actuals	**$140.72**	**$140.80**	**$149.28**	**$14.81**	**$14.81**	**$14.81**	**$821.35**	**$821.35**	**$821.35**	**$170.33**
% Change from FY 2008-09	12.35%	11.87%	-	1.02%	1.02%	1.02%	-10.31%	-10.13%	-	6.22%
FY 2010-11 Actuals	**$154.57**	**$153.54**	**$156.92**	**$14.40**	**$14.40**	**$14.40**	**$1,092.92**	**$1,092.92**	**$1,092.92**	**$192.40**
% Change from FY 2009-10	9.84%	9.05%	5.12%	-2.77%	-2.77%	-2.77%	33.06%	33.06%	33.06%	12.96%
FY 2011-12 Actuals	**$157.88**	**$156.97**	**$157.12**	**$15.27**	**$15.27**	**$15.27**	**$1,144.27**	**$1,144.27**	**$1,144.27**	**$199.28**
% Change from FY 2010-11	2.14%	2.23%	0.13%	6.04%	6.04%	6.04%	4.70%	4.70%	4.70%	3.58%
FY 2012-13 Actuals	**$147.73**	**$146.73**	**$147.33**	**$16.15**	**$16.15**	**$16.15**	**$928.30**	**$929.21**	**$929.21**	**$179.29**
% Change from FY 2011-12	-6.43%	-6.52%	-6.23%	5.76%	5.76%	5.76%	-18.87%	-18.79%	-18.79%	-10.03%
FY 2013-14 Estimated Average Rate	**$148.69**	**$150.11**	**$149.17**	**$15.97**	**$15.97**	**$15.97**	**$977.98**	**$970.08**	**$970.08**	**$173.95**
% Change from FY 2012-13	0.65%	2.30%	1.25%	-1.11%	-1.11%	-1.11%	5.35%	4.40%	4.40%	-12.71%
FY 2014-15 Weighted Average Rate	**$154.34**	**$155.80**	**$149.27**	**$16.37**	**$16.37**	**$16.37**	**$1,010.45**	**$1,000.83**	**$1,026.73**	**$181.29**
% Change from FY 2013-14 Average Rate	3.80%	3.79%	0.07%	2.50%	2.50%	2.50%	3.32%	3.17%	5.84%	4.22%
FY 2015-16 Estimated Average Rate	**$160.20**	**$161.70**	**$149.37**	**$16.78**	**$16.78**	**$16.78**	**$1,044.00**	**$1,032.56**	**$1,086.69**	**$182.33**
% Change from FY 2014-15 Average Rate	3.80%	3.79%	0.07%	2.50%	2.50%	2.50%	3.32%	3.17%	5.84%	0.57%

Exhibit C9 - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL
FY 2013-14 Estimated Rate									
Weighted Capitation Point Estimate	***$148.69***	***$150.11***	***$149.17***	***$15.97***	***$15.97***	***$15.97***	***$977.98***	***$970.08***	***$970.08***
Retroactivity Adjustment Multiplier (Exhibit C6)	3.70%	3.70%	3.70%	-10.31%	-10.31%	-10.31%	4.14%	4.14%	4.14%
Partial Month Adjustment Multiplier (Exhibit C6)	-0.48%	-0.48%	-0.48%	-1.90%	-1.90%	-1.90%	-2.64%	-1.78%	-2.65%
Final Adjustment Factor	**3.20%**	**3.20%**	**3.20%**	**-12.01%**	**-12.01%**	**-12.01%**	**1.39%**	**2.29%**	**1.38%**
FY 2013-14 Final Paid Rate	**$153.45**	**$154.91**	**$153.94**	**$14.05**	**$14.05**	**$14.05**	**$991.57**	**$992.29**	**$983.47**

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL
FY 2014-15 Estimated Rate [4]									
Weighted Capitation Point Estimate	***$154.34***	***$155.80***	***$149.27***	***$16.37***	***$16.37***	***$16.37***	***$1,010.45***	***$1,000.83***	***$1,026.73***
Retroactivity Adjustment Multiplier (Exhibit C6)	3.70%	3.70%	3.70%	-10.31%	-10.31%	-10.31%	4.14%	4.14%	4.14%
Partial Month Adjustment Multiplier (Exhibit C6)	-0.48%	-0.48%	-0.48%	-1.90%	-1.90%	-1.90%	-2.64%	-1.78%	-2.65%
Final Adjustment Factor [1]	**3.20%**	**3.20%**	**3.20%**	**-12.01%**	**-12.01%**	**-12.01%**	**1.39%**	**2.29%**	**1.38%**
FY 2014-15 Final Estimated Rate	**$159.28**	**$160.79**	**$154.05**	**$14.40**	**$14.40**	**$14.40**	**$1,024.50**	**$1,023.75**	**$1,040.90**

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL
FY 2015-16 Estimated Rate [3]									
Weighted Capitation Point Estimate	**$160.20**	**$161.70**	**$149.37**	**$16.78**	**$16.78**	**$16.78**	**$1,044.00**	**$1,032.56**	**$1,086.69**
Retroactivity Adjustment Multiplier (Exhibit C6)	3.70%	3.70%	3.70%	-10.31%	-10.31%	-10.31%	4.14%	4.14%	4.14%
Partial Month Adjustment Multiplier (Exhibit C6)	-0.48%	-0.48%	-0.48%	-1.90%	-1.90%	-1.90%	-2.64%	-1.78%	-2.65%
Final Adjustment Factor [2]	**3.20%**	**3.20%**	**3.20%**	**-12.01%**	**-12.01%**	**-12.01%**	**1.39%**	**2.29%**	**1.38%**
FY 2015-16 Final Estimated Rate	**$165.33**	**$166.87**	**$154.15**	**$14.76**	**$14.76**	**$14.76**	**$1,058.51**	**$1,056.21**	**$1,101.69**

Exhibit C9 - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2013-14

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-250% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-250% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-250% FPL
FY 2011-12 Actual Rate	$157.88	$156.97	$157.12	$15.27	$15.27	$15.27	$1,144.27	$1,144.27	$1,144.27
FY 2012-13 Full Year Average Rate	$147.73	$146.73	$147.33	$16.15	$16.15	$16.15	$928.30	$929.21	$929.21
FY 2013-14 Q1 & Q2	$148.69	$150.11	$149.17	$15.97	$15.97	$15.97	$977.98	$970.08	$970.08
Recent Growth Rates									
% Growth from FY 2012-13 to FY 2013-14 Rate	0.65%	2.30%	1.25%	-1.11%	-1.11%	-1.11%	5.35%	4.40%	4.40%
% Growth from CY 2012 to CY 2013 Rate	0.65%	2.30%	1.25%	-1.11%	-1.11%	**-1.11%**	**5.35%**	**4.40%**	**4.40%**
Selected Trend Models									
Average Growth Model	**$154.35**	**$155.79**	**$149.27**	**$16.37**	**$16.37**	**$16.37**	**$1,010.43**	**$1,000.81**	**$1,026.75**
% Difference from FY 2013-14 Q1 & Q2 Rate	3.80%	3.79%	0.07%	2.48%	2.48%	2.48%	3.32%	3.17%	5.84%
% Difference from FY 2013-14 Full Year Average Rate	**3.80%**	**3.79%**	**0.07%**	**2.48%**	**2.48%**	**2.48%**	**3.32%**	**3.17%**	**5.84%**
Two Period Moving Average Model	**$148.21**	**$148.42**	**$148.25**	**$16.06**	**$16.06**	**$16.06**	**$953.14**	**$949.65**	**$949.65**
% Difference from FY 2013-14 Q1 & Q2 Rate	-0.32%	-1.13%	-0.62%	0.56%	0.56%	0.56%	-2.54%	-2.11%	-2.11%
% Difference from FY 2013-14 Full Year Average Rate	**-0.32%**	**-1.13%**	**-0.62%**	**0.56%**	**0.56%**	**0.56%**	**-2.54%**	**-2.11%**	**-2.11%**
Exponential Growth Model	**$170.81**	**$164.59**	**$148.99**	**$16.57**	**$16.57**	**$16.46**	**$1,012.94**	**$1,058.62**	**$1,036.43**
% Difference from FY 2013-14 Q1 & Q2 Rate	14.88%	9.65%	-0.12%	3.77%	3.77%	3.08%	3.57%	9.13%	6.84%
% Difference from FY 2013-14 Full Year Average Rate	**14.88%**	**9.65%**	**-0.12%**	**3.77%**	**3.77%**	**3.08%**	**3.57%**	**9.13%**	**6.84%**
Linear Growth Model	**$167.00**	**$156.94**	**$149.02**	**$16.50**	**$16.50**	**$16.42**	**$1,016.94**	**$1,058.18**	**$1,031.69**
% Difference from FY 2013-14 Q1 & Q2 Rate	12.31%	4.55%	-0.10%	3.29%	3.29%	2.81%	3.98%	9.08%	6.35%
% Difference from FY 2013-14 Full Year Average Rate	**12.31%**	**4.55%**	**-0.10%**	**3.29%**	**3.29%**	**2.81%**	**3.98%**	**9.08%**	**6.35%**
FY 2014-15 Forecast Minimum	$148.21	$148.42	$148.25	$16.06	$16.06	$16.06	$953.14	$949.65	$949.65
FY 2014-15 Forecast Maximum	$170.81	$164.59	$149.27	$16.57	$16.57	$16.46	$1,016.94	$1,058.62	$1,036.43
% change from FY 2013-14 Rate to Selected FY 2014-15 Capitation Rate [2]	3.80%	3.79%	0.07%	2.48%	2.48%	2.48%	3.32%	3.17%	5.84%
FY 2014-15 Forecast Point Estimate	**$154.34**	**$155.80**	**$149.27**	**$16.37**	**$16.37**	**$16.37**	**$1,010.45**	**$1,000.83**	**$1,026.73**
% change from FY 2014-15 Rate to Selected FY 2015-16 Capitation Rate [3]	3.80%	3.79%	0.07%	2.48%	2.48%	2.48%	3.32%	3.17%	5.84%
FY 2015-16 Forecast Point Estimate	**$160.20**	**$161.70**	**$149.37**	**$16.78**	**$16.78**	**$16.78**	**$1,044.00**	**$1,032.56**	**$1,086.69**

[1] Percentage selected to modify capitation rates for FY 2014-15: Where applicable, percentage selections have been bolded for clarification.	Children Medical	Average rate change from FY 2008-09 to FY 2013-14
	Children Dental	Average rate change from FY 2008-09 to FY 2013-14
	Prenatal	Average rate change from FY 2008-09 to FY 2013-14
2 Percentage selected to modify capitation rates for FY 2015-16: Where applicable, percentage selections have been bolded for clarification.	Children Medical	Average rate change from FY 2008-09 to FY 2013-14
	Children Dental	Average rate change from FY 2008-09 to FY 2013-14
	Prenatal	Average rate change from FY 2008-09 to FY 2013-14

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicare Modernization Act of 2003 State Contribution Payment
Priority Number: R-4

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	107,173,869	-	107,173,869	(6,366,816)	(4,926,626)
	FTE	-	-	-	-	-
	GF	82,492,862	-	82,492,862	13,951,390	19,754,381
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	24,681,007	-	24,681,007	(20,318,206)	(24,681,007)
(5) Other Medical Services, Medicare Modernization Act of 2003 State Contribution Payment	**Total**	107,173,869	-	107,173,869	(6,366,816)	(4,926,626)
	FTE	-	-	-	-	-
	GF	82,492,862	-	82,492,862	13,951,390	19,754,381
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	24,681,007	-	24,681,007	(20,318,206)	(24,681,007)

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

Cash or Federal Fund Name and COFRS Fund Number: Federal funds: CHIPRA Bonus
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: N/A

Cost and FTE

- The Department requests an increase of $13,951,390 General Fund and a reduction of $20,318,206 federal funds, for a net reduction of $6,366,816 total funds to the Medicare Modernization Act of 2003 State Contribution Payment line item for FY 2014-15. This request does not require any additional FTE.

Link to Operations

- The Department serves clients who are eligible for both Medicaid and Medicare.
- Dual-eligible clients are provided prescription drug coverage through the federal Medicare program.
- The State then is required to reimburse the federal government for what the federal Centers for Medicare and Medicaid Services (CMS) determines the State's obligation to be.

Problem or Opportunity

- The State's obligation varies from year to year and is affected by changes in caseload and the per member per month (PMPM) rate, which is also determined by CMS.
- The Department must annually forecast both anticipated caseload and PMPM rate to ensure the State is adequately funded to meet its reimbursement obligation to the federal government.

Consequences of Problem

- If this request is not approved and the State is unable to meet its reimbursement obligation to the federal government, the Department would be at risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program, generating overexpenditures on other line items.

Proposed Solution

- The Department requests $13,951,390 General Fund and a reduction of $20,318,206 federal funds, for a net reduction of $6,366,816 total funds to the Medicare Modernization Act of 2003 State Contribution Payment line item for FY 2014-15.
- If approved, the Department would be able to meet the State's 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.

Department Priority: R-4
Request Detail: Medicare Modernization Act of 2006 State Contribution Payment

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
MMA State Contribution Payment	($6,366,816)	$13,951,390

Problem or Opportunity:

The Department is requesting a change in funding to its Medicare Modernization Act (MMA) of 2003 State Contribution Payment line item to match the Department's most recent caseload and expenditure projections.

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. These "clawback" payments, if left unpaid, are subject to automatic deduction – plus interest – from the federal funds the State receives for the Medicaid program.

Proposed Solution:

The Department requests an increase of $13,951,390 General Fund and a reduction of $20,318,206 federal funds, for a net reduction of $6,366,816 total funds to the Medicare Modernization Act of 2003 State Contribution Payment line item for FY 2014-15. This request is the result of a projected increase in caseload, a projected decrease in the PMPM rate paid by the State as required by federal regulations, and the expiration of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) performance bonus.

For FY 2014-15, the Department estimates the clawback payment will total $100,807,053, comprised of $96,444,252 General Fund and $4,362,801 federal funds. Typically, this line item is entirely General Fund, as it is a reimbursement to the federal government and is not eligible to receive a federal match; however, since 2010, the Department has elected to utilize federal funds received from the CHIPRA bonus to offset General Fund in this line item. The CHIPRA bonus is set to expire in 2014, at which point the State will need to reassume the General Fund portion offset by the bonus (see tables 5.1, 6.1, and 7.1 of the appendix for more detail on the CHIPRA bonus calculations).

The Department also estimates the FY 2013-14 General Fund need for this line item will decrease by $16,805,357 due to application of the CHIPRA bonus, while the FY 2015-16 General Fund need will increase by $19,754,381 due to expiration of the CHIPRA bonus. The Department will officially request the FY 2013-14 change in funding on January 2, 2014.

If the Department does not receive the requested appropriation and subsequently cannot make the required federal payment, the Department would be required to use overexpenditure authority to make the payment, pursuant to section 24-75-109(1)(a.6), C.R.S. Without overexpenditure authority, the Department would be at risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program, generating overexpenditures on other line items.

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.

Assumptions and Calculations:

The Department assumes the changes in the PMPM rate paid by the Department will be based on the formula established by CMS, which considers changes in annual growth of NHE prescription drug per capita estimates and are offset by the corresponding phasedown percentage rate. The Department further assumes the changes in dual-eligible caseload will follow a trend of 3.84% annual growth, as has been evidenced historically.

To calculate the PMPM rate, CMS multiplies the prior year's PMPM rate by the average growth rate of per capita prescription drug expenditures according to the annual National Health Expenditure (NHE) Projections between years 2003 and 2006. This figure is then multiplied by the state share and the "phasedown" percentage, which began at 90% in 2006 and is lowered 1.67% each year until it reaches 75% in 2015, where it will remain. The 2011-21 NHE Projections, released in 2012, is the last report to carry the 2003 expenditure estimates. CMS has not yet released a formula to calculate the PMPM rate beyond CY 2014.

Using the prescribed methodology provided by CMS, the Department estimates the CY 2014 PMPM rate to be $125.50 (see table 4.2 of the appendix); however, due to the data used by CMS to determine the PMPM rate becoming outdated and unavailable, this methodology cannot be applied to estimating the PMPM rates for CY 2015 and CY 2016. The Department has elected to estimate the PMPM rate for these years by averaging the average percentage change in per capita prescription drug expenditure estimates from the prior year for each NHE estimate from the previous three years. This approach yields a PMPM rate of $121.57 for CY 2015 and $120.38 for CY 2016 (see tables 4.2 and 4.3). Because CMS announces PMPM rates approximately three months prior to the rate taking effect, the Department should have more information regarding CMS' new PMPM calculation methodology in October 2014 and will make any necessary adjustments through the normal budget process.

To estimate caseload, the Department analyzed data from January 2006 through June 2013 and concluded a 3.84% annual growth trend, based upon a monthly average over the past two years, is the most reasonable forecast method for the MMA clawback population. This method estimates caseload by increasing the total caseload incurred each month by 0.32% to forecast the total caseload for the following month. Because clients are able to be retroactively enrolled and disenrolled for up to 24 months, retroactivity is also considered in this forecast. Due to a two-month delay between when the Department receives an invoice from CMS and when the invoice is paid, the amount paid in the July-through-June fiscal year are actually the invoices received between May and April. To improve the accuracy of the estimate for this line item, the caseload tables reflect this May-through-April period of time (see tables 3.1-3.3 of the appendix).

Based upon a 3.84% annual growth rate, the Department anticipates FY 2014-15 caseload will increase from 66,458 in May 2014 to 68,834 in April 2015. As a result, the total projected expenditure for the Medicare Modernization Act of 2003 State Contribution Payment for FY 2014-15 is $100,807,053 (see table 3.2).

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

Not applicable.

Table 1.1: FY 2013-14 Summary					
Row	Item	Total Funds	General Fund	Federal Funds	Notes
A	**FY 2013-14 Spending Authority**	**$107,173,869**	**$82,492,862**	**$24,681,007**	**Long Bill Appropriation**
B	Projected FY 2013-14 Expenditures	$102,256,317	$65,687,505	$36,568,812	Table 2.1 Row D
C	**FY 2013-14 Incremental**	**($4,917,552)**	**($16,805,357)**	**$11,887,805**	**Row B - Row A**

Table 1.2: FY 2014-15 Summary					
Row	Item	Total Funds	General Fund	Federal Funds	Notes
A	**FY 2013-14 Spending Authority**	**$107,173,869**	**$82,492,862**	**$24,681,007**	**Table 1.1 Row A**
B	Projected FY 2014-15 Expenditures	$100,807,053	$96,444,252	$4,362,801	Table 2.2 Row C
C	**FY 2014-15 Incremental**	**($6,366,816)**	**$13,951,390**	**($20,318,206)**	**Row B - Row A**

Table 1.3: FY 2015-16 Summary					
Row	Item	Total Funds	General Fund	Federal Funds	Notes
A	**FY 2013-14 Spending Authority**	**$107,173,869**	**$82,492,862**	**$24,681,007**	**Table 1.1 Row A**
B	Projected FY 2015-16 Expenditures	$102,247,243	$102,247,243	$0	Table 2.2 Row C
C	**FY 2015-16 Incremental**	**($4,926,626)**	**$19,754,381**	**($24,681,007)**	**Row B - Row A**

Table 2.1: FY 2013-14 Fund Splits					
Row	Item	Total Funds	General Fund	Federal Funds	Notes
A	November 2013 Forecast	$102,256,317	$102,256,317	$0	Table 3.1
B	CHIPRA Bonus	$0	($61,568,812)	$61,568,812	Table 5.1 Row C
C	JBC Transfer to CMTF	$0	$25,000,000	($25,000,000)	
D	**Projected FY 2013-14 Expenditures**	**$102,256,317**	**$65,687,505**	**$36,568,812**	**Row A + Row B + Row C**

Table 2.2: FY 2014-15 Fund Splits					
Row	Item	Total Funds	General Fund	Federal Funds	Notes
A	November 2013 Forecast	$100,807,053	$100,807,053	$0	Table 3.2
B	CHIPRA Bonus	$0	($4,362,801)	$4,362,801	Table 5.2 Row C
C	**Projected FY 2014-15 Expenditures**	**$100,807,053**	**$96,444,252**	**$4,362,801**	**Row A + Row B**

Table 2.3: FY 2015-16 Fund Splits					
Row	Item	Total Funds	General Fund	Federal Funds	Notes
A	November 2013 Forecast	$102,247,243	$102,247,243	$0	Table 3.2
B	**Projected FY 2014-15 Expenditures**	**$102,247,243**	**$102,247,243**	**$0**	**Row A**

Table 3.1: FY 2013-14 Caseload and Expenditures					
	CY 2011	CY 2012	CY 2013	CY 2014	FY 2013-14 TOTAL
May 2013	57	398	63,398	0	63,853
June 2013	(40)	98	64,085	0	64,143
July 2013	(65)	140	64,292	0	64,367
August 2013	(53)	76	64,551	0	64,574
September 2013	(39)	20	64,801	0	64,782
October 2013	(27)	(26)	65,042	0	64,989
November 2013	(13)	(64)	65,273	0	65,196
December 2013	0	(93)	65,498	0	65,405
January 2014	0	(103)	2,236	63,481	65,614
February 2014	0	(102)	1,293	64,633	65,824
March 2014	0	(103)	806	65,332	66,035
April 2014	0	(95)	530	65,812	66,247
CY Client Total	(180)	146	521,805	259,258	
CY Rate	Varies	$132.41	$133.62	$125.50	
Expenditures	**($23,478)**	**$19,332**	**$69,723,584**	**$32,536,879**	**$102,256,317**

Table 3.2: FY 2014-15 Caseload and Expenditures					
	CY 2012	CY 2013	CY 2014	CY 2015	FY 2014-15 TOTAL
May 2014	(86)	353	66,191	0	66,458
June 2014	(78)	235	66,512	0	66,669
July 2014	(66)	146	66,804	0	66,884
August 2014	(55)	82	67,073	0	67,100
September 2014	(41)	20	67,336	0	67,315
October 2014	(28)	(28)	67,583	0	67,527
November 2014	(13)	(67)	67,823	0	67,743
December 2014	0	(97)	68,059	0	67,962
January 2015	0	(108)	2,323	65,962	68,177
February 2015	0	(106)	1,343	67,160	68,397
March 2015	0	(105)	840	67,884	68,619
April 2015	0	(100)	549	68,385	68,834
CY Client Total	(367)	225	542,436	269,391	
CY Rate	$132.41	$133.62	$125.50	$121.57	
Expenditures	**($48,594)**	**$30,065**	**$68,075,718**	**$32,749,864**	**$100,807,053**

Table 3.3: FY 2015-16 Caseload and Expenditures					
	CY 2013	CY 2014	CY 2015	CY 2016	FY 2015-16 TOTAL
May 2015	(90)	367	68,778	0	69,055
June 2015	(79)	243	69,111	0	69,275
July 2015	(69)	154	69,416	0	69,501
August 2015	(57)	81	69,695	0	69,719
September 2015	(43)	22	69,966	0	69,945
October 2015	(28)	(29)	70,222	0	70,165
November 2015	(14)	(69)	70,478	0	70,395
December 2015	0	(101)	70,718	0	70,617
January 2016	0	(108)	2,414	68,540	70,846
February 2016	0	(114)	1,397	69,785	71,068
March 2016	0	(109)	871	70,536	71,298
April 2016	0	(104)	572	71,057	71,525
CY Client Total	(380)	233	563,638	279,918	
CY Rate	$133.62	$125.50	$121.57	$120.38	
Expenditures	**($50,776)**	**$29,242**	**$68,521,472**	**$33,696,529**	**$102,247,243**

Table 4.1: CY 2013 PMPM Rate Calculation			
Row	Item		Notes
	From 2011 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$603	
B	Estimated 2006 Per Capita Rx Drug Expenditures	$735	
C	Percentage Growth	21.89%	(Row B ÷ Row A) - 1
	From 2012 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
F	Percentage Growth	23.89%	(Row E ÷ Row D) - 1
G	**Change in Percentage Growth**	**1.64%**	**(Row F ÷ Row C) - 1**
	From Announcement of CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/2/12		
H	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2013 (Attachment V, Table III-2)	1.40%	
I	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013**	**3.06%**	**Row G + Row H**
J	CY 2012 PMPM Rate Prior to Phasedown	$331.01	
K	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013	3.06%	Row I
L	Projected CY 2013 PMPM Rate Prior to FMAP and Phasedown	$341.15	Row J × Row K
M	FMAP State Share	50.00%	
N	Projected CY 2013 PMPM Rate Prior to Phasedown	$170.57	Row L × Row M
O	CY 2013 Phasedown Percentage	78.33%	
P	**CY 2013 PMPM Rate**	**$133.62**	**Row N × Row O**
Sources: Centers for Medicare and Medicaid Services (CMS), 2011 and 2012 NHE estimates; and Announcement of CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage Part D Payment Policies, Attachment V, Table III-2.			

Table 4.2: CY 2014 PMPM Rate Calculation			
Row	Item		Notes
	From 2012 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
C	Percentage Growth	23.89%	(Row B ÷ Row A) - 1
	From 2013 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
F	Percentage Growth	23.89%	(Row E ÷ Row D) - 1
G	**Change in Percentage Growth**	**0.00%**	**(Row F ÷ Row C) - 1**
	From Announcement of CY 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/1/13		
H	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2014 (Attachment VI, Table IV-2)	-4.03%	
I	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013**	**-4.03%**	**Row G + Row H**
J	CY 2013 PMPM Rate Prior to FMAP and Phasedown	$341.15	Table 4.1 Row L
K	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2014	-4.03%	Row I
L	Projected CY 2014 PMPM Rate Prior to FMAP and Phasedown	$327.40	Row J × Row K
M	FMAP State Share	50.00%	
N	Projected CY 2014 PMPM Rate Prior to Phasedown	$163.70	Row L × Row M
O	CY 2014 Phasedown Percentage	76.67%	
P	**Projected CY 2014 PMPM Rate**	**$125.50**	**Row N × Row O**
Sources: Centers for Medicare and Medicaid Services (CMS), 2012 and 2013 NHE estimates; and Announcement of CY 2014 Medicare Advantage Capitation Rates and Medicare Advantage Part D Payment Policies, Attachment VI, Table IV-2.			

Table 4.3: CY 2015 PMPM Rate Calculation			
Row	Item		Notes
	From 2009-21 NHE Estimates		
A	2009-19 Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from Prior Year	-1.31%	
B	2010-20 Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from Prior Year	2.29%	
C	2011-21 Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from Prior Year	-4.63%	
D	**Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from 2009-21**	**-1.22%**	**(Rows A + B + C) ÷ 3**
	From Announcements of CYs 2012-14 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
E	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2012 (Attachment V, Table III-3)	3.34%	
F	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2013 (Attachment V, Table IV-2)	1.40%	
G	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2014 (Attachment VI, Table IV-2)	-4.03%	
H	**Average Annual Percentage Increase in Average Per-Capita Aggregate Part D Expenditures for 2012**	**0.24%**	**(Rows E + F + G) ÷ 3**
I	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2015**	**-0.98%**	**Row D + Row H**
J	CY 2014 PMPM Rate Prior to FMAP and Phasedown	$327.40	Table 4.2 Row L
K	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2015	-0.98%	Row I
L	Projected CY 2015 PMPM Rate Prior to FMAP and Phasedown	$324.19	Row J × Row K
M	FMAP State Share	50.00%	
N	Projected CY 2015 PMPM Rate Prior to Phasedown	$162.10	Row L × Row M
O	CY 2015 Phasedown Percentage	75.00%	
P	**Projected CY 2015 PMPM Rate**	**$121.57**	**Row N × Row O**
Sources: Centers for Medicare and Medicaid Services (CMS), 2011, 2012, and 2013 NHE estimates; and Announcement of CY 2012, 2013, and 2014 Medicare Advantage Capitation Rates and Medicare Advantage Part D Payment Policies			

Table 4.4: CY 2016 PMPM Rate Calculation			
Row	Item		Notes
	From 2009-21 NHE Estimates		
A	2009-19 Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from Prior Year	-1.31%	
B	2010-20 Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from Prior Year	2.29%	
C	2011-21 Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from Prior Year	-4.63%	
D	**Average Percentage Change in Per Capita Rx Drug Expenditure Estimates from 2009-21**	**-1.22%**	**(Rows A + B + C) ÷ 3**
	From Announcements of CYs 2012-14 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
E	Annual Percentage Increase in Average Per-Capita Aggregate Part D Expenditures for 2012 (Attachment V, Table III-3)	3.34%	
F	Annual Percentage Increase in Average Per-Capita Aggregate Part D Expenditures for 2013 (Attachment V, Table IV-2)	1.40%	
G	Annual Percentage Increase in Average Per-Capita Aggregate Part D Expenditures for 2014 (Attachment VI, Table IV-2)	-4.03%	
H	**Average Annual Percentage Increase in Average Per-Capita Aggregate Part D Expenditures for 2012**	**0.24%**	**(Rows E + F + G) ÷ 3**
I	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2016**	**-0.98%**	**Row D + Row H**
J	Projected CY 2015 PMPM Rate Prior to FMAP and Phasedown	$324.19	Table 4.3 Row L
K	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2016	-0.98%	Row I
L	Projected CY 2016 PMPM Rate Prior to FMAP and Phasedown	$321.01	Row J × Row K
M	FMAP State Share	50.00%	
N	Projected CY 2016 PMPM Rate Prior to Phasedown	$160.51	Row L × Row M
O	CY 2016 Phasedown Percentage	75.00%	
P	**Projected CY 2016 PMPM Rate**	**$120.38**	**Row N × Row O**
Sources: Centers for Medicare and Medicaid Services (CMS), 2011, 2012, and 2013 NHE estimates; and Announcement of CY 2012, 2013, and 2014 Medicare Advantage Capitation Rates and Medicare Advantage Part D Payment Policies			

Table 5.1: FY 2013-14 CHIPRA Bonus			
Row	Item	Federal Funds	Notes
A	Projected Supplemental FFY 2012 CHIPRA Bonus	$4,030,024	Table 7.1 Row D
B	Projected FFY 2013 CHIPRA Bonus	$57,538,788	Table 7.1 Row A
C	**Total Projected CHIPRA Bonus for FY 2013-14**	**$61,568,812**	**Row A + Row B**

Table 5.2: FY 2014-15 CHIPRA Bonus			
Row	Item	Federal Funds	Notes
A	Projected Supplemental FFY 2013 CHIPRA Bonus	$4,362,801	Table 7.1 Row D
B	Projected FFY 2014 CHIPRA Bonus	$0	Table 7.1 Row A
C	**Total Projected CHIPRA Bonus for FY 2014-15**	**$4,362,801**	**Row A + Row B**

Table 6.1: CHIPRA Bonus Calculations						
Caseload for Initial Payment Calculation						
Row		FFY 2010	FFY 2011	FFY 2012	FFY 2013	Notes
A	Baseline Enrollment	263,497	276,408	288,238	300,920	Department estimate
B	Estimated Child Population Growth Factor[1]	4.90%	4.28%	4.40%	4.07%	See Footnote 1
C	Tier 1 Bonus Target Enrollment Estimate	276,408	288,238	300,920	313,167	Row A * Row B
D	Tier 2 Bonus Target Enrollment Estimate	304,049	317,062	331,012	344,484	Row C * 110%
E	Projected Enrollment	313,759	342,341	373,399	398,613	Department estimate
F	**Projected Initial Tier 1 Bonus Enrollment**	**27,641**	**28,824**	**30,092**	**31,317**	**Row C * 10%**
G	**Projected Initial Tier 2 Bonus Enrollment**	**9,710**	**25,279**	**42,387**	**54,129**	**Row E - Row D**
Per Capita for Initial Payment Calculation						
H	Kaiser State Health Facts CO Child Medicaid Cost[2]	$2,478.75	$2,406.62	$2,564.06	$2,767.39	See Footnote 2
I	Estimated Increase in National Health Expenditures	7.93%	7.93%	7.93%	7.93%	Provided by CMS
J	State FMAP Rate	50.00%	50.00%	50.00%	50.00%	
K	**Applicable Per Capita**	**$1,337.66**	**$1,298.73**	**$1,383.69**	**$1,493.42**	**Row H * (1 + Row I) * Row J**
Initial Payment Calculation						
L	Projected Tier 1 Bonus Enrollment	27,641	28,824	30,092	31,317	Row F
M	Projected Tier 1 Per Capita Bonus[3]	$200.64	$194.81	$207.55	$224.01	Row K * 15%
N	**Projected Tier 1 Bonus Payment**	**$5,545,890**	**$5,615,203**	**$6,245,595**	**$7,015,321**	**Row L * Row M**
O	Projected Tier 2 Bonus Enrollment	9,710	25,279	42,387	54,129	Row G
P	Projected Tier 2 Per Capita Bonus[3]	$836.04	$811.71	$864.81	$933.39	Row K * 62.5%
Q	**Projected Tier 2 Bonus Payment**	**$8,117,948**	**$20,519,149**	**$36,656,701**	**$50,523,467**	**Row O * Row P**
R	**Projected Initial CHIPRA Bonus Payment**	**$13,663,838**	**$26,134,352**	**$42,902,296**	**$57,538,788**	**Row N + Row Q**
Caseload and Per Capita for Supplemental Payment Calculation						
S	Projected Enrollment with Retroactivity	319,961	350,762	380,005	405,665	Department estimate
T	Projected Tier 1 Bonus Enrollment with Retroactivity	27,641	28,824	30,092	31,317	Row F
U	Projected Tier 2 Bonus Enrollment with Retroactivity	15,912	33,700	48,993	61,181	Row S - Row D
V	**Applicable Per Capita**	**$1,291.35**	**$1,295.95**	**$1,335.79**	**$1,441.72**	**Department estimate**
Final Payment Calculation						
W	Projected Tier 1 Bonus Enrollment	27,641	28,824	30,092	31,317	Row F
X	Projected Tier 1 Per Capita Bonus	$193.70	$194.39	$200.37	$216.26	Row V * 15%
Y	**Projected Tier 1 Bonus Payment**	**$5,354,062**	**$5,603,097**	**$6,029,534**	**$6,772,614**	**Row W * Row X**
Z	Projected Tier 2 Bonus Enrollment	15,912	33,700	48,993	61,181	Row U
AA	Projected Tier 2 Per Capita Bonus	$807.09	$809.97	$834.87	$901.08	Row V * 62.5%
AB	**Projected Tier 2 Bonus Payment**	**$12,842,013**	**$27,296,191**	**$40,902,786**	**$55,128,975**	**Row Z * Row AA**
AC	**Projected Total CHIPRA Bonus Payment**	**$18,196,075**	**$32,899,288**	**$46,932,320**	**$61,901,589**	**Row Y + Row AB**
AD	**Actual Total CHIPRA Bonus Payment**	**$18,203,273**	**$32,906,502**	**N/A**	**N/A**	
AE	Forecast Variance	$7,198	$7,214	N/A	N/A	Row AD - Row AC

[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] 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.

[3] 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 7.1: CHIPRA Bonus Payments by State Fiscal Year							
Row		FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	Notes
A	Projected Initial Payment	$13,663,838	$26,134,352	$42,902,296	$57,538,788	$0	Table 6.1 Row R
B	**Actual Initial Payment**	**$13,666,043**	**$26,141,460**	**$42,909,585**	**N/A**	**N/A**	
C	Forecast Variance	$2,205	$7,108	$7,289	N/A	N/A	Row B - Row A
D	Projected Supplemental Payment from Prior FFY	$0	$4,532,237	$6,764,936	$4,030,024	$4,362,801	Table 6.1 Row AC - Table 6.1 Row R
E	**Actual Supplemental Payment from Prior FFY**	**$0**	**$4,501,822**	**$6,771,422**	**N/A**	**N/A**	
F	Forecast Variance*	$0	($30,415)	$6,486	N/A	N/A	Row E - Dow D
G	**Total Projected Payment**	**$13,663,838**	**$30,666,589**	**$49,667,232**	**$61,568,812**	**$4,362,801**	**Row A + Row D**
H	**Total Actual Payment**	**$13,666,043**	**$30,643,282**	**$49,681,007**	**N/A**	**N/A**	**Row B + Row E**
I	Forecast Variance	$2,205	($23,307)	$13,775	N/A	N/A	Row H - Row G
* The supplemental payment for FFY 2010 received in SFY 2011-12 was reduced by $30,000 for IDEA awards. Please see narrative for details.							

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicaid Health Information Exchange
Priority Number: R-5

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	10,256,618	-	8,398,735	5,748,926	9,716,176
	FTE	-	-	-	-	-
	GF	3,240,943	-	2,336,492	1,054,893	1,451,618
	GFE	-	-	-	-	-
	CF	699,910	-	625,557	-	-
	RF	23,910	-	23,910	-	-
	FF	6,291,855	-	5,412,776	4,694,033	8,264,558
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	1,764,066	-	1,738,183	20,000	20,000
	FTE	-	-	-	-	-
	GF	733,525	-	789,074	2,000	2,000
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	18,000	18,000
(1) Executive Director's Office; (A) General Adminstration, General Professional Sevices and Special Projects	**Total**	8,492,552	-	6,660,552	(2,500,000)	(2,500,000)
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	(250,000)	(250,000)
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	(2,250,000)	(2,250,000)
NEW ITEM (1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance and Projects	**Total**	-	-	-	8,228,926	12,196,176
	FTE	-	-	-	-	-
	GF	-	-	-	1,302,893	1,699,618
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	-	6,926,033	10,496,558

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- FY 2014-15: $5,748,926 total funds, $1,054,893 General Fund, and $4,694,033 federal funds;
- FY 2015-16: $9,716,176 total funds, $1,451,618 General Fund, and $8,264,558 federal funds;
- FY 2016-17: $6,657,176 total funds, $1,445,718 General Fund, and $5,211,458 federal funds;
- FY 2017-18 and ongoing: $4,442,176 total funds, $1,222,218 General Fund, and $3,199,958 federal funds.

Link to Operations

- Enhancing the Department's and Medicaid providers' ability to exchange and aggregate Medicaid client health-related information would result in improved care coordination and client experience, better-informed care decisions, expanded opportunities for preventative care, and advanced clinical and cost analytics to identify Medicaid cost-savings opportunities.

Problem or Opportunity

- Health-related information about Colorado Medicaid clients is fragmented and isolated in doctors' offices, clinics, hospitals, labs, and state government databases.
- The Department has a unique opportunity to build a shared Medicaid health information resource for relatively little state investment by utilizing time-limited enhanced federal matching funds and leveraging the infrastructure of Colorado's health information exchange (HIE) network.
- This would enable the Department and Medicaid providers to aggregate and exchange their Medicaid client health-related information; this would improve care coordination and client experience; prevent duplicative and unnecessary treatments; create new opportunities to identify health risks and provide preventative services; and generate novel data analytics that could identify the most effective health care services for the least cost, providing a basis for payment reform.

Consequences of Problem

- Without this resource, the Department has a compromised ability to proactively understand and improve client health and measure the effectiveness of Medicaid services; Medicaid providers have a compromised ability to coordinate care and avoid duplicative or unnecessary treatments.

Proposed Solution

- The Department requests funding to assist Medicaid providers with adopting electronic health record (EHR) systems and with connecting to Colorado's HIE network; the Department also requests funding for interfaces and electronic infrastructure that would allow Medicaid client health data to be aggregated and exchanged between provider EHR systems, the Department's Medicaid Management Information System (MMIS), and other Medicaid-related systems in the state.

Department Priority: R-5
Request Detail: Medicaid Health Information Exchange

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Medicaid Health Information Exchange	$5,748,926	$1,054,893

Problem or Opportunity:

Medicaid client health-related information is fragmented and isolated in doctor's offices, clinics, hospitals, labs, and state government databases, giving the Department and Medicaid providers limited ability to view a holistic record of a client's health. As a result, the Department has a compromised ability to measure and predict the impact of its services on client health and providers have a compromised ability to coordinate care and prevent duplicative or unnecessary treatments. Given the high level of investment in improving Medicaid client health care access and outcomes and the significant impact a complete health record has on care decisions, this scarce access to health information is unacceptable.

The Department has an opportunity to ameliorate this lack of access to Medicaid health-related information for a relatively small investment of state funds due to a time-limited enhanced federal funding opportunity and an opportunity to leverage existing infrastructure created for Colorado's health information exchange (HIE) network.

Background

Colorado's HIE network is a developing "network of networks" that enables secure electronic exchange of patient medical records, referrals, lab results, and other health information between health entities in the state. These entities include electronic health record (EHR) systems at physician offices, hospitals, and clinical laboratories; independently-created regional HIE networks; and electronic public health registries at the Colorado Department of Public Health and Environment (DPHE). In many cases, the HIE network currently enables real-time communication between these entities and many, but not all, Colorado Medicaid providers are beginning to connect to and utilize the network.

The ongoing effort to create Colorado's HIE network was spurred in particular by federal investments and grants to support HIE under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a portion of the federal American Recovery and Reinvestment Act (ARRA) of 2009. The HITECH Act made a 90% federal financial participation (FFP) rate available to state Medicaid agencies through 2021 for Medicaid-related HIE projects.

The lead coordinating entity for Colorado's HIE network is the nonprofit Colorado Regional Health Information Organization (CORHIO). CORHIO coordinates with Colorado health entities to develop data sharing policies, provide technical assistance, promote HIE, and build electronic infrastructure that allows data exchange between different health systems. CORHIO works alongside the nonprofit Quality Health Network (QHN), the organization leading the HIE effort on Colorado's western slope. Together, CORHIO and QHN have been responsible for facilitating a state-wide Colorado HIE network.

Colorado's HIE network primarily connects provider EHR systems. EHR systems are specialized computer software products at physicians' offices and hospitals meant to replace paper medical records. Connecting to the state's HIE network allows an EHR system to realize its greatest benefit: the ability to instantly query and exchange patient health information such as past complaints, diagnoses, treatments, doctor's notes, lab results, and insurance information with any other EHR system connected to the HIE network. The benefit of the state's HIE network is only fully realized when a critical mass of provider EHR systems are connected to the network, because only then can providers rely on the network for comprehensive, cross-provider patient health information.

However, due to cost, necessary staff training, and technical complexity, not all Colorado medical providers have purchased EHR systems or have connected their system to Colorado's HIE network. To assist Medicaid providers in reaching these goals, the Department implemented the Medicaid Provider EHR Incentive Payment Program, which pays Medicaid providers for adopting an EHR system. The program was created by the HITECH Act; the incentive payments are 100% federally funded and the program's administrative costs receive a 90% FFP rate through 2021. This program has made it possible for many Medicaid providers to adopt EHR systems and begin connecting to and utilizing the state's HIE network, helping to alleviate some of the problems caused by lack of access to health information. However, many Medicaid providers have yet to adopt EHR systems and among those who have, many are only in the beginning stages of implementation, only modestly utilizing the technology and able only to receive but not send data to the HIE network.

The Department's main business intelligence system and repository of Medicaid client and provider data, the Medicaid Management Information System (MMIS), is not connected to Colorado's HIE network. Thus, the MMIS cannot access or communicate with provider EHR systems and other systems connected to the state's HIE network. The MMIS was built for the primary purpose of processing the Department's medical claims and so only houses the minimal data necessary to adjudicate and facilitate payment of claims. This claims data is of limited usefulness in understanding the actual clinical outcomes of medical claims and the health of Medicaid clients. The Department's MMIS is currently being re-procured per the Department's FY 2013-14 R-5 Budget Request, "Medicaid Management Information System Reprocurement," and will be built to integrate with Colorado's HIE infrastructure for both public and private providers. However, such integration would require new Medicaid HIE infrastructure and interfacing with the MMIS.

Enhanced Federal Funding for Investment in Health Information Exchange Technology

Recognizing the potential of EHR technology and state HIE networks to reduce health care costs and improve health care quality through administrative efficiencies and better care coordination, the United States Congress, through the HITECH Act, has granted 90% FFP rates through 2021 to state Medicaid agencies for projects that support and expand HIE. This enhanced federal funding gives the Department an opportunity, for relatively little state investment, to build upon the existing infrastructure of Colorado's HIE network in order to expand HIE to the Department's MMIS and to continue assisting Medicaid providers in utilizing EHR technology and in connecting to Colorado's HIE network. Such an investment would allow both the Department and Medicaid providers greater access to Medicaid client health information and improve the problems described above that result from the current lack of access to this information.

Proposed Solution:

The Department requests $5,748,926 total funds, $1,054,893 General Fund, and $4,694,033 federal funds in FY 2014-15; $9,716,176 total funds, $1,451,618 General Fund, and $8,264,558 federal funds in FY 2015-16; $6,657,176 total funds, $1,445,718 General Fund, and $5,211,458 federal funds in FY 2016-17; and $4,442,176 total funds, $1,222,218 General Fund, and $3,199,958 federal funds in FY 2017-18 and ongoing in order to carry out the following proposed projects:

First, leveraging Colorado's already existing HIE network infrastructure, the Department proposes to build interfaces and expand the network's infrastructure so that more Medicaid provider EHR systems, the Department's MMIS, and several other Medicaid-related systems become fully connected to the HIE network. This infrastructure and the resulting enhanced ability to securely exchange Medicaid client health data would allow the Department to more accurately measure Medicaid services and understand the health of Medicaid clients and would enable Medicaid providers to make better-informed clinical decisions and achieve more congruent care coordination.

Second, the Department proposes to support Medicaid providers with continued incentive payments, outreach, and training in adopting and utilizing EHR technology and the state's HIE network in their practice. Supporting providers in this way is critical to the success of the proposed expanded HIE infrastructure because the availability of Medicaid client clinical data on the HIE network depends upon Medicaid providers connecting their EHR systems to the network and providing the information. Moreover, much of the benefit of the HIE network such as better care coordination and better-informed care decisions directly depends on providers being knowledgeable about their EHR systems and participating in statewide HIE. Details of the proposed solution are discussed below.

Build and Maintain HIE Infrastructure

Directory of HIE Systems and Reporting Tools

In order to accurately cross-reference the client data found in Medicaid provider EHR systems, the Department's MMIS, and several other health information systems, and then combine and store this data, the Department requests funding to expand the electronic client and provider directories created for the

Colorado HIE network and to create a clinical data repository. To then allow the Department and providers to analyze and gain insight from this newly linked data, as well as ease interface management and accommodate expected increases in public health reporting, the Department requests funding to procure various software tools and enhance the reporting capacity of public health reporting systems.

To accurately cross-reference client data found in different systems, the Department requests funding to contract with CORHIO to expand the existing client and provider directories of the Colorado HIE network so that it encompasses the MMIS and several other Medicaid-related systems.[1] These expanded directories would allow fragmented information about the same client or provider found in these different systems to be cross-referenced and combined. Cross-referencing data in this way would enable the Department to access data that would allow better measurement of the full impact and effectiveness of its policies, ranging from prior authorizations on individual services, to drug utilization, and the overall efficacy of the Accountable Care Collaborative.

The Department requests funding for a clinical data repository to securely combine and efficiently store this cross-referenced data. This would be an electronic storage system that Department staff and Medicaid providers could securely access for viewing and analysis of the combined data from the different systems. Without this repository, Department staff and Medicaid providers would have no way to actually reference the data that was cross-referenced together by the client and provider directories, limiting data access to time-consuming data requests and thus undermining the ability to analyze and act on the data in a timely fashion.

The Department requests funding to contract with CORHIO and QHN to develop various helpful software tools accessible to entities connected to the Colorado HIE network to enable the Department and Medicaid providers to better analyze and act on the health-related data exchanged on the Colorado HIE network and ease interface management between various systems,. The software would include: Transition of Care (ToC) and Continuity of Care Document (CCD) tools that expand electronic health information exchange between providers when clients change providers; a Clinical Quality Measure (CQM) analysis tool that would measure provider activities; clinical data analytical tools that would allow grouping and analysis of Medicaid client clinical data; and, an interface engine tool that would ease management of interfaces between the Colorado HIE network and other entities.

Also, in order to accommodate expected increases in electronic public health reporting by Medicaid providers (due to adoption of EHR and HIE technology), the Department requests funding to expand the capacity of DPHE public health reporting systems. Specifically, this would include increasing server storage for public health reporting databases, rebuilding public health reporting databases as necessary to make them more robust, and contracting with CORHIO to perform data validation. Without this increased capacity, the expanded public health reporting data would be more than current systems could handle and consequently Medicaid public health data would be backlogged and inaccessible. The Department requests

[1] These systems include the Department's MMIS, Colorado's HIE network (which would encompass all Medicaid provider EHR systems), the Center for Improving Value in Health Care's (CIVHC's) All-Payer Claims Database (APCD), the Colorado Department of Public Health and Environment's (DPHE's) public health registries, the Colorado Department of Regulatory Agencies' (DORA's) provider licensing system, the Colorado Department of Human Services' (DHS's) mental health and substance use systems, and the Department of Corrections' (DOC's) facility-based health care systems.

funding only for the portion of increased public health reporting that is due to Medicaid providers; DPHE's FY 2014-15 Budget Request R-4 "Health Information Exchange" requests funding for the portion of these upgrades that is not eligible for Medicaid funding.

If the above-proposed projects are not approved, the benefits of the projects to the Department, Medicaid clients, and providers would likely not otherwise be realized. Data in these isolated systems would remain fragmented and unable to be accessed by the Department or Medicaid providers, and useful analytical software tools and public health reporting data would be unavailable. If the proposed projects are approved, but the approval is significantly delayed, then the projects would likely cost more in state funds to implement due to the 2021 expiration of time-limited HITECH funding; furthermore, the benefits of these projects would be delayed.

Interfaces

In order for the expanded client and provider directories to aggregate information from the various health information records maintained by providers and other entities, the Department would be required to build interfaces that would allow for the actual flow of electronic information between the systems and the directories. These interfaces would not just enable reporting to the directory; rather, they would allow for the various health-related information systems and HIE networks around the state to communicate with each other. For example, interfaces would connect Medicaid providers and public health reporting systems at DPHE with the CORHIO or QHN HIE network, as well as connect the QHN and CORHIO HIE networks together. These interfaces would enable connected Medicaid providers to both send and receive health-related information with the HIE network, allowing instant access to useful and relevant data, such as past health services and diagnoses, lab results, public health reports, and referrals, enabling all HIE users to develop a better informed plan of care, while avoiding duplicative treatments.

If these interfaces are not built, it would severely limit the actual flow of data between entities connected to the HIE network, or may result in the interfaces being created at a later time, which would cost more in state funds (due to the 2021 expiration of enhanced HITECH funding) and would delay the benefits of building the interfaces. As an alternative, many of the interfaces could be implemented as more traditional point-to-point interfaces between each of the various systems; for instance, multiple point-to-point interfaces could be built between each DPHE public health system and the MMIS or between each DHS system and the MMIS instead of a single interface between each relevant system and the expanded client or provider directory. However, this approach would not leverage the existing infrastructure of Colorado's HIE network; it would also be less flexible because multiple interfaces would need to be rebuilt whenever a system was changed or created and any unforeseen future data exchange paths would require a new point-to-point interface.

Ongoing Costs

The Department requests funding to maintain and operate the infrastructure proposed above, regularly updating software, refreshing and replacing hardware, and troubleshooting and repairing problems. Supporting ongoing maintenance and operations allows the infrastructure to work as intended and exchange information securely in the future. Without ongoing maintenance and operations, the infrastructure

proposed above could not function after it was built. The Department also proposes to subscribe to ongoing transmission of data and analytics to the proposed clinical data repository from the Colorado HIE network via CORHIO and CIVHC's ACPD. Subscribing to these data sources would provide the Department with access to up-to-date data and analytics from these systems including clinical data and cross-payer claims data. Without these subscriptions, the Department would not have access to Colorado's HIE network or APCD data, severely diminishing the amount of data available to the Department through the proposed infrastructure.

Coordination and Oversight

The Department does not have the capability to coordinate and maintain this infrastructure project. Rather than request a large number of FTE and internal resources to manage this project, the Department proposes to contract with CORHIO to coordinate and oversee the entire infrastructure project. CORHIO is uniquely qualified to handle this project because, as the designated lead organization for expanding HIE in Colorado (per Executive Order D 008 09), it has not only the in-house technical, policy, and coordinating expertise for HIE projects, but also the relationships within Colorado's health information community and broad public and private governance structures and input channels that would be necessary for implementing the proposed projects.

This CORHIO resource would ensure coordination between the Department, CORHIO, QHN, CIVHC, OIT, and other state agencies to expand and connect to the client and provider directories including coordinating and directing the vision, creating data sharing agreements, and developing appropriate policies and inclusive governance structures. If this request is approved, the Department would work closely with OIT and other state agencies that are investing in HIE solutions to ensure that all state resources are leveraged and the Department's efforts are not duplicative or misguided. This would include working closely with DPHE on their FY 2014-15 Budget Request R-4 "Health Information Exchange," mentioned above. With this coordination, oversight, and dedicated resources, the Department will avoid unintentionally duplicating efforts by other departments, gain opportunities to leverage shared visions and resources with other departments and health entities, ensure compliance with security and privacy policies, and efficiently and adequately manage required contractors.

Support Providers

Provider Incentive Payments, Outreach, and Training

The success of any HIE solution is dependent on provider engagement and adoption. In order to encourage Medicaid Providers to install, maintain, and use EHR technology and connect to the Colorado HIE network, the Department intends to continue administering the Medicaid Provider EHR Incentive Payment Program previously approved with the Department's FY 2011-12 BA-8 budget request "ARRA HITECH Provider Incentive Payments," and requests additional funding to conduct provider outreach and training about EHR technology. Provider outreach and training such as mailings, seminars, written training materials, and live technical support are currently offered to Medicaid providers by CORHIO using funds under an ARRA HITECH grant received by CORHIO called the Regional Extension Center (REC) program. However, this federal funding is slated to expire and because of the benefits of this program, the

Department is requesting funding to continue these integral outreach and training efforts to Medicaid providers.

Without this continued provider support, the Department believes that Medicaid providers would be less likely to continue adopting EHR technology and interfacing with Colorado's HIE network due to the high costs and complexity of EHR and HIE technology. This would undermine the usefulness of the infrastructure proposed in this request because much of its benefit derives from provider participation, and moreover, the availability of the infrastructure's intended data depends upon providers supplying it through HIE-connected EHR systems.

Anticipated Outcomes:

The proposed solution would allow Medicaid provider EHR systems, the MMIS, public health reporting systems, and other currently isolated systems to securely exchange electronic Medicaid client data gradually as infrastructure is built between FY 2014-15 and FY 2017-18. The proposed solution would allow the fragmented data in these systems to be aggregated and analyzed by the Department and Medicaid providers. Ultimately, the ability of the Department and Medicaid providers to securely exchange, aggregate, and analyze this Medicaid health-related data would enable better Medicaid client care and lower Medicaid health care costs.

With the proposed solution, the Department and providers would be alerted to certain client clinical conditions in real-time, allowing the Department and providers to take actions that are clinically beneficial or would reduce costs. For example, if a client requires follow-up care after an emergency room discharge, then thanks to real-time alerts from hospital EHR systems, the Department and providers could reach out to a client to use a less-costly clinic for follow-up care instead of going back to the emergency room. As another example, thanks to the availability of diabetes-related lab results from lab EHR systems, the Department and providers could be alerted to abnormal results and follow up with clients to advise proper care. This would help to improve client health and would lower costs by potentially avoiding costly acute care later on.

Similarly, the proposed solution would enable the Department to contain health care costs and improve client health by identifying patterns in client demographic and other data that correlate with certain health risks. For instance, through the proposed data repository, the Department would be able to search for correlations between client data housed in DHS's mental health and substance use systems with the clinical data found in provider EHR systems. Such analysis could identify common demographic or other patterns in clients that indicate higher risk for certain health conditions. This would allow the Department to then reach out to these clients and providers to mitigate potential health risks, and thus improve client health and avoid costlier care later on.

The proposed solution would also allow the Department to understand the clinical outcomes of the medical services for which it pays, giving the Department the ability to reform payment policies to be based on clinical outcomes, promoting more effective care and containing costs. Currently the Department pays for allowable services with little ability to evaluate the effectiveness of the service. Access to additional data about a client allows comprehensive measurement of outcomes of services. For instance, surgeons often

use different prosthetic devices for knee replacements. Access to the data repository would allow measurement of the effectiveness of different types of devices based on client clinical data found in provider EHR systems. This would allow for potential payment reform that supports the most clinically-effective prosthetic device at the lowest cost.

The proposed solution would also allow Medicaid providers to access and analyze the information about their patients across the different systems as well as instantly and securely exchange patient health information with other providers, leading to better informed and timelier health care decisions, better care coordination, and administrative efficiencies. For instance, Medicaid providers would be able to quickly query the state's HIE network to view health information from other provider EHR systems on a new patient and use this information to avoid treatments that are duplicative or have been ineffective in the past, thus providing better care and avoiding unnecessary costs. Providers would also be able to easily send patient information to a referred specialist or receive lab results, resulting in administrative efficiencies, better care coordination, and better client experience. This access to and timely exchange of client health information would not be possible without the proposed HIE infrastructure.

If approved, the proposed solution would help the Department achieve three goals of the Department's five-year strategy plan. First, the proposed solution would help achieve the goal to "improve health outcomes, client experience, and lower per capita costs" by delivering comprehensive client information to the Department and Medicaid providers for better-informed care decisions, leading to improved health outcomes and less waste on duplicative or unnecessary treatment; better care coordination between providers for improved client experience; and, proactive prediction and prevention of health risks to avoid costly future care. Second, the proposed solution would help achieve the goal to "provide exceptional service through technological innovation" by implementing state-of-the-art HIE technology that provides secure patient health care information sharing and analysis never before possible in the Medicaid program. Lastly, the proposed solution would help achieve the goal to "ensure sound stewardship of financial resources" by correlating clinical data with claims data and thereby allowing the Department and providers to identify services and practices that lead to the same or better clinical outcomes for the least cost.

Assumptions and Calculations:

Cost Estimates

Cost estimates for the proposed solution are based on estimates and actual costs from CORHIO, DPHE, and CIVHC, and are also based on the Department's experience with systems of similar technical complexity such as the MMIS.

The Department assumes that many of the proposed projects would be able to leverage the already-existing infrastructure of Colorado's HIE network. For instance, instead of building client and provider directories from scratch, the Department assumes it would expand the existing directories of CORHIO and QHN that are already used by the Colorado HIE network to route patient health data between provider EHR systems.

The Department also assumes that many of the proposed projects could be utilized for payers other than Medicaid, and as such, the cost estimates for the proposed solution only reflect Medicaid's assumed fair

share of the cost. For instance, many interfaces are expected to be used to exchange both Medicaid and non-Medicaid health-related information, so cost estimates for building the interfaces are prorated based on the expected amount of Medicaid data flowing across the interfaces divided by the expected total amount of data flowing across the interfaces. CORHIO would be required to obtain investment from other payers to cover costs that do not benefit the Medicaid program.

Cost estimates for coordination and oversight are based on estimates from CORHIO of 2 FTE for this purpose. Although the coordination and oversight required for the proposed projects would be extensive, the Department assumes that 2 FTE at CORHIO would be sufficient because of their opportunity, as CORHIO personnel, to leverage CORHIO's existing resources and expertise.

The Department assumes that Medicaid would pay its fair share for operations and maintenance of the expanded provider and client directories, clinical data repository, and interfaces between health systems and the expanded provider and client directories. The Department assumes DPHE would cover ongoing costs for public health reporting capacity enhancements. The Department assumes that ongoing costs for provider and critical access hospital interfaces with the Colorado HIE network as well as the software tools to be used on the network would be covered by CORHIO. The Department assumes that the long-term financial sustainability of CORHIO, QHN, and the Colorado HIE network would be self-sustaining and not supported by Department funding, except for specific value-add services such as providing ongoing data and analytics to the Department.

Cost estimates for supporting providers are based on the Department's actual current costs for administering the Medicaid Provider EHR Incentive Payment Program and actual current costs to CORHIO for conducting provider outreach and training under the REC program grant.

Based on the cost estimates and assumptions described above, Tables 1.1 through 1.4 in the attached appendix provide a summary of the request by line item. Tables 2.1 through 2.4 summarize the request by FFP rate and major project heading while Table 3 summarizes the request by major project heading and shows detailed sub-projects. Table 4 summarizes existing funding and need for the Medicaid Provider EHR Incentive Program.

Financing

As shown in Tables 1.1 through 1.4, the Department assumes most of the requested funding would be housed in a new line item named Health Information Exchange Maintenance and Projects in the Department's (1) Executive Director's Office; (C) Information Technology Contracts and Projects Long Bill group. As shown, the Department assumes that $20,000 each fiscal year for state staff travel for the EHR incentive payment program would be housed in the Department's Operating Expenses line item.

Also shown in Tables 1.1 through 1.4 is a requested $2,500,000 ongoing reduction to the General Professional Services and Special Projects line item. The Department was appropriated this $2,500,000 with the Department's FY 2011-12 Budget Request BA-8 "ARRA HITECH Provider Incentive Payments" for the purpose of administering the Medicaid Provider EHR Incentive Payment Program. The Department now requests to move the funding for this program from the General Professional Services and Special

Projects line item into the new Health Information Exchange Maintenance and Projects and Operating Expenses line items. However, as shown in Table 4, the actual need for administering the EHR incentive payment program is significantly less than the original $2,500,000 appropriation for the program, resulting in an overall cost savings for the program of $1,391,824. As shown in Table 3, the Department is consequently requesting an overall reduction in funding for the EHR incentive payment program equal to this cost savings.

The Department assumes that a 90% FFP rate will be available for all items of the proposed solution except for ongoing maintenance, operations, and data subscriptions, which the Department assumes will receive 75% and 50% FFP rates. The Department assumes all enhanced FFP rates will be granted under either the HITECH Act or under the enhanced FFP available for MMIS projects outlined in Chapter 11 of the State Medicaid Manual.

Table 1.1 - Total Request for FY 2014-15 by Line Item			
Line Item	**Total Funds**	**General Fund**	**Federal Funds**
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$20,000	$2,000	$18,000
(1) Executive Director's Office; (A) General Adminstration, General Professional Services and Special Projects	($2,500,000)	($250,000)	($2,250,000)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance and Projects	$8,228,926	$1,302,893	$6,926,033
Total Request for FY 2014-15	**$5,748,926**	**$1,054,893**	**$4,694,033**

Table 1.2 - Total Request for FY 2015-16 by Line Item			
Line Item	**Total Funds**	**General Fund**	**Federal Funds**
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$20,000	$2,000	$18,000
(1) Executive Director's Office; (A) General Adminstration, General Professional Services and Special Projects	($2,500,000)	($250,000)	($2,250,000)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance and Projects	$12,196,176	$1,699,618	$10,496,558
Total Request for FY 2015-16	**$9,716,176**	**$1,451,618**	**$8,264,558**

Table 1.3 - Total Request for FY 2016-17 by Line Item			
Line Item	**Total Funds**	**General Fund**	**Federal Funds**
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$20,000	$2,000	$18,000
(1) Executive Director's Office; (A) General Adminstration, General Professional Services and Special Projects	($2,500,000)	($250,000)	($2,250,000)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance and Projects	$9,137,176	$1,693,718	$7,443,458
Total Request for FY 2016-17	**$6,657,176**	**$1,445,718**	**$5,211,458**

Table 1.4 - Total Request for FY 2017-18 by Line Item			
Line Item	**Total Funds**	**General Fund**	**Federal Funds**
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$20,000	$2,000	$18,000
(1) Executive Director's Office; (A) General Adminstration, General Professional Services and Special Projects	($2,500,000)	($250,000)	($2,250,000)
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance and Projects	$6,902,176	$1,470,218	$5,431,958
Total Request for FY 2017-18	**$4,422,176**	**$1,222,218**	**$3,199,958**

Table 2.1 - Total Request for FY 2014-15 by FFP Rate				
Item	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
90% FFP Rate				
Directory of HIE Systems and Reporting Tools	$1,202,000	$120,200	$1,081,800	90%
Interfaces	$2,938,750	$293,875	$2,644,875	90%
Coordination and Oversight	$250,000	$25,000	$225,000	90%
Provider EHR Incentive Payments, Outreach, and Training	$158,176	$15,818	$142,358	90%
Subtotal: 90% FFP Rate	**$4,548,926**	**$454,893**	**$4,094,033**	**90%**
75% FFP Rate				
Ongoing Costs: Operations and Maintenance	$0	$0	$0	75%
Subtotal: 75% FFP Rate	**$0**	**$0**	**$0**	**75%**
50% FFP Rate				
Ongoing Costs: HIE network data and analytics; APCD data and analytics	$1,200,000	$600,000	$600,000	50%
Subtotal: 50% FFP Rate	**$1,200,000**	**$600,000**	**$600,000**	**50%**
Total Request for FY 2014-15	**$5,748,926**	**$1,054,893**	**$4,694,033**	**Mix**

Table 2.2 - Total Request for FY 2015-16 by FFP Rate				
Item	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
90% FFP Rate				
Directory of HIE Systems and Reporting Tools	$1,913,000	$191,300	$1,721,700	90%
Interfaces	$6,195,000	$619,500	$5,575,500	90%
Coordination and Oversight	$250,000	$25,000	$225,000	90%
Provider EHR Incentive Payments, Outreach, and Training	$158,176	$15,818	$142,358	90%
Subtotal: 90% FFP Rate	**$8,516,176**	**$851,618**	**$7,664,558**	**90%**
75% FFP Rate				
Ongoing Costs: Operations and Maintenance	$0	$0	$0	75%
Subtotal: 75% FFP Rate	**$0**	**$0**	**$0**	**75%**
50% FFP Rate				
Ongoing Costs: HIE network data and analytics; APCD data and analytics	$1,200,000	$600,000	$600,000	50%
Subtotal: 50% FFP Rate	**$1,200,000**	**$600,000**	**$600,000**	**50%**
Total Request for FY 2015-16	**$9,716,176**	**$1,451,618**	**$8,264,558**	**Mix**

Table 2.3 - Total Request for FY 2016-17 by FFP Rate				
Item	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
90% FFP Rate				
Directory of HIE Systems and Reporting Tools	$1,419,000	$141,900	$1,277,100	90%
Interfaces	$1,630,000	$163,000	$1,467,000	90%
Coordination and Oversight	$250,000	$25,000	$225,000	90%
Provider EHR Incentive Payments, Outreach, and Training	$158,176	$15,818	$142,358	90%
Subtotal: 90% FFP Rate	**$3,457,176**	**$345,718**	**$3,111,458**	**90%**
75% FFP Rate				
Ongoing Costs: Operations and Maintenance	$2,000,000	$500,000	$1,500,000	75%
Subtotal: 75% FFP Rate	**$2,000,000**	**$500,000**	**$1,500,000**	**75%**
50% FFP Rate				
Ongoing Costs: HIE network data and analytics; APCD data and analytics	$1,200,000	$600,000	$600,000	50%
Subtotal: 50% FFP Rate	**$1,200,000**	**$600,000**	**$600,000**	**50%**
Total Request for FY 2016-17	**$6,657,176**	**$1,445,718**	**$5,211,458**	**Mix**

Table 2.4 - Total Request for FY 2017-18 by FFP Rate				
Item	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**
90% FFP Rate				
Directory of HIE Systems and Reporting Tools	$794,000	$79,400	$714,600	90%
Interfaces	$20,000	$2,000	$18,000	90%
Coordination and Oversight	$250,000	$25,000	$225,000	90%
Provider EHR Incentive Payments, Outreach, and Training	$158,176	$15,818	$142,358	90%
Subtotal: 90% FFP Rate	**$1,222,176**	**$122,218**	**$1,099,958**	**90%**
75% FFP Rate				
Ongoing Costs: Operations and Maintenance	$2,000,000	$500,000	$1,500,000	75%
Subtotal: 75% FFP Rate	**$2,000,000**	**$500,000**	**$1,500,000**	**75%**
50% FFP Rate				
Ongoing Costs: HIE network data and analytics; APCD data and analytics	$1,200,000	$600,000	$600,000	50%
Subtotal: 50% FFP Rate	**$1,200,000**	**$600,000**	**$600,000**	**50%**
Total Request for FY 2017-18	**$4,422,176**	**$1,222,218**	**$3,199,958**	**Mix**

Table 3 - Total Request by Project						
Item	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**Total**	**FFP**
Build and Maintain HIE Infrastructure						
Directory of HIE Systems and Reporting Tools						
Client directory	$200,000	$250,000	$0	$0	**$450,000**	90%
Provider directory	$300,000	$500,000	$0	$0	**$800,000**	90%
Clinical data repository	$0	$500,000	$500,000	$0	**$1,000,000**	90%
ToC and CCD tools	$125,000	$125,000	$0	$0	**$250,000**	90%
CQM analytical tool	$0	$125,000	$125,000	$0	**$250,000**	90%
Clinical data analytical tools	$0	$0	$576,000	$576,000	**$1,152,000**	90%
Interface engine	$195,000	$195,000	$0	$0	**$390,000**	90%
Public health reporting capacity increase	$164,000	$0	$0	$0	**$164,000**	90%
Public health reporting data validation	$218,000	$218,000	$218,000	$218,000	**$872,000**	90%
Subtotal: Directory of HIE Systems and Reporting Tools	**$1,202,000**	**$1,913,000**	**$1,419,000**	**$794,000**	**$5,328,000**	**90%**
Interfaces						
Medicaid provider interfaces	$1,500,000	$1,500,000	$1,500,000	$0	**$4,500,000**	90%
Critical access hospital interfaces	$138,750	$125,000	$110,000	$0	**$373,750**	90%
QHN to CORHIO interface	$40,000	$20,000	$20,000	$20,000	**$100,000**	90%
Interfaces with the expanded client/provider directories (including the MMIS, APCD, and systems at DPHE, DHS and DORA)	$1,260,000	$4,550,000	$0	$0	**$5,810,000**	90%
Subtotal: Interfaces	**$2,938,750**	**$6,195,000**	**$1,630,000**	**$20,000**	**$10,783,750**	**90%**
Ongoing Costs						
Operations and maintenance	$0	$0	$2,000,000	$2,000,000	**$4,000,000**	75%
HIE network data and analytics	$800,000	$800,000	$800,000	$800,000	**$3,200,000**	50%
APCD data and analytics	$400,000	$400,000	$400,000	$400,000	**$1,600,000**	50%
Subtotal: Ongoing Costs	**$1,200,000**	**$1,200,000**	**$3,200,000**	**$3,200,000**	**$8,800,000**	**Mix**
Coordination and Oversight						
2 FTE at CORHIO	$250,000	$250,000	$250,000	$250,000	**$1,000,000**	90%
Subtotal: Coordination and Oversight	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$1,000,000**	**90%**
Support Providers						
Provider EHR Incentive Payments, Outreach, and Training						
EHR Incentive Payment Program Cost Savings (See Table 4)	($1,391,824)	($1,391,824)	($1,391,824)	($1,391,824)	**($5,567,296)**	90%
Outreach, education, and technical services	$1,550,000	$1,550,000	$1,550,000	$1,550,000	**$6,200,000**	90%
Subtotal: Provider EHR Incentive Payments, Outreach, and Training	**$158,176**	**$158,176**	**$158,176**	**$158,176**	**$632,704**	**90%**
Total Request	**$5,748,926**	**$9,716,176**	**$6,657,176**	**$4,422,176**	**$26,544,454**	**Mix**

Table 4 - Medicaid Provider EHR Incentive Program Administrative Costs			
Row	**Item**	**FY 2014-15[1]**	**FFP**
	Existing Appropriation		
A	FY 2011-12 BA-8 "ARRA HITECH Provider Incentive Payments"	$2,500,000	90%
	Actual Program Need		
B	Provider attestation processing	$439,176	90%
C	Auditing	$424,000	90%
D	Coordination and oversight	$225,000	90%
E	Department staff travel (Operating Expenses Line Item)	$20,000	90%
F	**Subtotal: Program Need**	**$1,108,176**	**90%**
G	**Program Cost Savings (Row A - Row F)**	**$1,391,824**	**90%**

[1]These amounts are the same for FY 2015-16, FY 2016-17, and FY 2017-18.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Eligibility Determination Enhanced Match
Priority Number: R-6

Dept. Approval by: Josh Block 4/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	Total	42,966,752	-	45,053,873	15,677,849	13,141,781
	FTE	-	-	-	-	-
	GF	10,731,704	-	10,886,729	-	0
	GFE	-	-	-	-	-
	CF	10,717,018	-	11,665,554	-	-
	RF	-	-	-	-	-
	FF	21,518,030	-	22,501,590	15,677,849	13,141,781
(1) Executive Director's Office; (C) Information Technology Contracts and Projects: Centralized Eligibility Vendor Contract Project	Total	6,745,159	-	7,151,142	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	3,357,390	-	3,560,382	(1,099,009)	(1,406,291)
	RF	-	-	-	-	-
	FF	3,387,769	-	3,590,760	1,099,009	1,406,291
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: County Administration	Total	32,591,259	-	33,108,009	8,610,333	5,669,405
	FTE	-	-	-	-	-
	GF	10,731,704	-	10,886,729	(314,109)	0
	GFE	-	-	-	-	-
	CF	5,604,460	-	5,707,810	-	-
	RF	-	-	-	-	-
	FF	16,255,095	-	16,513,470	8,924,442	5,669,405
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Hospital Provider Fee County Administration	Total	3,630,334	-	4,794,722	4,881,080	5,972,376
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	1,755,168	-	2,397,362	799,009	1,031,291
	RF	-	-	-	-	-
	FF	1,875,166	-	2,397,360	4,082,071	4,941,085
NEW ITEM (1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Medical Assistance Sites	Total	-	-	-	1,200,000	1,500,000
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	300,000	375,000
	RF	-	-	-	-	-
	FF	-	-	-	900,000	1,125,000
NEW ITEM (1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Affordable Care Act Implementation Technical Support and Eligibility Determination Overflow Contingency	Total	-	-	-	986,436	-
	FTE	-	-	-	-	-
	GF	-	-	-	314,109	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	-	672,327	-

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

Cash or Federal Fund Name and COFRS Fund Number: Hospital (24A) EAU2, Local Funds

Reappropriated Funds Source, by Department and Line Item Name: NA

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

Schedule 13s from Affected Departments: NA

Other Information: NA

COLORADO
Department of Health Care Policy and Financing

Priority: R-6
Eligibility Determination Enhanced Match
FY 2014-15 Change Request

Cost and FTE

- The Department requests an increase of approximately $15.7 million total funds in FY 2014-15, an approximate 30% increase over the current appropriation. This amount is comprised of a $15.7 million increase to federal funds. No additional General Fund is requested.

Link to Operations

- Counties and the Department's Eligibility and Enrollment Services for Medical Assistance Program (EEMAP) contractor, Maximus, are responsible for processing most Medicaid and other major federally funded public assistance programs applications.

Problem or Opportunity

- Counties continue to be reimbursed below cost for the processing of Medicaid and other major federally funded public assistance programs applications. For Medicaid programs, counties are required to contribute 20% of the total cost of processing applications.
- The Department is able to draw a 75% federal match for application processing services under the Affordable Care Act (ACA). This would free up General Fund and Hospital Provider Fee dollars which could be appropriated to offer incentives to counties for processing online Medicaid applications and incent other application sites to move towards online applications and create a pool of funding to assist any site with technology to do so.
- Medical Assistance (MA) sites and other sites are not currently paid for processing applications.

Consequences of Problem

- Counties continue to be paid below their total cost, which has lead to application processing delays and lawsuits against the state.
- The Department is not currently able to incentivize counties to keep up with system and processing changing and caseload associated with the ACA; if counties and other eligibility assistance sites cannot process applications timely, clients are delayed from receiving services, which may lead to additional lawsuits.

Proposed Solution

- The Department requests to repurpose General Fund from the enhanced match to: fund incentives for counties for improvement in application processing; fund Medical Assistance (MA) sites; and establish coordinated payment methodologies for all Medicaid application processing sites.
- With proper financial incentives, trainings, and resources, the Department would help counties reduce costs, increase reimbursement and make application processing more efficient.
- By improving funding methodologies to MA and other eligibility sites, the Department would ensure timeliness and accuracy in application processing while offering clients alternative sites to enroll in Medicaid.

Department Priority: R-6
Request Detail: Eligibility Determination Enhanced Match

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Eligibility Determination Enhanced Match	$15,677,849	$0

Problem or Opportunity:

The Department works with 64 counties in Colorado to assist in determining eligibility and enrolling clients into the Medicaid and other federally funded assistance programs. While the Department and the Department of Human services share the cost of administering these services, counties continue to be underfunded each year as the actual cost of providing administrative services exceed the appropriations from both agencies. As caseloads for public assistance programs continue to grow, counties are required to maintain timely application processing standards and ensure eligibility determination accuracy; because there are still uncompensated costs, counties continue to have difficulty maintaining compliance with processing standards. Medicaid expansion under the Affordable Care Act (ACA) put further strain on counties as they are required to enroll newly eligible clients within more stringent application processing performance standards, including federal requirements pushing states to adopt real-time eligibility determinations.

In addition to pressure from Medicaid expansion, counties face challenges in application processing as a result of consistent underfunding which compounds the need for additional funding. Many consumers continue to utilize and submit paper applications. Other counties are not allocated enough funding to hire the number of FTE needed to process Medicaid and other federally funded program applications and are therefore forced to stretch their existing FTE for multiple activities, not necessarily related to eligibility determination. Although the General Assembly appropriated some additional funding to counties in SB 13-200, which authorized Medicaid expansion under the Affordable Care Act, counties are now projected to incur costs well beyond the state's appropriations for County Administration as projected enrollment has changed since the passage of SB 13-200.

To met the expected high demand for eligibility determination services, the Centers for Medicare and Medicaid Services (CMS) has examined its current practices under Medicaid Management Information Systems (MMIS) rules for approval of 75% federal match for maintenance and operations in the context of eligibility determinations and has confirmed that certain eligibility determination-related costs are eligible for 75% federal financial participation (FFP). Further guidance from a CMS issued Frequently Asked

Questions document, released on April 24, 2013, and additional information on August 9, 2013, outlined specific activities that would receive the additional federal funding for an unspecified length of time. Based on this information, the Department believes the majority of its County Administration appropriation would be eligible for the enhanced match; however, the true amount of the enhanced match will not be known until the Department receives approval for a Maintenance and Operations Advance Planning Document (MOAPD); the Department submitted this document to CMS on August 21, 2013 and is awaiting a reply.

Based on CMS' guidance, in an effort to mitigate the funding issues and provide additional resources to counties, the Department submitted an interim supplemental request in August 2013 to remove the (M) head note from the County Administration appropriation. After reviewing the request, the Joint Budget Committee (JBC) determined it best to leave the (M) headnote on the line item but appropriated the Department approximately $9 million to fund unexpected costs as a result of ACA and Medicaid expansion implementation and provide additional funding to counties to support the expected influx of clients.

Proposed Solution:

The Department requests $15,677,849, comprised of $15,677,849 federal funds to improve the eligibility determination process statewide. The Department would use the requested funding to provide grants to counties to improve their eligibility processing infrastructure, provide incentive payments for meeting application processing benchmarks, provide additional funding to counties for ongoing operations, and provide funding to medical assistance sites. This funding would also continue funding the Department's ACA implementation plan. In total, this request would require no new investment of state funds, while allowing the Department to obtain an estimated $15,677,849 in new federal funds.

The increase in the federal match rate for eligibility determination activities creates a surplus of General Fund and Hospital Provider Fee in the Department's appropriations for County Administration. Essentially, because the Department is able to draw down additional federal funds, it can provide the same level of total funding to counties using fewer state dollars. Because there are significant additional needs related to the timely processing of eligibility, and because the counties continue to be under-reimbursed for their costs to process applications for public assistance, the Department requests to maintain the level of its General Fund and Hospital Provider Fee appropriations in FY 2014-15 and beyond for the purpose of providing as much additional federal funding to counties as possible, along with providing funding for other eligibility processing activities.

Infrastructure Grants

The Department proposes to provide $1,000,000 per fiscal year to counties in the form of infrastructure grants. These grants would be offered to counties for one-time funding requirements to improve the eligibility determination process. For example, counties could use funding to create a computer room for applicants to enter their information into PEAK. The Department would require counties to submit written proposals for funding at the beginning of the fiscal year and would offer awards to the proposals that most align with the Department's goal to improve the client eligibility determination process. The structure of the award process and a rating system to rank requests would be established through stakeholder outreach.

The Department assumes a small internal workgroup would be necessary to review and recommend infrastructure grants for the Department to fund. Although the Department currently has only 1 FTE allocated to program management of County Administration, the Department believes that the additional workload of reviewing applications once or twice a year would be absorbable.

Incentive Payment Structure and Increased Funding for Counties

The Department proposes to provide $2,853,905 General Fund to provide an incentive payment to counties for meeting application processing and other benchmarks established by the Department in conjunction with the counties. Additionally, the Department would increase county allocations by an estimated $9,685,508 total funds, including $1,439,107 General Fund, $982,270 Hospital Provider Fee funds and $7,264,131 federal funds in FY 2014-15 to allow counties to maintain effective administration of Medicaid eligibility determination and application processing.

In order to improve the eligibility determination methodology, the Department requests to repurpose General Fund in the County Administration and Hospital Provider Fee County Administration line items to create incentive payments, with counties. Application processing requirements, established at 42 CFR § 435.911 and in rule at 10 CCR 2505 section 8.100.3D, necessitate the processing of applications within 90 days for a person applying for Medical Assistance Programs with a disability determination and 45 days for all other applicants. By creating an incentive program, the Department would be able to encourage faster and more accurate application processing and other activities such as the movement away from paper applications, responsiveness to Random Moment Sampling (RMS) surveys, or other activities to create a more efficient and effective eligibility determination process. The Department would utilize an intensive stakeholder outreach process to engage counties in discussions about application processing benchmarks and incentive payment structure.

To create an incentive payment, the Department would create contracts with participating counties. Creating contracts with counties for Medicaid eligibility determination would enable the Department to set specific benchmarks for application processing and timeliness while offering incentives to meet the benchmarks. These contracts would also create repercussions for counties that are unable to meet application processing standards.

Due to federal requirements, the Department cannot reimburse counties above their cost. Therefore, incentive payments would be provided by reducing the funds that counties are required to contribute, currently approximately 20% of the total funding for regular activities, and replace those funds with General Fund dollars. While this is the proposed methodology for incentive payments, the Department would work with counties and DHS to reach an agreed upon standard.

The Department proposes that any remaining appropriation from the County Administration and Hospital Provider Fee County Administration lines would be included in the counties' allocation budgets to support regular county administration activities and assure that counties have necessary resources to provide Medicaid eligibility determination services. Any unspent General Fund in the County Administration appropriation would be transferred at the end of the year to DHS to support other federally funded program administration provided by the counties, consistent with the current program operation.

Medical Assistance (MA) Site Funding

The Department proposes to provide funding for MA sites to assist in Medicaid eligibility determination and to hire a contractor to review statewide eligibility determination reimbursement methodologies. The Department estimates that $1,200,000 total funds, $300,000 Hospital Provider Fee and $900,000 federal funds, would be required in FY 2014-15, increasing to $1,500,000 in FY 2015-16.

A number of different eligibility determination sites exist around the state with varying degrees of services. The Department funds some of these sites, such as Federally Qualified Health Centers (FQHC), but does not fund others like Medical Assistance sites. The Department proposes to contract with a vendor to support an effort to evaluate all payment methodologies for eligibility determination. The range and scope of activities that are performed to assist clients in Medicaid eligibility has become more complicated over time, for instance with the implementation of the Program Eligibility and Application Kit (PEAK) system. In order to insure consistency across multiple organizations, including counties, the Department would hire a contractor to evaluate the current payment system, make recommendations for improvement, engage in stakeholder outreach to determine the most appropriate program structure moving forward, work with federal partners to ensure program compliance with federal regulation and potentially perform and new workload study on county activities.

In addition to funding a contractor to review overall eligibility site functionality, the Department proposes to fund Medical Assistance (MA) sites. The Department currently contracts with 7 MA sites to conduct Medicaid eligibility determination on location. MA sites offer additional points of contact for Medicaid eligibility determination. Eligibility workers are stationed at places such as schools, clinics, and hospitals in order to assist clients that may otherwise not visit a county location to be enrolled in Medicaid. These sites are required to meet the same application processing performance standards and requirements that counties are required to meet and support the Department's aim to have "no wrong door" in determining client eligibility. Historically the Department has not reimbursed MA sites for application processing because funding has not been available. Rather, MA sites utilize grant funds and internal funding to pay for eligibility services. The enhanced match on eligibility determination activities would, however, enable the Department to utilize freed up Hospital Provider Fee from the Centralized Eligibility Vendor appropriation to pay MA sites for processing Medicaid applications. With Medicaid expansion, counties are likely to face an unprecedented volume of applications; to maintain timely eligibility processing, funding MA sites would ensure enough resources are provided to maintain timeliness in application processing as the number of applications increase. The Department would employ a stakeholder outreach process with MA sites to determine the best payment methodology for services while being mindful of existing programs, such as FQHC outstationing services. Outstationing clinics accept and perform the initial processing of Medicaid applications from the designated eligibility groups at outstationing locations. Initial processing means taking applications, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. Outstationing clinics do not evaluate the information or make a determination of eligibility and are therefore do not meet the eligibility criteria for enhanced funding.

Should this initiative not be approved, the Department would continue to contract for the operation of MA sites without funding and would keep other eligibility assistance programs as they are currently. While the

MA site program has been successful in the past, Medicaid expansion may make it difficult for sites to continue to meet timely filing requirements. Site managers have informed the Department that it is a continuous struggle to obtain and maintain local grant funds to keep the sites operational. Additionally, with more and more clients enrolling in Medicaid, the overhead costs of being a site continues to increase annually placing a financial burden on the organizations. With ACA moving forward and more adults programs being offered, the burden will only continue to increase and could lead MA sites to close resulting in a greater burden on counties.

Funding for ACA Implementation Contracts

In order to continue supporting the call center and back office functions necessary for ACA implementation the Department requests $986,436 total funds, $314,104 General Fund and $672,327 federal funds in FY 2014-15.

The Department issued two Invitation for Bids (IFB) for contractors to operate a back up call center and back office activities. These contracts, in conjunction with internal staff and system changes, are designed to mitigate any issues with ACA implementation and support overflow from counties efforts in order to maintain application processing requirements. For further detail see the Department's September 1331 Interim Supplemental request.

The Department estimates these contracts would only be required through FY 2014-15. For more detail on the contractors' activities and associated costs see Table 8 in Appendix A.

Without approval to continue funding the Department's ACA implementation efforts, the Department would be required to repurpose existing resources that are already allocated to other purposes in order to fund activities related to eligibility processing and ACA implementation. This could cause shortfalls in contracts or create delays in implementation and execution of other programs, including County Administration.

Anticipated Outcomes:

The approval of this request would allow the Department to take advantage of the current opportunity to utilize freed up General Fund to be repurposed towards ACA implementation without requiring any additional General Fund or cash funds appropriations. The Department would be able to ensure new clients have the necessary resources available to determine their eligibility, make certain all information from Connect for Health Colorado is consistent with Medicaid eligibility rules, and ensure accurate and timely eligibility determinations.

Additionally, the Department would be able to improve the eligibility determination process for clients by creating incentives for counties who demonstrate improvements to their services while also offering infrastructure support to counties that would not otherwise be available.

Finally, with approval of this request, the Department would be able to fund a review of eligibility assistance and determination sites as well as fund MA sites for their Medicaid eligibility determination activities. This would allow the Department to ensure all points of entry for clients are streamlined and

meet accuracy and application processing requirements. This opportunity would also provide resources to enable the MA sites to continue to determine eligibility for the Medicaid program.

This request would also help the Department achieve three of the stated goals on the Department's Five-Year Strategy Map. This request would allow the Department to improve health outcomes, client experience and lower per capita costs by making resources available to ensure newly eligible clients are correctly enrolled into Medicaid in a timely manner. The Department would be able to provide service through technological innovation by providing support for unexpected complications as the State and the Department implement ACA requirements. Additionally the Department would be able to ensure sound stewardship of financial resources by identifying the potential for overpayment as a result of new system processes and eliminating the risk.

Overall, this request would ensure the Department has adequate resources to anticipate issues with ACA implementation and make sure clients' experience with Medicaid enrollment is efficient and effective, giving Coloradoans the services they need.

Assumptions and Calculations:

A detailed description of the Department's calculations for this request can be found in Appendix A. Additional information and assumptions for each section can be found below.

County Administration

The Department assumes an additional $4,607,121 General Fund and $1,770,270 Hospital Provider Fee will be available in FY 2014-15 as a result of the enhanced match available for eligibility determination. See tables 3 through 5 for detailed calculations. In calculating the amount of General Fund freed up through the enhanced match, the Department reviewed FY 2012-13 expenditure reports submitted by counties through CFMS and eliminated cost pools the Department believed would not be eligible for the enhanced match. The Department then reviewed the RMS activities performed in the same year, made assumptions about which activities would be eligible for the enhanced funding and which would not, and applied that metric to the estimated eligible expenditure. While this methodology creates an estimate to the amount of funding available for the match, the actual activities and cost pools eligible for enhanced funding will be determined by CMS. The Department submitted the list of activities with the MOAPD and will continue to work with CMS to reach an agreement on the activities and costs pools eligible for enhanced funding. For the purposes of this request, and using the methodology described above, the Department estimates 56% of Medicaid County Administration is eligible for additional funding.

The Department assumes it would engage in extensive outreach to create an incentive program within contracts for counties. Although actual implementation may differ, in order to estimate costs, the Department assumed it would provide this incentive through a reduction to the local funds counties are expected to contribute to county administration. The Department assumed that in the first year of the program there would be a reduction to the local share of 50%, ramping up to 90% reduction in FY 2015-16. In order to receive the reduction in local share, counties would be expected to meet or exceed the benchmarks established in the contracts. While the increase to General Fund to offset the local share should lead to a decrease in the needed appropriation for local funds, the Department would maintain the local

funds appropriation, as it is not guaranteed counties will meet the benchmarks established. Should a county be unable to attain the level of application processing required to decrease the local share amount, this funding would be necessary to draw federal funds to pay for services.

The Department assumes that any remaining General Fund and Hospital Provider Fee dollars will be utilized to increase county allocations for County Administration. In estimating this increase, the Department assumes all additional activities the county would be able to perform with freed up funding would be eligible for the 75% enhanced match. This assumption is made to estimate the highest amount of federal funds that might be necessary to operate the program and under the assumption that counties would need to increase the number of FTE performing Medicaid eligibility determination under Medicaid expansion in order to meet application processing requirements.

The Department assumes county infrastructure grants, incentive payments, and additional funds to counties would remain in the County Administration line item. The Department needs to maintain flexibility between these tasks as counties are not guaranteed to utilize all grant and incentive funds available. Should this happen, the Department could increase allocations to the counties without requesting approval from the JBC. If the program initiatives are separated the Department would be unable to utilize remaining funds in the grant and incentive lines to increase allocations without additional spending authority.

Medical Assistance Site Funding

The Department assumes a contractor would be required to evaluate the current payment structure for eligibility assistance and determination sites and work with stakeholders to establish payment methodologies and funding levels. The Department estimates no greater than $500,000 would be issued to the contractor and that new methodologies would be implemented by January 1, 2015. The Department would issue an Information For Bid (IFB) to award the contract. Any funding not distributed to the contractor would be utilized for payment to the MA sites.

The Department assumes a new line item, (1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Medical Assistance Sites, would be created to delineate MA site activities from the Centralized Eligibility Vendor line item. In FY 2014-15 the Department assumes $1,200,000 total funds, including $300,000 Hospital Provider Fee and $900,000 federal funds, would be necessary to implement the program. Because the estimated appropriation for MA sites is based on caseload growth, it is likely the Department would need to increase the appropriation as caseload increases.

ACA Implementation

The Department has issued IFBs for two contractors to provide the call center and administrative activities discussed above. The Department made estimates based on current contracts and processing times to reach the estimated $2.5 million in costs in FY 2013-14 and $986,000 in FY 2014-15 for the additional ACA implementation requirements; the Department provided estimates for these functions in its September 20, 2013 interim supplemental request. Once the contracts have been evaluated and awarded, the Department intends to provide updated cost estimates in a January 2014 supplemental request and budget amendment. Please see Appendix A: Table 7 for further detail of estimated costs.

The Department assumes a new line item, (1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Affordable Care Act Implementation Technical Support and Eligibility Determination Overflow Contingency would be created to appropriate funding for ACA implementation activities. The Department estimates $986,436 total funds, including $314,109 General Fund and $672,327 federal funds would be necessary to continue the call center and back office activities through FY 2014-15. The Department assumes no funding would be necessary in FY 2015-16 and subsequent years.

Table 1.1 Summary by Line Item							
FY 2014-15	**FTE**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Total Request	**0.0**	**$15,677,849**	**$0**	**$0**	**$0**	**$0**	**$15,677,849**
(1) Executive Director's Office; (C) Information Technology Contracts and Projects: Centralized Eligibility Vendor Contract Project	0.0	$0	$0	$0	($1,099,009)	$0	$1,099,009
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: County Administration	0.0	$8,610,333	($314,109)	$0	$0	$0	$8,924,442
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Hospital Provider Fee County Administration	0.0	$4,881,080	$0	$0	$799,009	$0	$4,082,071
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Medical Assistance Sites	0.0	$1,200,000	$0	$0	$300,000	$0	$900,000
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Affordable Care Act Implementation Technical Support and Eligibility Determination Overflow Contingency	0.0	$986,436	$314,109	$0	$0	$0	$672,327

Table 1.2 Summary by Line Item							
FY 2015-16	**FTE**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Total Request	**0.0**	**$13,141,781**	**$0**	**$0**	**$0**	**$0**	**$13,141,781**
(1) Executive Director's Office; (C) Information Technology Contracts and Projects: Centralized Eligibility Vendor Contract Project	0.0	$0	$0	$0	($1,406,291)	$0	$1,406,291
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: County Administration	0.0	$5,669,405	$0	$0	$0	$0	$5,669,405
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Hospital Provider Fee County Administration	0.0	$5,972,376	$0	$0	$1,031,291	$0	$4,941,085
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Medical Assistance Sites	0.0	$1,500,000	$0	$0	$375,000	$0	$1,125,000
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services: Affordable Care Act Implementation Technical Support and Eligibility Determination Overflow Contingency	0.0	$0	$0	$0	$0	$0	$0

Table 2.1 - FY 2014-15 Summary by Initiative								
Item	**FMAP**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**Source**
Reduction Due to Enhanced Match								
County Administration Savings from Enhanced Funding	75%	$0	($4,607,121)	$0	($671,261)	$0	$5,278,382	Table 3.3 - FY 2014-15 Total Year County Administration with Enhanced Federal Match
Centralized Eligibility Vendor Savings from Enhanced Funding	75%	$0	$0	$0	($1,099,009)	$0	$1,099,009	Table 5.1 - FY 2014-15 Eligibility and Enrollment Medical Assistance Program Budget
Repurposed Funding								
County Grant Support	50%	$1,000,000	$0	$0	$500,000	$0	$500,000	Estimate
County Incentive Payment	75%	$2,853,905	$2,853,905	$0	$0	$0	$0	Table 6 - Estimated Cost for County Administration Incentive Payment
Increase in County Allocation	75%	$9,637,508	$1,439,107	$0	$970,270	$0	$7,228,131	Estimated assuming any remaining General Fund or Hospital Provider Fee funds would be utilized to increase allocations to counties.
Medical Assistance Site Funding	75%	$1,200,000	$0	$0	$300,000	$0	$900,000	Estimate
ACA Implementation	75%	$716,436	$179,109	$0	$0	$0	$537,327	Table 7 - Estimated Additional Affordable Care Act Implementation Costs
ACA Implementation	50%	$270,000	$135,000	$0	$0	$0	$135,000	Table 7 - Estimated Additional Affordable Care Act Implementation Costs
Estimated Total Cost		$15,677,849	$0	$0	$0	$0	$15,677,849	

Table 2.2 - FY 2015-16 Summary by Initiative								
Item	**FMAP**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**	**Source**
Reduction Due to Enhanced Match								
County Administration Savings from Enhanced Funding	75%	$0	($4,713,389)	$0	($711,803)	$0	$5,425,192	Table 4.3 - FY 2015-16 Total Year County Administration Appropriation with Enhanced Federal Match
Centralized Eligibility Vendor Savings from Enhanced Funding	75%	$0	$0	$0	($1,406,291)	$0	$1,406,291	Table 5.2 - FY 2015-16 Eligibility and Enrollment Medical Assistance Program Budget
Repurposed Funding								
County Grant Support	50%	$1,000,000	$0	$0	$500,000	$0	$500,000	Estimate
County Incentive Payment	75%	$4,394,717	$4,394,717	$0	$0	$0	$0	Table 6 - Estimated Cost for County Administration Incentive Payment
Increase in County Allocation	75%	$6,247,064	$318,672	$0	$1,243,094	$0	$4,685,298	Estimated assuming any remaining General Fund or Hospital Provider Fee funds would be utilized to increase allocations to counties.
Medical Assistance Site Funding	75%	$1,500,000	$0	$0	$375,000	$0	$1,125,000	Estimate
ACA Implementation	75%	$0	$0	$0	$0	$0	$0	Table 7 - Estimated Additional Affordable Care Act Implementation Costs
ACA Implementation	50%	$0	$0	$0	$0	$0	$0	Table 7 - Estimated Additional Affordable Care Act Implementation Costs
Estimated Total Cost		$13,141,781	$0	$0	$0	$0	$13,141,781	

Table 3.1 - FY 2014-15 County Administration Current Appropriation

Appropriation	FMAP	Total Funds	General Fund	Local Funds	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds
Regular County Administration	50%	$28,801,635	$8,733,542	$5,707,810	$0	$0	$14,360,283
County Administration Requiring No Local Share	50%	$4,106,374	$2,053,187	$0	$0	$0	$2,053,187
PARIS	50%	$200,000	$100,000	$0	$0	$0	$100,000
Hospital Provider Fee County Administration	50%	$4,794,722	$0	$0	$2,397,361	$0	$2,397,361
Total Appropriation		$37,902,731	$10,886,729	$5,707,810	$2,397,361	$0	$18,910,831

Table 3.2 - FY 2014-15 County Administration Assuming 56% of County Activities are Eligible for the Enhanced Match

Appropriation	FMAP	Total Funds	General Fund	Local Funds	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds
Regular County Administration	50%	$16,128,916	$4,838,675	$3,225,783	$0	$0	$8,064,458
County Administration Requiring No Local Share	50%	$2,299,569	$1,149,784	$0	$0	$0	$1,149,785
PARIS	50%	$200,000	$100,000	$0	$0	$0	$100,000
Hospital Provider Fee County Administration	50%	$2,685,044	$0	$0	$1,342,522	$0	$1,342,522
Total Appropriation		$21,313,529	$6,088,459	$3,225,783	$1,342,522	$0	$10,656,765

Table 3.3 - FY 2014-15 Total Year County Administration with Enhanced Federal Match

Appropriation	FMAP	Total Funds	General Fund	Local Funds	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds
Regular County Administration	75%	$16,128,916	$806,446	$3,225,783	$0	$0	$12,096,687
County Administration Requiring No Local Share	75%	$2,299,569	$574,892	$0	$0	$0	$1,724,677
PARIS Holdout	50%	$200,000	$100,000	$0	$0	$0	$100,000
Hospital Provider Fee County Administration	75%	$2,685,044	$0	$0	$671,261	$0	$2,013,783
Total [(1)]		$21,313,529	$1,481,338	$3,225,783	$671,261	$0	$15,935,147
Estimated Impact of Enhanced Match Funding		$0	($4,607,121)	$0	($671,261)	$0	$5,278,382

[(1)] The Department assumes the local share will remain constant and all savings will be attributed to General Fund.

Table 4.1 - FY 2015-16 County Administration Current Appropriation							
Appropriation	**FMAP**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Regular County Administration	50%	$29,560,699	$8,961,261	$5,859,623	$0	$0	$14,739,815
County Administration Requiring No Local Share	50%	$4,106,374	$2,053,187	$0	$0	$0	$2,053,187
PARIS Holdout	50%	$200,000	$100,000	$0	$0	$0	$100,000
Hospital Provider Fee County Administration	50%	$5,084,308	$0	$0	$2,542,154	$0	$2,542,154
Total		$38,951,381	$11,114,448	$5,859,623	$2,542,154	$0	$19,435,156

Table 4.2 - FY 2015-16 County Administration Assuming 56% of County Activities are Eligible for the Enhanced Match							
Appropriation	**FMAP**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Regular County Administration	50%	$16,553,991	$4,966,197	$3,310,798	$0	$0	$8,276,996
County Administration Requiring No Local Share	50%	$2,299,569	$1,149,784	$0	$0	$0	$1,149,785
PARIS	50%	$200,000	$100,000	$0	$0	$0	$100,000
Hospital Provider Fee County Administration	50%	$2,847,212	$0	$0	$1,423,606	$0	$1,423,606
Total Appropriation		$21,900,772	$6,215,981	$3,310,798	$1,423,606	$0	$10,950,387

Table 4.3 - FY 2015-16 Total Year County Administration Appropriation with Enhanced Federal Match							
Appropriation	**FMAP**	**Total Funds**	**General Fund**	**Local Funds**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
Regular County Administration	75%	$16,553,991	$827,700	$3,310,798	$0	$0	$12,415,493
County Administration Requiring No Local Share	75%	$2,299,569	$574,892	$0	$0	$0	$1,724,677
PARIS Holdout	50%	$200,000	$100,000	$0	$0	$0	$100,000
Hospital Provider Fee County Administration	75%	$2,847,212	$0	$0	$711,803	$0	$2,135,409
Total [(1)]		$21,900,772	$1,502,592	$3,310,798	$711,803	$0	$16,375,579
Estimated Impact of Enhanced Match Funding		$0	($4,713,389)	$0	($711,803)	$0	$5,425,192

[(1)] The Department assumes the local share will remain constant and all savings will be attributed to General Fund.

Table 5.1 - FY 2014-15 Eligibility and Enrollment Medical Assistance Program Budget						
Appropriation	**FMAP**	**Total Funds**	**General Fund**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
FY 2014-15 Appropriation	50%	$7,151,142	$0	$3,560,381	$0	$3,590,761
FY 2014-15 Appropriation Assuming 62% of the Contract is Eligible for the Enhanced Match	50%	$4,433,708	$0	$2,207,436	$0	$2,226,272
FY 2014-15 Appropriation with Enhanced Funding	75%	$4,433,708	$0	$1,108,427	$0	$3,325,281
Estimated Impact of Enhanced Match Funding		$0	$0	($1,099,009)	$0	$1,099,009

Table 5.2 - FY 2015-16 Eligibility and Enrollment Medical Assistance Program Budget						
Appropriation	**FMAP**	**Total Funds**	**General Fund**	**Hospital Provider Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
FY 2015-16 Appropriation	50%	$9,133,612	$0	$4,551,616	$0	$4,581,996
FY 2015-16 Appropriation Assuming 62% of the Contract is Eligible for the Enhanced Match	50%	$5,662,839	$0	$2,822,001	$0	$2,840,838
FY 2015-16 Appropriation with Enhanced Funding	75%	$5,662,839	$0	$1,415,710	$0	$4,247,129
Estimated Impact of Enhanced Match Funding		$0	$0	($1,406,291)	$0	$1,406,291

Table 6 - Estimated Cost for County Administration Incentive Payment				
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**Comment/Calculation**
A	Estimated County Share	$5,707,810	$5,859,623	Estimated County Share of Appropriation
B	Estimated Percentage to be Replaced with General Fund Incentive	50%	75%	Assumed gradual increase as counties are better able to meet established benchmarks.
C	Estimated Incentive Payment Cost	$2,853,905	$4,394,717	Row A * Row B

Table 7 - Estimated Additional Affordable Care Act Implementation Costs				
Item	**FMAP**	**FY 2013-14**	**FY 2014-15**	**Esimated Project End Date**
SYSTEM CHANGES				
CBMS				
System change to CBMS to differentiate between verified and unverified records received from the Marketplace	90%	$168,000	$0	December 2013
System change to CBMS to report on unverified Medicaid eligible determinations, so that staffing can identify and collect missing verifications.	90%	$50,400	$0	December 2013
System change to CBMS to identify assumed relationships received from the Marketplace	90%	$168,000	$0	December 2013
System change to CBMS to report on potential households that may not be accurately determined due to this assumption	90%	$50,400	$0	December 2013
OIT / MARKETPLACE				
System change to the Marketplace to cross walk and send the Department necessary data for the affected relationships	90%	$190,400	$0	December 2013
Subtotal System Changes		**$627,200**	**$0**	
HCPF IN-HOUSE				
Temporary FTE to perform quality control on the cases that should already be executed to ensure timely filing. Also mitigate issues with various contracts and create communication plans.	75%	$53,295	$72,748	June 2014
The Department is requesting increased funding for printing and stocking paper applications.	50%	$270,000	$270,000	On-going
Subtotal HCPF In-House		**$323,295**	**$342,748**	
CONTRACTOR				
Staffing to process phone applications	75%	$749,649	$321,844	October 2014
Subtotal Call Center		**$749,649**	**$321,844**	
Staffing to manage and process the reports to collect verifications and finalize eligibility determinations	75%	$187,413	$53,641	August 2014
Staffing to review, process and collect the accurate household compositions and determine final eligibility	75%	$187,412	$53,641	August 2014
The Department is requesting additional funding to create an overflow team who can serve as a temporary resource to manage all overflow and backlogged requests for applications with minimal wait time	75%	$187,412	$107,281	October 2014
Increase staffing to manage and process data entry of paper applications	75%	$187,412	$107,281	October 2014
Subtotal Back of the Office Contract		**$749,649**	**$321,844**	
Total Cost		**$2,449,793**	**$986,436**	

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase

Priority Number: R-7

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/24/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 6 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	5,117,662,301	0	5,854,420,807	15,472,452	30,082,871
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	1,187,078,554	0	1,231,183,790	7,736,227	15,041,435
	GFE	0	0	0	0	0
	CF	595,915,946	0	696,187,530	0	0
	RF	2,936,892	0	2,000,000	0	0
	FF	2,861,888,826	0	3,455,207,403	7,736,225	15,041,436
(2) Medical Services Premiums	**Total**	4,736,824,877	-	5,323,832,795	2,626,699	5,253,399
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	1,313,350	2,626,699
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	1,313,349	2,626,700
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	**Total**	380,837,424	-	456,935,528	622,616	1,245,232
	FTE	-	-	-	-	-
	GF	151,060,588	-	153,425,552	311,308	622,616
	GFE	-	-	-	-	-
	CF	2,033,883	-	12,646,177	-	-
	RF	-	-	-	-	-
	FF	227,742,954	-	290,863,799	311,308	622,616
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	**Total**	-	-	47,042,236	9,887,594	19,715,830
	FTE	-	-	-	-	-
	GF	-	-	27,481,475	4,943,797	9,857,915
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	19,560,761	4,943,797	9,857,915

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	6
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	Total	-	-	26,610,248	2,335,543	3,868,410
	FTE	-	-	-	-	-
	GF	-	-	14,454,444	1,167,772	1,934,205
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	12,155,804	1,167,771	1,934,205

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: Pursuant to HB 13-1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, the line items impacted by the request will be reflected in the Department of Health Care Policy and Financing.

COLORADO
Department of Health Care Policy and Financing

Priority: R-7
Supported Living Services Waiting List Elimination and Service Plan Authorization Limits Increase
FY 2014-15 Change Request

Cost and FTE

- $15,472,452 total funds, $7,736,227 General Fund, and 0.0 FTE in FY 2014-15; $30,082,871 total funds, $15,041,435 General Fund, and 0.0 FTE in FY 2015-16 and beyond.

Link to Operations

- Home and Community Based Services-Supported Living Services (HCBS-SLS) are for adults with developmental disabilities who can either live independently with limited to moderate supports or who need more extensive support provided by other persons such as their family

Problem or Opportunity

- There are 1,526 people on the waiting list for HCBS-SLS services (based on June 30, 2013 waiting list data). This includes those on the HCBS-SLS waiting list who have indicated they would accept HCBS-DD enrollment if available.
- The HCBS-SLS program support levels are determined, in part, through Service Plan Authorization Limits (SPALs 1-6) representing six levels of service based on the individual's level of need. Service levels are capped and are not sufficient for some individuals who would benefit from additional services.
- This request is critical as people with developmental disabilities are waiting for needed services. The need for more costly Residential Habilitation in the Home and Community Based Services for People with Developmental Disabilities (HCBS-DD) waiver is avoided by serving people through HCBS-SLS.

Consequences of Problem

- Without new funding people will continue to wait for an enrollment to become available through attrition, which cannot keep up with demand, therefore growing the waiting list.
- Individuals waiting to receive services may experience deterioration in their medical or behavioral conditions and their quality of life may suffer as a result.

Proposed Solution

- The request is for 1,526 enrollments to eliminate the HCBS-SLS waiting list, increase each SPAL by 20%, and increase the maximum service limit to $45,000.
- The SPAL increase will better meet the needs of clients by providing them access to more units of service or other services that could not be authorized under the current limits of the SPAL.
- Increasing the overall waiver cap and SPAL amounts will enable people to receive needed services in the frequency they need them to live safe and self-determined lives in their own homes and communities.

Department Priority: R-7
Request Detail: Supported Living Services Waiting List Elimination and Service Plan Authorization Limits Increase

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Supported Living Services Waiting List Elimination and Service Plan Authorization Limits Increase	$15,472,452	$7,736,227

Problem or Opportunity:

The Home and Community Based Services – Supported Living Services (HCBS-SLS) waiver services are for adults who can either live independently with limited to moderate supports or who need more extensive support provided by other persons, such as their family. The HCBS-SLS waiver program provides a variety of services, such as personal care to assist with activities of daily living (i.e. eating, bathing and dressing); homemaking needs; employment or other day services; community connections; assistive technology; home modification; professional therapies; transportation; and twenty-four hour emergency assistance. Supported Living Services are not intended to meet all needs. Service needs and the level of support are prioritized within the overall Service Plan developed by the Case Management Agency. The person receiving services is responsible for his or her living arrangements, which can include living with family or in their own residence.

There are a growing number of people waiting for HCBS-SLS services, and the Service Plan Authorization Limits (SPAL) within SLS are not adequate to meet the needs of participants in the program. The Department does not have the funding needed to address these critical issues, which is why we are requesting funding to eliminate the HCBS-SLS waiting list and increase the maximum service limits on the SPALs.

The maximum annual expenditure for any single participant within the HCBS-SLS waiver services is $35,000, which is inclusive of all services. Within HCBS-SLS, there are six Support Levels which are tied to six Service Plan Authorization Limits (SPALs 1-6). Each authorization limit identifies an annual maximum dollar amount available to address all ongoing service needs based on a uniform method for assessing Support Levels using the Supports Intensity Scale (SIS) tool. These authorization limits provide a statewide uniform method for assuring that waiver participants with higher Support Level needs can receive sufficient services to meet those needs, while still meeting cost effectiveness and containment requirements. These authorization limits apply only to ongoing services, excluding intermittent services

(e.g. transportation, dental services, vision services, assistive technology, home accessibility adaptations, and vehicle modifications).

The method used to determine the dollar values associated with each SPAL is based on an analysis of historical utilization of authorized waiver services by participants, and appropriated funds available for this waiver. The implementation of SPALs was phased in at the time of each annual Service Plan renewal starting July 1, 2009 and resulted in a more equitable distribution of services and supports across the waiver population.

Proposed Solution:

This request is for $15,472,452 total funds, $7,736,227 General Fund in FY 2014-15; $30,082,871 total funds, $15,041,435 General Fund in FY 2015-16 and beyond, to:

- Eliminate the current waiting list for services through the Home and Community Based Services - Supported Living Services Medicaid waiver program;
- Increase the maximum annual expenditure for any single participant receiving HCBS-SLS waiver services from $35,000 to $45,000 per year (28.6% increase in maximum amount allowed);
- Increase the maximum amount for each Service Plan Authorization Limit level by 20%;
- Provide adequate Medicaid state plan and Behavioral Health Community Programs funding.

The Department is proposing to fully fund services for all individuals on the waiting list as well as increase the SPAL limits to improve access to needed services. There are 1,526 people on the waiting list for HCBS-SLS services, based on June 30, 2013 waiting list data. This includes individuals who are on both the HCBS-SLS waiting list and the waiting list for HCBS-DD waiver services. These individuals indicate they will accept the first available enrollment from either waiver program.

This request is critical because people with developmental disabilities are waiting for needed services, especially those that are at high risk of harm or homelessness. Individuals waiting to receive services may experience deterioration in their medical or behavioral conditions, their caregivers may struggle to continue to provide support, and their quality of life may suffer as a result. Providing services addresses all aspects of health, safety and quality of life for these individuals. Increasing the overall waiver cap and SPAL amounts will enable people to receive needed services in the frequency they need them to live safe and self-determined lives in their own homes and communities.

Funding this request will address the Department's goal of serving the needs of clients with developmental disabilities in the least restrictive setting. The alternative is to leave enrollments and SPAL limits at the current funding level. People with intellectual and developmental disabilities would wait for an enrollment to become available through attrition, which cannot keep up with demand, therefore growing the waiting list for HCBS-SLS services. Some people may accept enrollment in the more expensive and restrictive HCBS-DD waiver if the HCBS-SLS enrollment is not available, and the SPAL limits in the HCBS-SLS waiver would not sufficiently address all individual needs for services and supports.

Anticipated Outcomes:

The current HCBS-SLS waiting list will be eliminated by funding enrollments for the number of individuals identified as waiting and in need of services by FY 2014-15. Those individuals that are on the HCBS-SLS waiting list and the HCBS-DD waiting list would receive services through the HCBS-SLS waiver, which is less restrictive and more cost effective than the HCBS-DD waiver. By increasing the waiver cap and the SPAL limits, individuals who currently are not able to access full time day services would have access as their needs dictate. Increasing the limit on services in the HCBS-SLS waiver would allow some people that need more extensive dental services, assistive technology, home modifications or vehicle modifications to obtain these services, providing the support individuals need to stay in their own homes or their family's home by promoting independence through technology and accessibility adaptations.

Raising the SPAL limits will also allow more people who have Supported Employment as part of their Service Plan to benefit by providing them the ability to have more units of Supported Employment, expanding their ability to participate in employment activities. The Division for Developmental Disabilities (DDD) is currently engaged in a performance management strategy that allows the Division to better focus on and improve performance outcomes. Currently, DDD examines the performance measure titled "*Participants Receiving Supported Employment in Group and Individualized Settings*." The goal of this measure is to increase the number of participants receiving Supported Employment in group and individualized settings to 23% among those adults in the community with developmental disabilities who are enrolled in day services. Performance trends from calendar year 2012 to the first six months of 2013 have shown improvement, ranging from 19.3% to 22.4% in 2012, and peaking at 24.5% as of June 2013. The DDD has surpassed the 23% goal for improving Supported Employment outcomes and has exceeded the national Supported Employment average of 20.3%.

Recently, a more targeted performance measure was introduced titled *"Participants Receiving Supported Employment in Individualized Settings."* This measure focuses on efforts to customize employment opportunities and serve individuals in the most integrated setting possible. The goal of this measure is to increase the number of participants receiving Supported Employment in individualized settings to 13% among those adults in the community with developmental disabilities who are enrolled in day services. Performance trends from calendar year 2012 to the first six months of 2013 have been stagnant, ranging from 8.5% to 9.3%. Increasing the SPAL limits and the overall cap on services in the HCBS-SLS waiver can improve an individual's access to needed Supported Employment services, as some clients have not been able to fully access their Supported Employment potential because of the SPAL limits currently in place. In addition, funding enrollments for those on the waiting list will allow these individuals access to Supported Employment services.

Assumptions and Calculations:

Based on the FY 2013-14 SPAL amounts, the Department calculates that the limit for each SPAL level would increase as shown in the following table.

Service Plan Authorization Limits by Support Level			
SPAL Levels	FY 2013-14 SPAL Amounts	Proposed Percent Increase	Revised SPAL Amount
SPAL 1	$12,193	20%	$14,632
SPAL 2	$13,367	20%	$16,040
SPAL 3	$15,038	20%	$18,046
SPAL 4	$17,296	20%	$20,755
SPAL 5	$20,818	20%	$24,982
SPAL 6	$27,366	20%	$32,839

The impact of the SPAL increase is anticipated to be partially realized in FY 2014-15 and be fully realized in FY 2015-16 because the limits would be applied as individuals begin or renew their service plan throughout FY 2014-15. The cost projection shown for FY 2014-15 on Attachment A, and for FY 2015-16 in Attachment B, assumes that the impact applies to clients with expenditures at 80% of their SPAL limit or greater. The Department assumes that these clients are managing within the service limits and would see a proportionate increase if the SPAL limits are increased by 20%. There is no anticipated cost increase for clients with expenditures that are less than 80% of their SPAL limit. The Department assumes that these clients are fully receiving the amount of service needed within the current SPAL limit; therefore an increase in the SPAL limit would not benefit them.

In order to forecast Medical Services Premiums (state plan) and mental health service (Behavioral Health Community Programs) cost shift estimates, the Department assumes that the current wait list demographic is statistically identical to the pool of individuals currently served in the SLS waiver who entered into the waiver over the past three years. The forecast includes factors such as number of individuals on the wait list currently receiving state plan and/or mental health services, the number receiving service through an alternate waiver, and anticipated state plan and mental health service utilization costs for individuals before and after transitioning to the SLS waiver. Forecast calculations are shown on Tables 2.1 and 2.2.

Table 1.1
Calculation of Fund Splits - FY 2014-15

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums	$2,626,699	$1,313,350	$0	$0	$1,313,349
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$622,616	$311,308	$0	$0	$311,308
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$9,887,594	$4,943,797	$0	$0	$4,943,797
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$2,335,543	$1,167,772	$0	$0	$1,167,771
Total Projected FY 2014-15 Expenditures	**$15,472,452**	**$7,736,227**	**$0**	**$0**	**$7,736,225**

Table 1.2
Calculation of Fund Splits - FY 2015-16

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums	$5,253,399	$2,626,699	$0	$0	$2,626,700
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$1,245,232	$622,616	$0	$0	$622,616
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$19,715,830	$9,857,915	$0	$0	$9,857,915
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$3,868,410	$1,934,205	$0	$0	$1,934,205
Total Projected FY 2015-16 Expenditures	**$30,082,871**	**$15,041,435**	**$0**	**$0**	**$15,041,436**

Table 2.1
FY 2014-15
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to SLS Waiver Wait List Reduction

		Current Medicaid Recipients		Current Non-Medicaid Recipients	*Total FY 2014-15*	Formula/Assumptions
		Waiver	No Waiver			
A	Client Count	26	871	629	1526	
B	Average Months Enrolled	6	6	6	6	6
C	Estimated Full Participant Equivalents	13	435.5	314.5	763	Row A * (Row B/12)
D	Current State Plan Costs	$7,065	$9,027	$0		MMIS Claims Data
E	Future State Plan costs per person[1]	$8,878	$8,878	$8,878		See Footnote
F	Net difference per person	$1,812	($149)	$8,878		Row D * Row E
G	Total Increase (Decrease)	$23,561	($65,062)	$2,792,001	$2,750,500	Row F * Row C
H	Current MSP[2] Waiver[3] costs per person	$9,523	$0	$0		MMIS Claims Data
I	Future Waiver costs per person	$0	$0	$0		
J	Net difference per person	($9,523)	$0	$0		Row H - Row I
K	Total Increase (Decrease)	($123,801)	$0	$0	($123,801)	Row J * Row C
L	**Total Medical Services Premiums Impact**	**($100,239)**	**($65,062)**	**$2,792,001**	**$2,626,699**	Row G + Row K
M	Current Mental Health costs per person	$1,980	$1,980	$0		FY 2013-14 S-2
N	Future Mental Health costs per person	$1,980	$1,980	$1,980		FY 2013-14 S-2
O	Net difference per person	$0	$0	$1,980		Row M - Row N
P	**Total Mental Health Increase (Decrease)**	**$0**	**$0**	**$622,616**	**$622,616**	Row O * Row C
Q	**Total**	**($100,239)**	**($65,062)**	**$3,414,617**	**$3,249,316**	Row L + Row P

1) CMS 372 less Targeted Case Management and Mental Health

2) *Definition* : MSP - Medical Services Premiums.

3) MSP Waivers include Children's Home and Community Based Services (CHCBS) and Elderly Blind and Disabled (EBD); both administered by HCPF

Table 2.2
FY 2015-16
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to SLS Waiver Wait List Reduction

		Current Medicaid Recipients		Current Non-Medicaid Recipients	*Total FY 2015-16*	Formula/Assumptions
		Waiver	No Waiver			
A	Client Count	26	871	629	1526	
B	Average Months Enrolled	12	12	12	12	Evenly through the year
C	Estimated Full Participant Equivalents	26	871	629	1526	Row A * (Row B/12)
D	Current State Plan Costs	$7,065	$9,027	$0		MMIS Claims Data
E	Future State Plan costs per person[1]	$8,878	$8,878	$8,878		See Footnote
F	Net difference per person	$1,812	($149)	$8,878		Row D * Row E
G	Total Increase (Decrease)	$47,122	($130,124)	$5,584,002	$5,501,000	Row F * Row C
H	Current MSP[2] Waiver[3] costs per person	$9,523	$0	$0		MMIS Claims Data
I	Future Waiver costs per person	$0	$0	$0		
J	Net difference per person	($9,523)	$0	$0		Row H - Row I
K	Total Increase (Decrease)	($247,601)	$0	$0	($247,601)	Row J * Row C
L	**Total Medical Services Premiums Impact**	**($200,479)**	**($130,124)**	**$5,584,002**	**$5,253,399**	Row G + Row K
M	Current Mental Health costs per person	$1,980	$1,980	$0		FY 2013-14 S-2
N	Future Mental Health costs per person	$1,980	$1,980	$1,980		FY 2013-14 S-2
O	Net difference per person	$0	$0	$1,980		Row M - Row N
P	**Total Mental Health Increase (Decrease)**	**$0**	**$0**	**$1,245,232**	**$1,245,232**	Row O * Row C
Q	**Total**	**($200,479)**	**($130,124)**	**$6,829,234**	**$6,498,631**	Row L + Row P

1) CMS 372 less Targeted Case Management and Mental Health

2) *Definition* : MSP - Medical Services Premiums.

3) MSP Waivers include Children's Home and Community Based Services (CHCBS) and Elderly Blind and Disabled (EBD); both administered by HCPF

Table 3.1
FY 2014-15
Impact to New Office of Community Living Program Costs Due to SLS Waiver Wait List Reduction

FY 2014-15 HCBS-SLS Waiting List Elimination Funding Calculations

	Number of Enrollments* (a)	Months Enrolled (b)	Average Annual FPE Cost** (c)	Total Annual Cost All New Enrollments (d)	TF (e)	GF (f)
1) HCBS-SLS Waiting List Reduction	1,526	6	$12,414	$9,471,882	$9,471,882	$4,735,941
2) Targeted Case Management	1,526	6	$2,157	$1,645,791	$1,645,791	$822,896
3) Quality Assurance	1,526	6	$300	$228,900	$228,900	$114,450
4) Utilization Review	1,526	Annually	$78	$119,028	$119,028	$59,514
5) Supports Intensity Scale Assessment	1,526	One Time	$224	$341,824	$341,824	$170,912
Total (7)(A) Program Costs				**$11,807,425**	**$11,807,425**	**$5,903,713**
Calculation (rounded)				*(a)*(b)* (c)/12*		*(e) * 50%,*

* The number of enrollment is based on all persons waiting for HCBS-SLS waiver services through FY 2014-15.

** Average Annual FPE Cost is based on FY 2012-13 average cost per FPE plus 4% provider rate increase approved for FY 2013-14.

Table 3.2
FY 2015-16
Impact to New Office of Community Living Program Costs Due to SLS Waiver Wait List Reduction

FY 2015-16 HCBS-SLS Waiting List Elimination Funding Calculations

	Number of Enrollments* (a)	Months Enrolled (b)	Average Annual FPE Cost** (c)	Total Annual Cost All New Enrollments (d)	TF (e)	GF (f)
1) HCBS-SLS Waiting List Reduction	1,526	12	$12,414	$18,943,764	$18,943,764	$9,471,882
2) Targeted Case Management	1,526	12	$2,157	$3,291,582	$3,291,582	$1,645,791
3) Quality Assurance	1,526	12	$300	$457,800	$457,800	$228,900
4) Utilization Review	1,526	Annually	$78	$119,028	$119,028	$59,514
Total (7)(A) Program Costs				**$22,812,174**	**$22,812,174**	**$11,406,087**
Calculation (rounded)				*(a)*(b)* (c)/12*		*(e) * 50%,*

* The number of enrollment is based on all persons waiting for HCBS-SLS waiver services through FY 2014-15.

** Average Annual FPE Cost is based on FY 2012-13 average cost per FPE plus 4% provider rate increase approved for FY 2013-14.

Attachment A Projected FY 2014-15 Cost Increase with 20% Increase in SPALs

Calculation of Annual Cost of SPAL Increase on Base Enrollments

	Number of Clients	Percent of Total Clients	Annual Cost of HCBS-SLS Services	Increased Percentage Of Proposed Increase Over Current SPAL Limit	Total Increase	Monthly Cost of Increase Per Person	Projected Impact for New FY 2014-15 HCBS-SLS FPE Requested
Maximum SPAL	3	0.08%	$43,039	28.50%	$12,266	$340.72	1
90% to 99% of SPAL	84	2.30%	$1,051,903	20%	$210,381	$208.71	35
80% to 89% of SPAL	146	3.99%	$1,614,010	20%	$322,802	$184.25	61
Total Increase	**233**	**6.37%**			**$545,449**	**$195.08**	**97**
Total Client Count	**3,659**						**1,526**

FY 2014-15 Cost Increase for Service Plan Authorization Limits on Base Enrollments

	July	August	September	October	November	December	January	February	March	April	May	June	Total Cost
Clients At Maximum SLS Service CAP	0	0	0	1	1	1	1	2	2	2	2	3	
Cost	$0.00	$0.00	$0.00	$340.72	$340.72	$340.72	$340.72	$681.44	$681.44	$681.44	$681.44	$1,022.17	$5,110.81
Clients at 90% to 99% of SPAL	7	14	21	28	35	42	49	56	63	70	77	84	
Cost	$1,460.98	$2,921.96	$4,382.94	$5,843.92	$7,304.90	$8,765.88	$10,226.85	$11,687.83	$13,148.81	$14,609.79	$16,070.77	$17,531.75	$113,956.38
Clients at 80% to 89% of SPAL	12	24	36	48	60	73	85	97	109	121	133	146	
Cost	$2,210.97	$4,421.95	$6,632.92	$8,843.89	$11,054.86	$13,450.08	$15,661.06	$17,872.03	$20,083.00	$22,293.97	$24,504.95	$26,900.17	$173,929.85
													$292,997.04

FY 2014-15 Projected Cost Increase for Service Plan Authorization Limits of New FY 2014-15 HCBS-SLS FPE Requested

	July	August	September	October	November	December	January	February	March	April	May	June	Total Cost
Clients At Maximum SLS Service CAP	0	0	0	0	0	0	1	1	1	1	1	1	
Cost	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$2,044.32
Clients at 90% to 99% of SPAL	3	6	9	12	15	18	21	24	27	30	33	35	
Cost	$626.13	$1,252.27	$1,878.40	$2,504.54	$3,130.67	$3,756.80	$4,382.94	$5,009.07	$5,635.21	$6,261.34	$6,887.47	$7,304.90	$48,629.74
Clients at 80% to 89% of SPAL	5	10	15	20	25	30	35	40	45	50	55	61	
Cost	$921.24	$1,842.48	$2,763.72	$3,684.95	$4,606.19	$5,527.43	$6,448.67	$7,369.91	$8,291.15	$9,212.39	$10,133.62	$11,239.11	$72,040.86
													$122,714.92
Total FY 2014-15 Projected Cost Increase of 20% SPAL Increase													**$415,712**

** Number of clients is an estimate based on the proportion of new HCBS-SLS FPE requested in FY 2014-15 change requests.*

Attachment B Projected FY 2015-16 Cost Increase with 20% Increase in SPALs

Calculation of Annual Cost of SPAL Increase on Base Enrollments

	Number of Clients	Percent of Total Clients	Annual Cost of HCBS-SLS Services	Increased Percentage Of Proposed Increase Over Current SPAL Limit	Total Increase	Monthly Cost of Increase Per Person	Projected Impact for New HCBS-SLS FPE Requested
Maximum SPAL	3	0.08%	$43,039	28.50%	$12,266	$340.72	1
90% to 99% of SPAL	84	2.30%	$1,051,903	20%	$210,381	$208.71	35
80% to 89% of SPAL	146	3.99%	$1,614,010	20%	$322,802	$184.25	61
Total Increase	**233**	**6.37%**			**$545,449**	**$195.08**	97
Total Client Count	**3659**						**1526**

FY 2015-16 Cost Increase for Service Plan Authorization Limits on Base Enrollments

	July	August	September	October	November	December	January	February	March	April	May	June	Total Cost
Number of Clients													
Cost													
At Maximum SLS Service CAP	3	3	3	3	3	3	3	3	3	3	3	3	
Cost	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$1,022.17	$12,266.04
90% to 99% of SPAL	84	84	84	84	84	84	84	84	84	84	84	84	
Cost	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$17,531.75	$210,381.00
80% to 89% of SPAL	146	146	146	146	146	146	146	146	146	146	146	146	
Cost	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$26,900.17	$322,802.04
													$545,449.08

FY 2015-16 Projected Cost Increase for Service Plan Authorization Limits of New FY 2014-15 HCBS-SLS FPE Requested

Number of Clients/Costs	July	August	September	October	November	December	January	February	March	April	May	June	Total Cost
At Maximum SLS Service CAP	1	1	1	1	1	1	1	1	1	1	1	1	
Cost	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$340.72	$4,088.64
90% to 99% of SPAL	35	35	35	35	35	35	35	35	35	35	35	35	
Cost	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$7,304.90	$87,658.80
80% to 89% of SPAL	61	61	61	61	61	61	61	61	61	61	61	61	
Cost	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$11,239.11	$134,869.32
													$226,616.76
Total FY 2015-16 Projected Cost Increase of 20% SPAL Increase													**$772,066**

** Number of clients is an estimate based on the proportion of new HCBS-SLS FPE requested in FY 2014-15 change requests.*

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Developmental Disabilities New Full Program Equivalents
Priority Number: R-8

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 6 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	5,117,662,302	-	5,733,730,346	2,845,976	5,660,020
	FTE	-	-	-	-	-
	GF	1,187,078,554	-	1,231,366,731	1,422,989	2,830,010
	GFE	469,842,084	-	469,842,084	-	-
	CF	595,915,946	-	714,340,068	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,861,888,826	-	3,317,952,096	1,422,987	2,830,010
(2) Medical Services Premiums	**Total**	4,736,824,877	-	5,323,832,795	(1,933,750)	(3,802,439)
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	(966,875)	(1,901,220)
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	(966,875)	(1,901,219)
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	**Total**	380,837,425	-	-	14,426	29,696
	FTE	-	-	-	-	-
	GF	151,060,588	-	-	7,213	14,848
	GFE	-	-	-	-	-
	CF	2,033,883	-	-	-	-
	RF	-	-	-	-	-
	FF	227,742,954	-	-	7,213	14,848
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	**Total**	-	-	336,245,067	4,102,000	8,204,000
	FTE	-	-	-	-	-
	GF	-	-	153,608,493	2,051,000	4,102,000
	GFE	-	-	-	-	-
	CF	-	-	30,798,715	-	-
	RF	-	-	-	-	-
	FF	-	-	153,608,492	2,051,000	4,102,000

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	6
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	Total	-	-	47,042,236	378,627	757,254
	FTE	-	-	-	-	-
	GF	-	-	27,481,475	189,314	378,627
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	19,560,761	189,313	378,627
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	Total	-	-	26,610,248	284,673	471,510
	FTE	-	-	-	-	-
	GF	-	-	14,454,444	142,337	235,755
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	12,155,804	142,336	235,755

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: Pursuant to HB 13-1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, the line items impacted by the request will be reflected in the Department of Health Care Policy and Financing.

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- $2,845,976 total funds, $1,422,989 General Fund, and 0.0 FTE in FY 2014-15, and for $5,660,020 total funds, $2,830,010 General Fund, and 0.0 FTE in FY 2015-16 and beyond.

Link to Operations

- Home and Community Based Services (HCBS) for Persons with Developmental Disabilities (HCBS-DD) are provided to meet the needs of adults with developmental disabilities who require extensive supports and who do not have the resources available to meet their needs.
- HCBS Supported Living Services (HCBS-SLS) are for adults who can either live independently with limited to moderate supports or who need more extensive support provided by other persons.

Problem or Opportunity

- Funding is needed for youth who are transitioning from children's services into the adult HCBS Waiver services for continuity of care. Individuals transitioning from institutional settings to the community also require continuation of services through HCBS Waiver services.
- Emergency enrollments are needed when an individual becomes at risk for homelessness or experiences circumstances or crises requiring immediate services. The waiting list may include those requiring emergency enrollments as well as those transitioning out of institutional settings.

Consequences of Problem

- Without additional Full Program Equivalents (FPE), people with developmental disabilities will transition to other less appropriate, more costly settings or become vulnerable to abuse, neglect or homelessness.
- The waiting lists for HCBS services will grow and demand for services will remain unmet.

Proposed Solution

- The proposed solution will address the most critical need by providing funds (FPE) for:
- 55 youth transitioning out of foster care from the Child Welfare system into HCBS-DD;
- 61 youth transitioning from the HCBS Children's Extensive Support (HCBS-CES) to HCBS-SLS;
- 40 emergency enrollments through HCBS-DD; and
- 30 individuals transitioning out of institutional settings into HCBS-DD.
- The request includes funding for Targeted Case Management, Quality Assurance, Utilization Review, and Supports Intensity Scale assessments.

Department Priority: R-8
Request Detail: Developmental Disabilities New Full Program Equivalents

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Developmental Disabilities New Full Program Equivalents	$2,845,976	$1,422,989

Problem or Opportunity:

Home and Community Based Services (HCBS) for Persons with Developmental Disabilities (HCBS-DD) are provided to meet the needs of adults with developmental disabilities who require extensive supports to live safely in the community and who do not have the resources available to meet their needs. Home and Community Based Services-Supported Living Services (HCBS-SLS) are for adults who can either live independently with limited to moderate supports or who need more extensive support provided by other persons, such as their family.

Funding is needed for youth with intellectual and developmental disabilities transitioning from children's services into the adult Home and Community Based Services waiver program for continuity of care. Individuals transitioning from institutional settings to the community also require continuation of services through HCBS waiver services. Emergency enrollments in the HCBS-DD waiver are needed when an individual becomes at risk for homelessness or experiences circumstances or crises requiring immediate services. The waiting list may include those requiring emergency enrollments as well as those transitioning out of institutional settings.

The mission for the Division for Developmental Disabilities (DDD) is to join with others to offer the necessary supports with which all people with developmental disabilities have their rightful chance to:

- Be included in Colorado community life
- Make increasingly responsible choices
- Exert greater control over their life circumstances
- Establish and maintain relationships and a sense of belonging
- Develop and exercise their competencies and talents
- Experience personal security and self-respect

Without additional Full Program Equivalents (FPE), people with developmental disabilities will transition to other less appropriate, more costly settings or become vulnerable to abuse, neglect or homelessness. The waiting lists for HCBS services will grow and demand for services will remain unmet. An FPE is the cost of services for one individual for one year.

Proposed Solution:

The Department requests $2,845,976 total funds and 0.0 FTE in FY 2014-15, and for $5,660,020 total funds and 0.0 FTE in FY 2015-16 and beyond for program costs to provide services for 186 people with developmental disabilities to address high demand and access to services.

The proposed solution will address the most critical need by providing funds for FPE for:

- 55 youth transitioning out of foster care from the Child Welfare system into the HCBS-DD waiver;
- 61 youth transitioning from Home and Community Based Services-Children's Extensive Support (HCBS-CES) to HCBS-SLS;
- 40 emergency enrollments through HCBS-DD; and
- 30 individuals transitioning out of institutional settings into HCBS-DD, including the mental health institutes and the Regional Centers, to less restrictive community settings.
- The request includes funding for Targeted Case Management, Quality Assurance, Utilization Review, and Supports Intensity Scale assessments.
- The request also includes cost shifts from Medical Services Premiums and Behavioral Health Community Programs

New Resources for Adults Receiving HCBS-DD

HCBS-DD services include group and individualized residential services in a variety of community-based settings, supported employment or other day services, and transportation. These services include access to 24-hour supervision. The day services component offers support, habilitation and training on work habits and work-related skills, so that adults receiving services can acquire and maintain paid employment and attain maximum functioning in the community. Providing services through the HCBS-DD program can avoid the need to access more costly services, such as emergency room care, mental health institutes, nursing facilities and Regional Center Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The new enrollments for adults receiving HCBS-DD services include:

27 Foster Care Transition Enrollments for Youth Turning 21 Years of Age

The Department currently serves 27 youth in the Child Welfare foster care system who have a developmental disability, will turn 21 years of age in FY 2013-14 and require continuity of residential services through the HCBS-DD waiver program. These youth will no longer qualify for foster care once they turn age 21 and have no appropriate family or other alternative for assistance. The number of enrollments requested is based on the actual number of youth in the Child Welfare foster care system who will turn 21 years of age in FY 2014-15 and who are appropriate for HCBS-DD waiver services.

28 Foster Care Transition Enrollments for Youth Turning 20 Years of Age

The Department currently serves 28 youth in the Child Welfare foster care system who will turn 20 years of age in FY 2014-15. These youth will no longer qualify for foster care once they turn age 21, however, based on their needs may be more appropriate for transition to services through the HCBS-DD waiver program. The number of enrollments requested is based on the actual number of youth with developmental disabilities in the Child Welfare foster care system who will turn 20 years of age in FY 2014-15 and who are appropriate for HCBS-DD waiver services.

40 Emergency Enrollments

The Department anticipates that 40 people will face an emergency or crisis in their current living setting and will need residential services immediately through the HCBS-DD waiver. Emergencies are defined by one or more of the following criteria:

a. Homeless: the person does not have a place to live or is in imminent danger of losing his or her place of abode.
b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy.
c. Danger to others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by this person. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of the person in the community.
d. Danger to self: a person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.

Availability of community-based residential services provides an alternative to more costly and inappropriate services, such as hospitalization or institutional care. There were 74 emergency enrollments into HCBS-DD waiver over a 12-month period from April 1, 2012 through March 31, 2013. The request is for 40 additional FPE to address this need on an ongoing basis.

30 HCBS-DD Enrollments for De-institutionalization of People with Developmental Disabilities

The Department of Human Services provides institutional care to people with intellectual and developmental disabilities through the Regional Centers' ICF/IID and through the mental health institutes for individuals who pose such a risk to themselves or others that they require the controlled and secure environment of the mental health institutes. The request will provide enrollments for individuals in the Regional Center ICF/IID that can be served in less restrictive community settings, and for individuals with co-occurring disorders of developmental disabilities and mental illness residing in the Colorado Mental Health Institutes at Ft. Logan and Pueblo (FTLMHI,CMHIP) whose treatment is completed and who no longer represent a high risk. These individuals no longer need institutional level mental health services and are ready for transition to a community setting through the Home and Community Based Services (HCBS) Waivers. This request is for financial resources to support these transitions. By transitioning individuals to the HCBS-DD waiver, the vacated enrollments at the Mental Health Institutes will then become available for individuals waiting for mental health services. Continued placement of these individuals in the Mental

Health Institutes or Regional Centers is contrary to the philosophy of community inclusion and least restrictive environment.

New Resources for Adults Receiving HCBS-SLS:

HCBS-SLS offers a variety of individualized and flexible supports to enable individuals to live on their own or in the family home and avoid or delay more costly HCBS-DD services. The new enrollments for adults receiving HCBS-SLS services include:

61 HCBS-CES Enrollments Transitioning to HCBS-SLS Enrollments

The Department has identified 61 children who will turn 18 years of age, the maximum age for the HCBS-CES program, in FY 2013-14. These 61 youth will require continuity of care through the HCBS-SLS waiver program for adults. By targeting service to young adults transitioning from the HCBS-CES program, the Department ensures that families with the highest level of need and children with the highest level of demand are served.

The request moves some individuals off the adult waiting lists for services. As of June 30, 2013, the waiting list reflects 2,011 individuals for HCBS-DD and 285 for HCBS-SLS (individuals on both the HCBS-DD and HCBS-SLS waiting list are counted only in HCBS-DD).

This request impacts the Department of Health Care Policy and Financing (HCPF). As a result of HB 13-1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, HCBS programs for persons with developmental disabilities included in this request will be managed and supervised by HCPF. A statutory change is not required for this request.

Anticipated Outcomes:

The Developmental Disabilities system provides long term support services in the community to children and adults with developmental disabilities who would otherwise receive services in more restrictive and expensive institutional settings. Individuals will be included in Colorado community life in fulfillment of the mission of the DDD. An additional 186 people will receive appropriate community services and supports by June 30, 2015, thereby improving their physical, mental, and social functioning as well as their general well-being and quality of life.

Assumptions and Calculations:

See Appendix A, FY 2014-15 and FY 2015-16 Assumptions and Calculations, for further details the assumptions and calculations for this request.

In order to forecast Medical Services Premiums (state plan) and mental health service (Behavioral Health Community Programs) cost shift estimates, the Department assumes that the current wait list demographic is statistically identical to the pool of individuals who will transition into the respective waiver. The forecast includes factors such as number of individuals on the wait list currently receiving state plan and/or mental health services, the number receiving service through an alternate waiver, and anticipated state plan

and mental health service utilization costs for individuals before and after transitioning to the waiver. Forecast calculations and footnotes are shown on Tables 2A.1 and 2A.2.

Table 1.1
Calculation of Fund Splits - FY 2014-15

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums	($1,933,750)	($966,875)	$0	$0	($966,875)
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$14,426	$7,213	$0	$0	$7,213
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	$4,102,000	$2,051,000	$0	$0	$2,051,000
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$378,627	$189,314	$0	$0	$189,313
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$284,673	$142,337	$0	$0	$142,336
Total Projected FY 2014-15 Expenditures	**$2,845,976**	**$1,422,989**	**$0**	**$0**	**$1,422,987**

Table 1.2
Calculation of Fund Splits - FY 2015-16

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums	($3,802,439)	($1,901,220)	$0	$0	($1,901,219)
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$29,696	$14,848	$0	$0	$14,848
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	$8,204,000	$4,102,000	$0	$0	$4,102,000
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$757,254	$378,627	$0	$0	$378,627
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$471,510	$235,755	$0	$0	$235,755
Total Projected FY 2015-16 Expenditures	**$5,660,020**	**$2,830,010**	**$0**	**$0**	**$2,830,010**

Table 2A.1
FY 2014-15
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to New DD Waiver Resources

		Current Medicaid Recipients		Current Non-Medicaid Recipients	*Total FY 2014-15*	Formula/Assumptions
		Waiver[1]	No Waiver[6]			
		1	2	3	4	
A	Client Count	26	84	15	125	
B	Average Months Enrolled	6	6	6	6	
C	Estimated Full Participant Equivalents[1]	13	42	7.5	62.5	Row A * Row B/12
D	Current State Plan Costs[2]	$14,128	$13,447	$0		MMIS Claims Data
E	Future State Plan costs per person[3]	$8,447	$8,447	$8,447		
F	Net difference per person	($5,682)	($5,001)	$8,447		Row D * Row E
G	New Cost for ICF/IID Transfers[4, 5]	$0	$126,701	$0		
H	Total Increase (Decrease)[6]	($73,861)	($8,319)	$63,350	($18,830)	(Row F * Row C) + Row G
I	Current Waiver costs per person (exludes CHRP)[2, 7]	$12,000	$0	$0		MMIS Claims Data
J	Future State Plan costs per person[3]	$8,447	$8,447	$8,447		
K	Net difference per person	($3,553)	$8,447	$8,447		Row I - Row J
L	Total Increase (Decrease)[1]	($3,553)	$0	$0	($3,553)	Row K * (Row C minus CHRP[7] Transitions)
M	Current Waiver costs per person (CHRP only)[2, 7]	$44,679	$0	$0		MMIS Claims Data
N	Future State Plan costs per person[3]	$8,447	$8,447	$8,447		
O	Net difference per person	($36,232)	$8,447	$8,447		Row M - Row N
P	Total Increase (Decrease)	($434,787)	$0	$0	($434,787)	Row O * CHRP[7] Transitions
Q	**Total Medical Services Premiums Impact**	**($512,201)**	**($8,319)**	**$63,350**	**($457,169)**	Row H + Row L + Row P
R	Current Mental Health costs per person	$1,923	$1,923	$0		Trended from FY 2013-14 S-2
S	Future Mental Health costs per person	$1,923	$1,923	$1,923		Trended from FY 2013-14 S-2
T	Net difference per person	$0	$0	$1,923		Row R - Row S
U	**Total Mental Health Increase (Decrease)**	**$0**	**$0**	**$14,426**	**$14,426**	Row T * Row C
V	**Total**	**($512,201)**	**($8,319)**	**$77,777**	**($442,743)**	Row Q + Row U

1) Of estimated FPE current Medicaid waiver recipients in Row C, 12 are CHRP and 1 is other.

2) Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13

3) CMS 372 less Targeted Case Management and Mental Health

4) *Definition* : ICF/IID - Intermediate Care Facility Institute for Intellectually Disabled

5) Transfers from ICF/IIDs represent only new State Fund costs because ICF/IID vacancies are expected to be refilled. 15 ICF/IID Transfers are expected

6) Cell C1 requires a unique calculation: ((11.5 FPE Emergency Enrollments + 15.5 Youth Transitions) * -$5,001) + $126,701

7) CHRP (Children's Habilitation Residential Program) Waiver State Plan expenditures are separated because of the significant difference in the costs of serving those individuals compared to individuals in other waivers

Table 2A.2
FY 2015-16
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to New DD Waiver Resources

		Current Medicaid Recipients		Current Non-Medicaid Recipients	*Total FY 2015-16*	Formula/Assumptions
		Waiver[1]	No Waiver[6]			
		1	2	3	4	
A	Client Count	26	84	15	125	
B	Average Months Enrolled	12	12	12	12	
C	Estimated Full Participant Equivalents[1]	26	84	15	125	Row A * (Row B/12)
D	Current State Plan Costs[2]	$14,128	$13,447	$0		MMIS Claims Data
E	Future State Plan costs per person[3]	$8,878	$8,878	$8,878		
F	Net difference per person	($5,251)	($4,570)	$8,878		Row D * Row E
G	New Cost for ICF/IID Transfers[4, 5]	$0	$266,328	$0		
H	Total Increase (Decrease)[6]	($136,519)	$19,554	$133,164	$16,199	(Row F * Row C) + Row G
I	Current Waiver costs per person (exludes CHRP)[2, 7]	$12,000	$0	$0		MMIS Claims Data
J	Future State Plan costs per person[3]	$8,878	$8,878	$8,878		
K	Net difference per person	($3,122)	$8,878	$8,878		Row I - Row J
L	Total Increase (Decrease)[1]	($6,245)	$0	$0	($6,245)	Row K * (Row C minus CHRP[7] Transitions)
M	Current Waiver costs per person (CHRP only)[2, 7]	$44,679	$0	$0		MMIS Claims Data
N	Future State Plan costs per person[3]	$8,878	$8,878	$8,878		
O	Net difference per person	($35,801)	$8,878	$8,878		Row M - Row N
P	Total Increase (Decrease)	($859,233)	$0	$0	($859,233)	Row O * CHRP[7] Transitions
Q	**Total Medical Services Premiums Impact**	**($1,001,997)**	**$19,554**	**$133,164**	**($849,278)**	Row H + Row L + Row P
R	Current Mental Health costs per person	$1,980	$1,980	$0		Trended from FY 2013-14 S-2
S	Future Mental Health costs per person	$1,980	$1,980	$1,980		Trended from FY 2013-14 S-2
T	Net difference per person	$0	$0	$1,980		Row R - Row S
U	**Total Mental Health Increase (Decrease)**	**$0**	**$0**	**$29,696**	**$29,696**	Row T * Row C
V	**Total**	**($1,001,997)**	**$19,554**	**$162,859**	**($819,583)**	Row Q + Row U

1) Of estimated FPE current Medicaid waiver recipients in Row C, 12 are CHRP and 1 is other.

2) Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13

3) CMS 372 less Targeted Case Management and Mental Health

4) *Definition* : ICF/IID - Intermediate Care Facility Institute for Intellectually Disabled

5) Transfers from ICF/IIDs represent only new State Fund costs because ICF/IID vacancies are expected to be refilled. 30 ICF/IID Transfers are expected

6) Cell C1 requires a unique calculation: ((23 FPE Emergency Enrollments + 31 Youth Transitions) * -$4,570) + $266,328

7) CHRP (Children's Habilitation Residential Program) Waiver State Plan expenditures are separated because of the significant difference in the costs of serving those individuals compared to individuals in other waivers

Table 2B.1
FY 2014-15
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to New SLS Waiver Resources

		Current Medicaid Recipients		Current Non-Medicaid Recipients	*Total FY 2014-15*	Formula/Assumptions
		Waiver[1]	No Waiver			
A	Client Count	61	0	0	61	
B	Average Months Enrolled	6	6	6	6	
C	Estimated Full Participant Equivalents[1]	30.5	0	0	30.5	Row A * Row (B/12)
D	Current State Plan Costs[2]	$57,290	$0	$0		MMIS Claims Data
E	Future State Plan costs per person[3]	$8,878	$8,878	$8,878		
F	Net difference per person	($48,412)	$8,878	$8,878		Row D - Row E
G	Total Increase (Decrease)	($1,476,580)	$0	$0	($1,476,580)	Row F * Row C
H	**Total Medical Services Premiums Impact**	**($1,476,580)**	**$0**	**$0**	**($1,476,580)**	Row G
I	Current Mental Health costs per person	$1,980	$1,980	$0		Trended from FY 2013-14 S-2
J	Future Mental Health costs per person	$1,980	$1,980	$1,980		Trended from FY 2013-14 S-2
K	Net difference per person	$0	$0	$1,980		Row I - Row J
L	**Total Mental Health Increase (Decrease)**	**$0**	**$0**	**$0**	**$0**	Row K * Row C
M	**Total**	**($1,476,580)**	**$0**	**$0**	**($1,476,580)**	Row H + Row L

1) Of Estimated FPE Current Medicaid Waiver Recipients in Row C, all are currently enrolled in the CES waiver

2) Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13

3) CMS 372 less Targeted Case Management and Mental Health

Table 2B.2
FY 2015-16
Impact to Medical Services Premiums and Behavioral Health Community Programs Due to New SLS Waiver Resources

		Current Medicaid Recipients		Current Non-Medicaid Recipients	*Total FY 2015-16*	Formula/Assumptions
		Waiver[1]	No Waiver			
A	Client Count	61	0	0	61	
B	Average Months Enrolled	12	12	12	12	
C	Estimated Full Participant Equivalents[1]	61	0	0	61	Row A * (Row B/12)
D	Current State Plan Costs[2]	$57,290	$0	$0		MMIS Claims Data
E	Future State Plan costs per person[3]	$8,878	$8,878	$8,878		
F	Net difference per person	($48,412)	$8,878	$8,878		Row D - Row E
G	Total Increase (Decrease)	($2,953,161)	$0	$0	($2,953,161)	Row F * Row C
H	**Total Medical Services Premiums Impact**	**($2,953,161)**	**$0**	**$0**	**($2,953,161)**	Row G
I	Current Mental Health costs per person	$1,980	$1,980	$0		Trended from FY 2013-14 S-2
J	Future Mental Health costs per person	$1,980	$1,980	$1,980		Trended from FY 2013-14 S-2
K	Net difference per person	$0	$0	$1,980		Row I - Row J
L	**Total Mental Health Increase (Decrease)**	**$0**	**$0**	**$0**	**$0**	Row K * Row C
M	**Total**	**($2,953,161)**	**$0**	**$0**	**($2,953,161)**	Row H + Row L

1) Of Estimated FPE Current Medicaid Waiver Recipients in Row C, all are currently enrolled in the CES waiver

2) Current costs taken from actual MMIS Claims Data history for new Medicaid recipients between FY 2010-11 through FY 2012-13

3) CMS 372 less Targeted Case Management and Mental Health

Table 3A
FY 2014-15
New Funding - Developmental Disabilities Services

Long Bill Line Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	$4,102,000	$2,051,000	$0	$0	$2,051,000
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$378,627	$189,314	$0	$0	$189,313
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$284,673	$142,337	$0	$0	$142,336
Total Request	$4,765,300	$2,382,651	$0	$0	$2,382,649

Table 3B
FY 2015-16
New Funding - Developmental Disabilities Services

Long Bill Line Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	$8,204,000	$4,102,000	$0	$0	$4,102,000
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	$757,254	$378,627	$0	$0	$378,627
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE	$471,510	$235,755	$0	$0	$235,755
Total Request	$9,432,764	$4,716,382	$0	$0	$4,716,382

Appendix A: FY 2014-15 and FY 2015-16 Assumptions and Calculations

Table 4A
FY 2014-15 Funding Calculations

	Number of Enrollments (a)	Months Enrolled (b)	Average Annual FPE Cost* (c)	Total Annual Cost All New Enrollments (d)	Total Funds (e)	General Fund (f)	Federal Funds (g)
1) HCBS-DD transition from Foster Care at age 21	27	6	$65,632	$886,032	$886,032	$443,016	$443,016
2) HCBS-DD transition from Foster Care at age 20	28	6	$65,632	$918,848	$918,848	$459,424	$459,424
3) HCBS-CES to HCBS-SLS	61	6	$12,414	$378,627	$378,627	$189,314	$189,313
4) Emergency HCBS-DD	40	6	$65,632	$1,312,640	$1,312,640	$656,320	$656,320
5) HCBS-DD for De-institutionalization	30	6	$65,632	$984,480	$984,480	$492,240	$492,240
6) Targeted Case Management	186	6	$2,157	$200,601	$200,601	$100,301	$100,300
7) Quality Assurance	186	6	$300	$27,900	$27,900	$13,950	$13,950
Calculation (rounded)				*(a)*(b)*(c)/12*		*(e) * 50%*	*(f)*
8) Utilization Review	186	Annually	$78	$14,508	$14,508	$7,254	$7,254
9) Supports Intensity Scale Assessment	186	One Time	$224	$41,664	$41,664	$20,832	$20,832
Calculation (rounded)				*(a)*(b)*(c)/12*		*(e) * 50%*	*(e-f)*
Total (7)(A)Program Costs				**$4,765,300**	**$4,765,300**	**$2,382,651**	**$2,382,649**

** The Total Annual Cost Per Full Program Equivalent (FPE) is based on the cost of services provided in FY 2012-13 as of 8-9-2013, plus the 4%*

Table 4B FY 2015-16 Funding Calculation							
	Number of Enrollments (a)	Months Enrolled (b)	Average Annual FPE Cost* (c)	Total Annual Cost All New Enrollments (d)	Total Funds (e)	General Fund (f)	Federal Funds (g)
1) Foster Care to HCBS-DD at age 21	27	12	$65,632	$1,772,064	$1,772,064	$886,032	$886,032
2) Foster Care to HCBS-DD age 20	28	12	$65,632	$1,837,696	$1,837,696	$918,848	$918,848
3) HCBS-CES to HCBS-SLS	61	12	$12,414	$757,254	$757,254	$378,627	$378,627
4) Emergency HCBS-DD	40	12	$65,632	$2,625,280	$2,625,280	$1,312,640	$1,312,640
5) HCBS-DD for De-institutionalization	30	12	$65,632	$1,968,960	$1,968,960	$984,480	$984,480
6) Targeted Case Management	186	12	$2,157	$401,202	$401,202	$200,601	$200,601
7) Quality Assurance	186	12	$300	$55,800	$55,800	$27,900	$27,900
8) Utilization Review	186	Annually	$78	$14,508	$14,508	$7,254	$7,254
Total (7)(A)Program Costs				**$9,432,764**	**$9,432,764**	**$4,716,382**	**$4,716,382**
Calculation (rounded)				*(a) * (c)*		*(e) * 50%*	*(e-f)*

** The Total Annual Cost Per Full Program Equivalent (FPE) is based on the cost of services provided in FY 2012-13 as of 8-9-2013, plus the 4% provider rate increase approved for FY 2013-14.*

Assumptions for the Amount Requested:

Foster Care Transition to HCBS-DD at age 21: The number of youth who are expected to transtion out of foster care from the Child Welfare system to HCBS-DD residential services is based on the number of youth expected to turn age 21 in FY 2014-15. The months of service needed is actual number of months the youth will be in residential services counting the month in which each youth turns 21 plus the remaining months in the fiscal year. HCBS-DD FPE amount is based on FY 2012-13 FPE (data ran 8/9/2013) which is $63,108.38 rounded to $63,108, plus 4% provider rate increase approved for FY 2013-14 rounded to $2,524 = $65,632.
Foster Care Transition to HCBS-DD at age 20: The number of youth who may transtion out of foster care from the Child Welfare system to HCBS-DD residential services is based on the number of youth expected to turn age 20 in FY 2014-15. The months of service needed is actual number of months the youth will be in residential services counting the month in which each youth turns 20 plus the remaining months in the fiscal year. HCBS-DD FPE amount is based on FY 2012-13 FPE (data ran 8/9/2013) which is $63,108.38 rounded to $63,108, plus 4% provider rate increase approved for FY 2013-14 rounded to $2,524 = $65,632.
HCBS-DD Emergency Enrollments: The calculation for the 40 emergency enrollments needed is based on the number of individuals who newly met the emergency criteria between April 1, 2011 to March 31, 2012. The number of individuals that met the emergency criteria from April 1, 2012 to March 31, 2013 was actually 74. However, it is presumed that this number is higher than recent year trends due to the division holding enrollment in FY 12. It is assumed that the same number of individuals can be expected to newly meet the emergency criteria for the HCBS-DD waiver program during the 12 month period for FY 2014-15. HCBS-DD FPE amount is based on FY 2012-13 FPE (data ran 8/9/2013) which is $63,108.38 rounded to $63,108, plus 4% provider rate increase approved for FY 2013-14 rounded to $2,524 = $65,632.
Children's Extensive Support Transition to Supported Living Services: The number of youth who are expected to transition out of the HCBS-CES program to HCBS-SLS waiver program is based on the actual number of youth in HCBS-CES waiver program who will turn age 18 in FY 2014-15 and youth currently on the HCBS-CES wait list that will likely enroll in the HCBS-CES waiver before they turn age 18. The months of service needed is actual number of months the youth will receive services counting the month in which each youth turns 18 plus the remaining months in the fiscal year. HCBS-SLS FPE amount is based on FY 2012-13 FPE (data ran 8/9/2013) which is $11,937.18 rounded to $11,937, plus 4% provider rate increase approved for FY 2013-14 rounded to $477 = $12,414.
TCM Waiver Programs: The total number of new resources requested for Foster Care Transition, CES Transitions, Emergency enrollments for HCBS-DD, and HCBS-CES wait list reduction will require case management services. Therefore, the number of new resources 186 is taken times the average TCM cost per person for waiver services in FY 2012-13 of $2,073.82 plus the 4% provider rate increase $82.95 approved for FY 2013-14 = $2,156.77 rounded to $2,157, pro-rated by the number of months expected to be used which rounds to 6 months.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicaid Community Living Inititative
Priority Number: R-9

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,736,824,877	-	5,323,832,795	1,243,201	1,747,994
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	846,787	1,342,371
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	396,414	405,623
NEW ITEM (1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Local Affairs for Home Modification Administration	**Total**	-	-	-	272,099	280,356
	FTE	-	-			
	GF	-	-		136,049	140,178
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-		136,050	140,178
(2) Medical Services Premiums	**Total**	4,736,824,877	-	5,323,832,795	971,102	1,467,638
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	710,738	1,202,193
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	260,364	265,445

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: Department of Local Affairs
Other Information: N/A

Cost and FTE

- The Department requests $1,243,201 total funds, $846,787 General Fund and $396,414 federal funds. This amount includes funding for 2.0 FTE for the Department of Local Affairs.

Link to Operations

- The Department actively promotes transitioning clients out of institutions and into the community; living in the community is generally better for clients' social needs and health outcomes, and is a less costly alternative than institutionalization in a nursing facility.

Problem or Opportunity

- The Department lacks the infrastructure to provide and pay for clients to receive counseling for community living options.
- The Department of Local Affairs was not a recipient of a HUD housing grant for transitioning clients out of institutions in FY 2013-14, jeopardizing savings included in the Department's budget.
- The Department estimates that 75% of clients that wish to transition out of institutions are lacking affordable housing options, and thus, remain in institutions.
- Because the Department does not have any dedicated resources for overseeing home modifications, these modifications are being overseen by case managers lacking training and experience.

Consequences of Problem

- Inadequate referral systems for transitions and lack of housing options for clients result in clients remaining institutionalized. This drives additional state expenditure and jeopardizes the Colorado Choice Transitions (CCT) program, which puts the state at risk for losing federal funding dedicated to deinstitutionalizing clients and the savings achieved from serving clients in a less costly setting.
- Insufficient oversight of home modifications leaves the state at risk for waste and abuse that is both costly and detrimental to clients receiving the benefit.
- Without affordable housing and home modifications that allow individuals with disabilities to live in their own home, many clients are at high risk for placement in a nursing facility.

Proposed Solution

- The Department requests $469,962 in order to create infrastructure for clients interested in transitioning by contracting with Adult Resources for Care and Help (ARCH) to respond to Nursing Facility referrals for options counseling.
- The Department requests $773,239 in order to partner with the Division of Housing in the Department of Local Affairs to provide both housing vouchers for CCT Program clients and to oversee the home modification benefit.

Department Priority: R-9
Request Detail: Medicaid Community Living Initiatives

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Medicaid Community Living Initiatives	$1,243,201	$846,787

Problem or Opportunity:

Clients who want to return to the community after receiving care in nursing facilities face a number of barriers that prevent them from doing so. The Department lacks the infrastructure for options counseling for clients interested in moving back into the community. To make an informed choice, options counseling provides an opportunity for clients in institutional placement to learn about housing options and the long-term services and supports (LTSS) available to them in the community. Clients that have been interested in exploring community living options have found housing options to be scarce, causing clients that could be served in the community to remain institutionalized. Many times, once a client has found a suitable housing option, the home has to be modified to allow for increased independence. These modifications lack licensed and experienced oversight, which could lead to harm to the client resulting in unwanted re-institutionalizations.

For the Department to serve clients in the most appropriate and cost effective setting, clients must first be assessed for their ability to live in the community with the right supports and services. In order for clients to live in the community, they must first have access to safe and suitable housing options. The Department actively seeks the most appropriate and cost effective placement for clients, whether that be in the community or in an institution; research indicates that community-based care enhances clinical and functional outcomes, as well as the satisfaction of long-term care participants[1]. Thus, if living in the community is appropriate, the client could achieve better health outcomes at lesser cost than in a nursing facility.

In March 2013, the Department implemented Colorado Choice Transitions (CCT), which is a federal grant program designed to facilitate transitioning clients currently residing in nursing facilities into the community, utilizing home- and community-based services (HCBS) and supports. Providing adequate levels of support in the community setting is critical to ensuring clients can live at home while receiving

[1] Marek, Karen Doreman; Popejoy, Lori; Petroski, Greg; Mehr, David; Rantz, Marily; Lin, Wen-Chieh. "Clinical Outcomes of Aging in Place", Nursing Research, V.53-3; May/June 2005

appropriate services and supports. For clients that transition out of institutions, the Department realizes savings from providing services in the community, as community-based services are generally less costly than providing services in a nursing facility.[2]

A stipulation of the CCT grant is that the Department needs to transition 100 clients per year. If this goal is not met, the Department is at risk of losing the grant's enhanced federal match rate, which is intended to improve the long-term care system. Further, the Department would not be able to achieve the savings that have been built into the Department's appropriation for Medical Services Premiums for serving clients in a less costly setting. For the CCT program to be successful, clients seeking alternatives to institutions must receive options counseling to fully inform them of their choices, and have access to stable housing options that safely allow the client to live independently. [3]

Currently, the Department lacks the infrastructure and resources to provide clients counseling on community living options. Although clients in nursing facilities are screened to determine if they want to live in the community, the Department does not have the necessary resources to respond to the vast number of requests from clients who want to learn about their options for leaving the nursing facility. Inadequate referral systems for transitions and lack of housing options for clients result in clients either being misplaced in an institution or remaining institutionalized when they could live in the community.

Stable and safe housing is a critical component of a successful transition. Of the clients who have expressed interest in transitioning out of institutions, approximately 75% are unable to transition because affordable housing is unavailable. Thus, these clients remain in institutions when they could be appropriately served in the community. During FY 2012-13, the Department partnered with the Division of Housing at the Department of Local Affairs (DOLA) to obtain a federal Housing and Urban Development (HUD) assistance grant for clients seeking to transition out of nursing facilities. Unfortunately, Colorado's application was not selected by the federal government for funding in FY 2013-14; as a result, there are a large number of clients who remain in nursing facilities because affordable housing remains unavailable. Further, for these clients, because community placement is less costly than placement in a nursing facility, this jeopardizes savings included in the Department's budget.

Once housing has been obtained, HCBS clients often need home modification to ensure they can live at home while receiving appropriate care. In FY 2012-13, under the Elderly, Blind, and Disabled, Community Mental Health Supports, and the Brain Injury HCBS waivers, the home modification benefit total expenditure was $3,698,550, which was an 11.64% increase from the previous fiscal year. The Department's home modification benefit makes accessibility improvements so clients can stay in their homes and live independently. Home modifications can range from simple hand rails in hallways and

[2] Colorado Choice Transitions (CCT) is part of the federal Money Follows the Person (MFP) Rebalancing Demonstration, which is a five year grant program. The goal of CCT is to facilitate transitioning Medicaid clients from long term care facilities to the community utilizing home and community based services and supports (HCBS). The Department receives a 25% enhanced federal match on HCBS. This additional funding is intended to improve the long-term care system by promoting awareness, use, and/or access to transition services, and to enhance HCBS waiver programs.

[3] In October of 2010 Centers for Medicare and Medicaid Services (CMS) passed new regulations that required nursing facilities to ask residents during their quarterly assessment, called the Minimum Data Set (MDS), if they are interested in the exploring community-based options.

bathrooms to replacing stairwells with wheelchair ramps. The expectations around the home modification benefit are different than other HCBS services; because the Department does not have any dedicated resources, case managers that lack appropriate training and experience in construction are expected to inspect and approve the work of the contractor, even though the Department does not expect case managers to inspect and approve the work performed with other HCBS services. Insufficient oversight of home modifications leaves the State at risk for waste and abuse that are both costly and detrimental to clients receiving the benefit. Without affordable housing and home modifications that allow individuals with disabilities to live in their own home, many clients are at high risk for placement or re-institutionalization in a nursing facility.

Proposed Solution:

The Department requests $1,243,201 total funds, including $846,787 General Fund and $396,414 federal funds, to fund the oversight of the home modifications benefit and obtain housing assistance payments (HAPs) by partnering with DOLA, and create infrastructure for options counseling in response to referrals from nursing facilities. Funding would be ongoing and includes 2.0 additional FTE at DOLA for the administration of the home modification benefit.

The Department would partner with the Division of Housing at DOLA to oversee the home modifications benefit and to obtain and manage HAPs. DOLA has existing infrastructure for oversight and quality control as well as the expertise to determine the appropriateness of contractor bids for home modification. DOLA does not currently perform this service for Medicaid clients, therefore DOLA would require two additional FTE for administration. Administration of the benefit would require specific project, over-all program and asset management capabilities, as well as codes inspection expertise. Additionally, each modification would require an inspection, at a cost of $65 per inspection.

To create the options counseling infrastructure, the Department would contract with regionally-based Adult Resources for Care and Help (ARCH), under the Division of Aging and Adult Services at the Department of Human Services, in order to provide LTSS options counseling to clients who express interest in transitioning and to coordinate with single entry points, community centered boards, and transition coordination agencies to help clients navigate and access the HCBS system. ARCHs would receive referrals for options counseling from nursing facilities and would be expected to provide LTSS options counseling to individuals considering LTSS. Currently, the ARCHs coordinate with SEPs and CCBs to help all individuals in need of LTSS access HCBS, without Medicaid funding. Establishing the ARCHs to coordinate housing options counseling for Medicaid presents an opportunity for the Department to integrate ARCHs in Medicaid processes and would generate more referrals for transitions, better positioning Colorado to meet its CCT goals and comply with the Olmstead decision, which requires states to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Anticipated Outcomes:

If approved, this request would help ensure clients are served in the most appropriate setting by allowing more clients the option to receive services in the community; this would help meet clients social needs and provide for better health outcomes, while serving clients in a less costly setting than a nursing facility.

Also, ensuring the quality and oversight of home modifications would increase the probability of clients' successfully living independently while decreasing the risk of placement in a nursing facility.

If this request is not approved, the Department risks losing revenue through the enhanced federal match received to run the CCT program. As a result, clients would remain in more costly institutions and the home modification benefit would continue to lack quality and oversight, leaving the state at risk for both waste and abuse that are costly and detrimental to clients receiving the benefit, putting clients at a higher risk for placement in a nursing facility. This would jeopardize the savings built into the budget from providing long-term services and supports in a less costly setting than a nursing facility.

Assumptions and Calculations:

This request is composed of three parts: creating options counseling infrastructure, providing HAPs, and funding home modification oversight. Of the FY 2014-15 total, the Department requests $469,962 for creating options counseling infrastructure, $450,375 for HAPs, and $322,864 for oversight of the home modification benefit. See Tables 1.1 through 1.4 in the appendix for a summary of the request.

Options Counseling

The Department's estimate of participants seeking options counseling is based on clients' responses to nursing home assessment data indicating that the client is interested in speaking with someone about leaving the nursing facility. Based on research and experience from the Division of Aging and Adult services, average counseling per client would be estimated at about 3 hours. Tables 2.1 through 2.3 in the appendix calculate the estimated expenditure and provide detail on the assumptions used.

Housing Assistance Payments

The Department would partner with the Division of Housing to obtain 75 HAPs per year for CCT clients. Thus the Department would fund 75 HAPs in FY 2014-15, 150 HAPs in FY 2015-16, and 225 HAPs in FY 2016-17. The departments would use the regular budget process to request funding for future years.

In order for clients to remain in the community, the Department expects that CCT clients could remain in need of HAPs for four years or risk unnecessary re-institutionalized. The Division of Housing will continue to aggressively apply for federal funding to provide permanent supportive housing, including HUD HOME funds, Community Development Block Grant funds, Housing Choice Voucher Section 8 housing subsidy funds, and Homeless Emergency Assistance and Rapid Transition to Housing Act funding for homeless population funds. If obtained, those federal funds could then be used for CCT clients and would replace the state-funded HAPs. HAPs cost information was obtained from DOLA: each HAP costs $6,005 per year and include an administrative fee. Tables 3.1 through 3.4 in the appendix calculate the estimated expenditure and provide detail on the assumptions used. The Department does not anticipate that Medicaid federal funding will be available for HAPs because housing is not a benefit under the Social Security Act.

Home Modification Quality Oversight

The administration of the home modification benefit would require 1.0 FTE General Professional V and 1.0 General Professional IV beginning in July 2014. The FTE would oversee construction duties, review bids, and manage assets. These FTE would be employed by DOLA and, because they would be responsible for

reviewing home modifications for Medicaid clients, the Department assumes that costs for these employees would receive Medicaid federal funding.

The home modification benefit has a lifetime maximum of $10,000 and historical data was used to trend forward the number of clients requiring home modifications, with a cost of $65 per modification inspection, based on current DOLA contracting agency fees with the Section 8 program. Tables 4.1 through 4.8 in the appendix calculate the estimated expenditure and provide detail on the assumptions used.

Table 1.1
Summary of Request
FY 2014-15

	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$1,243,201**	**0.0**	**$846,787**	**$0**	**$0**	**$0**	**$396,414**	
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Local Affairs for Home Modification Administration (new line)	$272,099	0.0	$136,049	$0	$0	$0	$136,050	Table 1.3
(2) Medical Services Premiums	$971,102	0.0	$710,738	$0	$0	$0	$260,364	Table 1.3

Table 1.2
Summary of Request
FY 2015-16

	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$1,747,994**	**0.0**	**$1,342,371**	**$0**	**$0**	**$0**	**$405,623**	
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Local Affairs for Home Modification Administration (new line)	$280,356	0.0	$140,178	$0	$0	$0	$140,178	Table 1.4
(2) Medical Services Premiums	$1,467,638	0.0	$1,202,193	$0	$0	$0	$265,445	Table 1.4

Table 1.3
Request Components by Line Item
FY 2014-15

	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$1,243,201**	**0.0**	**$846,787**	**$0**	**$0**	**$0**	**$396,414**	
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Local Affairs for Home Modification Administration (new line)	**$272,099**	0.0	**$136,049**	**$0**	**$0**	**$0**	**$136,050**	**Table 4.2 Row B**
Home Modifications Benefit - FTE for Construction Oversight	$272,099	0.0	$136,049	$0	$0	$0	$136,050	Table 4.2 Row B
(2) Medical Services Premiums	**$971,102**	**0.0**	**$710,738**	**$0**	**$0**	**$0**	**$260,364**	
Options Counseling	$469,962	0.0	$234,981	$0	$0	$0	$234,981	Table 2.1 Row D
Housing Assistance Payments (HAPs) for Colorado Choice Transitions	$450,375	0.0	$450,375	$0	$0	$0	$0	Table 3.1 Row C
Home Modifications Benefit - Inspections	$50,765	0.0	$25,382	$0	$0	$0	$25,383	Table 4.2 Row A

Table 1.4
Request Components by Line Item
FY 2015-16

	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$1,747,994**	**0.0**	**$1,342,371**	**$0**	**$0**	**$0**	**$405,623**	
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Local Affairs for Home Modification Administration (new line)	**$280,356**	**0.0**	**$140,178**	**$0**	**$0**	**$0**	**$140,178**	**Table 4.3 Row B**
Home Modifications Benefit - FTE for Construction Oversight	$280,356	0.0	$140,178	$0	$0	$0	$140,178	Table 4.3 Row B
(2) Medical Services Premiums	**$1,467,638**	**0.0**	**$1,202,193**	**$0**	**$0**	**$0**	**$265,445**	
Options Counseling	$478,953	0.0	$239,476	$0	$0	$0	$239,477	Table 2.1 Row D
Housing Assistance Payments (HAPs) for Colorado Choice Transitions	$936,750	0.0	$936,750	$0	$0	$0	$0	Table 3.1 Row C
Home Modifications Benefit - Inspections	$51,935	0.0	$25,967	$0	$0	$0	$25,968	Table 4.3 Row A

Table 2.1 - Estimated Expenditures on Options Counseling				
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**Notes**
A	Estimated Number of Residents	2,666	2,717	Table 2.2 Row D
B	Rate Per 15 Minute Counseling Session	$14.69	$14.69	Set by the Department's Rates Section
C	Estimated Number of Sessions	12	12	Estimate from the State Unit on Aging
D	**Total Estimated Expenditures**	**$469,962**	**$478,953**	**Row A * Row B * Row C**

Table 2.2 - Estimated Nursing Facility Residents Interested in Community Options Counseling				
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**Notes**
A	Residents Surveyed (April 2012-March 2013)	38,644	39,382	FY 2014-15: Table 2.3 Row A FY 2015-16: Row C
B	Estimated Growth Rate	1.91%	1.91%	Table 2.3 Row D
C	Estimated Residents Surveyed	39,382	40,134	Row A * (1 + Row B)
D	Estimated Percent Interested in Options Counseling	6.77%	6.77%	Table 2.3 Row E
E	**Estimated Interested Residents Surveyed**	**2,666**	**2,717**	Row C * Row D

Table 2.3 Historical Nursing Facility Residents Interested in Community Options Counseling				
Row	**Item**	**April 2011 - March 2012**	**April 2012 - March 2013**	**Notes**
A	Residents Surveyed	37,920	38,644	Data Source: MDS
B	Residents Interested in Options Counseling	2,604	2,578	Data Source: MDS
C	Percent Interested in Options Counseling	6.87%	6.67%	Row B / Row A
D	Residents Surveyed Growth	-	1.91%	Percent change from Row A
E	Average Percent Interested in Options Counseling	-	6.77%	Average of Row C
Source: Minimum Data Set (MDS) Versions 2.0 and 3.0				

Table 3.1 Total Estimated Expenditure on Housing Assistance Payments (HAPs)					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	Total Number of HAPs	75	150	225	Table 3.2 Row C
B	Total Cost Per HAP	$6,005	$6,245	$6,495	Table 3.3 Row C
C	**Total Cost for Housing Assistance Payments**	**$450,375**	**$936,750**	**$1,461,375**	**Row A * Row B**

Table 3.2 - Total Housing Assistance Payments (HAPs) Purchased Per Year					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	Estimated Number of Clients Able to Transition	100	200	300	CCT Goal: Transition 100 Client per Year
B	Percent Needing HAPs	75.00%	75.00%	75.00%	75% of clients transitions need HAP's per Year
C	**Estimated Number of Housing Assistance Payments**	**75**	**150**	**225**	**Row A * Row B**

Table 3.3 - Estimated Cost of Housing Assistance Payments (HAPs)					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	Prior Year Estimated Annual Cost Per HAP	-	$6,005	$6,245	
B	Estimated Growth Rate	4%	4%	4%	From the Division of Housing
C	**Estimated Annual HAP Cost**	**$6,005**	**$6,245**	**$6,495**	**Row A * (1 + Row B)**

Table 3.4 - Itemization of Annual Estimated Cost Per Housing Assistance Payments (HAPs)					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	HAP Cost Per Month	$450	$468	$487	From the Division of Housing
B	Annual HAP Cost	$5,400	$5,616	$5,841	Row A * 12
C	HAP Administrative Cost Per Month	$50.44	$52.42	$54.50	From the Division of Housing
D	Annual HAP Adminstrative Cost	$605	$629	$654	Row C * 12
E	**Total Annual Cost Per Housing Assistance Payment**	**$6,005**	**$6,245**	**$6,495**	**Row B + Row D**

Table 4.1 - Summary of Expenditure by Fund and Fiscal Year						
Fiscal Year	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
FY 2014-15 Estimates	$322,864	$161,432	$0	$0	$161,432	Table 4.2 Row C
FY 2015-16 Estimates	$332,291	$166,145	$0	$0	$166,146	Table 4.3 Row C
FY 2016-17 Estimates	$333,526	$166,763	$0	$0	$166,763	Table 4.4 Row C

Table 4.2 - Summary of Expenditure by Initiative FY 2014-15							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes**
A	Estimated Inspection Fee	$50,765	$25,382	$0	$0	$25,383	Table 4.5
B	Estimated Administration Expenditure	$272,099	$136,049	$0	$0	$136,050	Table 4.5
C	Total Estimated Expenditure	$322,864	$161,431	$0	$0	$161,433	Row A + Row B

Table 4.3 - Summary of Expenditure by Initiative FY 2015-16							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes**
A	Estimated Inspection Fee	$51,935	$25,967	$0	$0	$25,968	Table 4.5
B	Estimated Administration Expenditure	$280,356	$140,178	$0	$0	$140,178	Table 4.5
C	Total Estimated Expenditure	$332,291	$166,145	$0	$0	$166,146	Row A + Row B

Table 4.4 - Summary of Expenditure by Initiative FY 2016-17							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes**
A	Estimated Inspection Fee	$53,170	$26,585	$0	$0	$26,585	Table 4.5
B	Estimated Administration Expenditure	$280,356	$140,178	$0	$0	$140,178	Table 4.5
C	Total Estimated Expenditure	$333,526	$166,763	$0	$0	$166,763	Row A + Row B

Table 4.5 - Summary of Expenditure by Administrative Function					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	Estimated Administrative Fee - Inspection	$50,765	$51,935	$53,170	Table 4.6 Row C
B	Estimated Administration Expenditure - State	$272,099	$280,356	$280,356	Table 5.1
C	Total Estimated Cost for Home Modification Benefit Administration	$322,864	$332,291	$333,526	Row A + Row B

Table 4.6 - Estimated Home Modification Program Administrative Fee by Fiscal Year					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	Estimated Clients	781	799	818	Table 4.7 Row C
B	Cost per Modification Inspection	$65.00	$65.00	$65.00	Division of Housing
C	Estimated Home Modification Program Expenditure	$50,765	$51,935	$53,170	Row A * Row B

Table 4.7 - Estimated Home Modification Clients and Expenditure per Client					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Notes**
A	Previous Year Clients	746	781	799	Table 4.8 Row A
B	Estimated Client Growth Rate	2.32%	2.32%	2.32%	Table 4.8 Row C
C	**Estimated Clients**	**781**	**799**	**818**	**FY 2014-15: Row A * (1 + Row B)^2** **FY 2015-16 & FY 2016-17: Row A * (1 + Row B)**

Table 4.8- Historical Home Modification Expenditure, clients and Expenditure per client					
Row	**Item**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
A	Clients	634	651	658	746
B	Yearly Percent Change	-7.85%	2.68%	1.08%	13.37%
C	**Average Yearly Percent Change FY 2008-09 to FY 2012-13**				**2.32%**

Table 5.1 - FTE Calcuations

Calculation Assumptions:

Personal Services -- Based on the Department of Personnel and Administration's August 2012 Annual Compensation Survey Report. All postions below are at the bottom of the pay range for the given class title.

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in FY 2014-15

Expenditure Detail		FY 2014-15		FY 2015-06
Personal Services:	FTE	$	FTE	
Monthly Salary				
GENERAL PROFESSIONAL IV $4,764	0.9	$52,406	1.0	$57,168
PERA		$5,319		$5,803
AED		$1,887		$2,287
SAED		$1,703		$2,144
Medicare		$760		$829
STD		$93		$101
Health-Life-Dental		$4,421		$4,421
Subtotal GENERAL PROFESSIONAL IV	0.9	**$66,589**	1.0	**$72,753**
Monthly Salary				
GENERAL PROFESSIONAL V $5,960	0.9	$65,562	1.0	$71,520
PERA		$6,655		$7,259
AED		$2,360		$2,861
SAED		$2,131		$2,682
Medicare		$951		$1,037
STD		$116		$127
Health-Life-Dental		$4,421		$4,421
Subtotal GENERAL PROFESSIONAL V	0.9	**$82,196**	1.0	**$89,907**
Subtotal Personal Services	1.8	**$148,785**	2.0	**$162,660**
Operating Expenses				
1 Indirect Admin (29.3% for ED, 25,613	1.8	$46,959	2.0	$51,226
2 Regular FTE Operating Expenses 800	1.8	$1,467	2.0	$1,600
3 Telephone Expenses 450	1.8	$825	2.0	$900
4 PC, One-Time 1,230	2.0	$2,460		$0
5 Office Furniture, One-Time 3,473	2.0	$6,946		$0
6 Other New Staff start up, One-Time 950	2.0	$1,900		$0
7 Cell Phone (for one staff person) 900	0.9	$810	1.0	$900
8 Office Supplies 750	1.8	$1,375	2.0	$1,500
9 Copies 400	1.8	$733	2.0	$800
10 Staff training 571	1.8	$1,047	2.0	$1,142
11 Certified Aging in Place Specialist (CAPs) Certification for 3		$3,300		$3,300
12 CAPs Certification Renewal for 3		$0		$166
13 ICC Accessibility Inspector/Plans Examiner Certification for 2		$360		$360
14 Outreach (Brochures, etc.)		$1,000		$1,000
15 Training for SEPs & Providers		$500		$500
16 Postage		$1,000		$1,000
17 Inspection Tools, One-Time		$500		$0
18 Mileage (state car)		$1,367		$1,367
19 Contract Services for Inspections 65		$50,765		$51,935
20 IT - website & software development				
Subtotal Operating Expenses		**$123,314**		**$117,696**
TOTAL REQUEST	1.8	**$272,099**	2.0	**$280,356**
General Fund:		*$136,051*		*$140,178*
Cash funds:		*$0*		*$0*
Reappropriated Funds:		*$0*		*$0*
Federal Funds:		*$136,048*		*$140,178*

	FY 2014-15	FY 2015-16
PERA	10.15%	10.15%
AED	3.60%	4.00%
SAED	3.25%	3.75%
Medicare	1.45%	1.45%
STD	0.177%	0.177%
Health-Life-Dental	4,421.04	4,421.04

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Primary Care Specialty Collaboration

Priority Number: R-10

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/24/13

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2014-15
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,745,317,429	-	5,330,493,347	537,497	(173,987)
	FTE	-	-	-	-	-
	GF	1,038,525,384	-	1,037,369,737	224,061	(52,647)
	GFE	469,842,084	-	469,842,084	-	-
	CF	594,450,563	-	684,103,853	3,479	(2,714)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,639,562,506	-	3,137,177,673	309,957	(118,626)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	**Total**	8,492,552	-	6,660,552	300,000	-
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	150,000	-
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	150,000	-
(2) Medical Services Premiums	**Total**	4,736,824,877	-	5,323,832,795	237,497	(173,987)
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	74,061	(52,647)
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	3,479	(2,714)
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	159,957	(118,626)

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

Medical Services Premiums: Of this amount, ~~$2,535,659~~ $2,539,138 shall be from the **Hospital Provider Fee Cash Fund** created in Section 25.5-4-402.3 (4), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund [24A]; FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests $537,497 total funds, $224,061 General Fund, $3,479 cash funds, and $309,957 federal funds.

Link to Operations

- The Accountable Care Collaborative serves as the Department's platform for ensuring coordinated care and promoting practice transformation in Colorado. To date, efforts in the program have focused on primary care.
- Many Medicaid clients have conditions requiring a level of specialty expertise beyond primary care.

Problem or Opportunity

- The Department has identified opportunities to improve coordination and access to specialty care services. Currently, there are barriers (geography, reimbursement, coordination. primary care education, client transportation constraints, and technological) to appropriate utilization of specialty services.

Consequences of Problem

- A lack of appropriate care may result in worsened health outcomes and marked increases in treatment costs from emergency department (ED) visits and hospitalizations. Simultaneously, unnecessary utilization of specialty care inflates costs and further reduces available access for critical needs.

Proposed Solution

- The Department proposes to leverage the Accountable Care Collaborative infrastructure and technological innovations to address access and utilization issues associated with specialty care.
- The Department requests funds to implement telemedicine technology to allow primary care physicians to exchange patient information with specialist physicians without the need for an in person patient visit with the specialist. The technology would allow specialists to virtually screen clients to see if specialty care is necessary for their case.
- To further address access and reimbursement issues in the long term, the Department requests $300,000 in contractor funding to facilitate extensive stakeholder engagement, conduct research, and provide evidence based and stakeholder informed recommendations on payment reform options for specialty services through the Accountable Care Collaborative.

Department Priority: R-10
Request Detail: Primary Care Specialty Collaboration

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Primary Care Specialty Collaboration	$537,497	$224,061

Problem or Opportunity:

The Department has identified specialty care payment reform as the next pivotal venture in achieving better health and better care for Medicaid clients at lower cost to the State. The role of specialty care providers – often referred to as specialists – is to supplement primary care through the treatment of complex, specialized, or severe conditions. A lack of appropriate care may result in worsened health outcomes and marked increases in treatment costs from emergency department (ED) visits and hospitalizations. Simultaneously, unnecessary utilization of specialty care inflates costs and further reduces available access for critical needs. Access to care is often further complicated by socio-economic challenges, such as transportation difficulties or limited appointment options outside of school and working hours. These challenges are compounded in rural areas of the State, with the added demand of increased travel distance and fewer specialty providers.

By improving coordination between primary and specialty care, and by better managing the appropriate utilization of specialty care, the Department can promote better use of available resources for the benefit of clients' health. Care coordination activities may facilitate solutions to access challenges. In addition, payment reform strategies that incentivize more specialist participation in Medicaid would increase overall access to specialists. The Accountable Care Collaborative (ACC) offers an appropriate venue to implement these new reforms and solutions.

The Department currently spends over $32 million dollars per year on services provided by obstetricians, oncologists, podiatrists, neurologists, urologists, cardiologists, and dermatologists. Emergency department visits and hospitalizations that may result from the lack of access to specialty care are also very costly to the State. In addition to current efforts through the ACC to support care coordination and collaboration, the Department is developing program and payment reform strategies that promote proper management of care and that promote access to, and coordination with, specialty care providers.

Without proper management of care and coordination between primary care and specialists, the available supply of specialist appointments for Medicaid clients may be poorly allocated for unnecessary care, and

clients truly needing specialist attention must compete for the limited slots. Through payment reform, the Department has an opportunity to both increase total availability of specialty care with program and payment reform incentives, and to decrease inappropriate utilization through care management and coordination between providers. Examples of potential strategies to achieve these aims include developing new payment models for specialty care and providing new technologies to facilitate communication and coordination between primary and specialty providers.

Proposed Solution:

The Department requests $537,497 total funds, including $224,061 General Fund, $3,479 cash funds and $309,957 federal funds, to research and implement a technological solution to exchange patient information with specialists without the need for an in-person visit with the specialist, and hire a contractor to convene with stakeholders in a collaborative process to identify additional opportunities for specialty care reform and to assist in the implementation of a technological based solution to specialty care reform.

Part of these funds will be used for technological solutions to increase appropriate access to specialty care. A collaborative stakeholder process will help develop Colorado's telehealth program. Several programs are available that could inform Colorado's model, including the Doc2Doc model currently used by Oklahoma Medicaid. This model allows primary care physicians (PCPs) and specialty providers to communicate electronically and has proven successful and cost-effective in Oklahoma.

Doc2Doc Technology

The Department requests funds to implement technological solutions to specialist reform such as Oklahoma's Doc2Doc program. The Doc2Doc program uses store-and-forward technology to allow PCPs to exchange patient information with specialist physicians without the need for an in-person visit with the specialist.

Doc2Doc is a web-based application created by physicians to enhance communication and collaboration between medical care providers. The application allows PCPs and their office staff to discuss appropriate patient care with specialists asynchronously, securely, and at their convenience. Specialists receive referral requests through the application and advise PCPs on proper care of the patient and the necessity of a referral. PCPs and specialists can share written messages, documents, medical records, and consulting notes on patients. In this way, specialists can respond at a time that is more convenient to them, while still being held to a time window such as 48 hours to respond in order to receive the associated payment.

Oklahoma employed this technology within its Department of Corrections and found that face-to-face specialty visits were reduced by 71% in the first year. This reduction was maintained for over a decade. In over half of the online consultations, specialists could manage the patient's care entirely online. Guidance by specialists allowed PCPs to manage more of the care of the patient and allowed patients to avoid unnecessary travel and lengthy wait times.

The Department could purchase this application, or a similar application, for interested primary care medical providers and specialists in the Accountable Care Collaborative (ACC), though participation would not be mandatory. The Department anticipates that all PCPs in the ACC may not have the desire or the

capacity to use this technology. To encourage the use of this technology for Medicaid clients, the Department could offer an incentive payment to both the PCP and the specialist to collaborate on the necessity of potential referrals. Rather than paying an additional per-member per-month fee to incentivize this behavior, the Department would pay for the collaboration as it occurs, thereby making payment conditional on utilization.

Although the Department is interested in the Doc2Doc model, it serves as one example of how Colorado might implement a similar program. Other programs similar to Doc2Doc may be adopted, including Project ECHO through the University of New Mexico, a model for medical learning and collaborative practice that links primary care clinicians with specialist care teams at university medical centers to manage clients who have chronic conditions requiring complex care. Before any program is fully implemented, comprehensive stakeholder engagement and addressing the variation between Medicaid programs will be necessary.

Contractor Funding

The Department requests $300,000 to hire contractors for several necessary projects related to implementing this reform. A contractor would be needed to convene stakeholders in a collaborative process to identify additional opportunities for specialty care reform, research reforms from across the nation to identify reform options, formulate policy options related to reform, analyze new payment methodologies and complete data analysis, model the impact of proposed payment reform options in an actuarially sound manner, and seek any federal authorization that may be needed, including promulgating new rules necessary to implement reform. The contractor would make recommendations to the Department based on stakeholder input and evidence based research on the future of specialty care payment reform.

Alignment with Other Department Initiatives

Through the Department's ACC program, clients are each linked with a PCP who is responsible for the client's care, thereby improving health outcomes, reducing costs to the Medicaid program, and bettering the client and provider experience. Applying Doc2Doc technology or a similar application within the framework of the ACC allows the focus to continue to be the relationship between the PCP and the client, and helps the PCP to better understand the clients' needs and manage conditions previously addressed by the specialist or not treated at all.

Through the ACC program, the State hired a Statewide Data Analytics Contractor (SDAC) to provide electronic access to clinically actionable data to the RCCOs and PCPs to help meet the goals of the ACC program. However, the Department does not yet have the ability to collect data on how clients transition from a PCP to a specialist or hospital setting. Acquiring technology such as Doc2Doc will give the Department, RCCOs, and PCPs insight into the referral process and will identify areas of potential improvement and successful processes.

Anticipated Outcomes:

The Department anticipates significant savings and an opportunity to address care transitions in a meaningful way that will improve access to care, expand relationships between PCPs and specialists, increase the quality of care and reduce costs significantly. Limiting the number of unnecessary specialist visits will quickly offset any payments associated with PCPs and specialists consulting electronically. The

average reimbursement for a visit to a specialist is around $70, while the costs associated with programs such as Doc2Doc are roughly half that amount.

Alaska Medicaid implemented a program using telecommunication technologies to support long-distance clinical health care, commonly referred to as telehealth, and realized a savings of $8.5 million in travel costs for the state. Since the program's inception in 2003, Alaska estimates $38 million in savings. The need for travel was eliminated in 75% of the patients involved in specialty telehealth consultations and in 25% of patients involved in primary care telehealth consultations.

Similarly, through the Doc2Doc program's success reducing unnecessary referrals, Oklahoma was able to realize a savings of approximately $60 per-member per-month when patients received an online consult. In addition to cost savings, Oklahoma also conducted a study in 2004 with the conclusion that clients involved in an online specialist consultation through their PCP had better health outcomes than those without a specialist consultation.

Assumptions and Calculations:

The Department's estimates for costs and savings, shown in the appendix, are based on a proposed implementation of Oklahoma's Doc2Doc program. While this is necessary to provide an estimate for this budget request, the Department notes that its actual implementation of a technological solution may be different. The Department would determine the best implementation strategy in consultation with stakeholders during FY 2014-15, and use the budget process to adjust the estimates for program costs and savings.

The Department assumes in the calculation of this request that only some PCPs will have the capacity or interest to use this technology. Acquiring, learning, and using the product would need to be worth the time of the PCPs, particularly those with a small number of attributed clients. Therefore, the Department assumes that only a quarter of PCPs will begin utilization of the application in the first year. The Department anticipates that 30% of PCPs will be interested in acquiring the technology in FY 2015-16.

Oklahoma's Doc2Doc program experienced a 20-35% reduction in the number of specialist visits. Therefore, the Department believes that a large number of specialist visits would be avoided when a technological system has been fully deployed. However, because the Department's proposed deployment cannot be fully defined until consulting with stakeholders, the Department estimates that 30% of specialist visits can initially be avoided. The Department assumes that the ratio of PCPs participating in the ACC to specialists is approximately 4:1. This is due to the fact that there will likely be several PCPs consulting with the same specialist.

Savings are realized in future years through deferred specialist visits as the initial costs of acquiring the technology are absorbed. Further savings may be realized through averted transportation cost in out years. Colorado spends approximately $4.9 million on non-emergency medical transportation per year for clients outside of the metro area and over $5.6 million per year on non-emergent medical transportation for clients within the metro area. This cost to the State and burden on the client could be minimized by reducing unnecessary travel for Medicaid clients. However, these savings are not yet included in the model, as the

time frame on which savings would occur, particularly because a large portion of the Department's transportation contract is currently based on a fixed price, is uncertain. The Department would use the regular budget process to account for any savings achieved.

Table 1.A
Summary of Request
FY 2014-15

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**$537,497**	**$224,061**	**$3,479**	**$0**	**$309,957**	**0.0**
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$300,000	$150,000	$0	$0	$150,000	0.0
(2) Medical Services Premiums	$237,497	$74,061	$3,479	$0	$159,957	0.0

Table 1.B
Summary of Request
FY 2015-16

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Total Request	**($173,987)**	**($52,647)**	**($2,714)**	**$0**	**($118,626)**	**0.0**
(2) Medical Services Premiums	($173,987)	($52,647)	($2,714)	$0	($118,626)	0.0

Table 2.A - Summary of Program Expenditure				
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**Source**
A	Estimated Program Costs	$441,330	$2,275,723	Table 2.B Row O
B	Estimated Savings	($203,833)	($2,449,710)	Table 2.C Row D
C	**Net Program Costs**	**$237,497**	**($173,987)**	**Row A + Row B**

Table 2.B - Estimated Costs of Technology for Specialty Care Reform				
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**Source**
A	Total Primary Care Physicians (PCP) in the Accountable Care Collaborative (ACC)	2,300	2,415	Approximate number of PCPs participating in the ACC as of August 2013 (inflated by 5% for FY 2015-16)
B	Percent of PCP Participation	25%	30%	Assumed, see narrative for additional information
C	Number of PCPs Participating	575	725	Row A * Row B
E	Number of Specialist Utilizers	144	181	Assumes a 4:1 ratio of PCP utilizers to specialist utilizers - see narrative for additional information
F	Estimated Fee to Acquire Technology per Specialist and PCP per Month	$25	$25	Doc2Doc fee to acquire technology
G	Number of Applicable Months in Fiscal Year	6	12	Assumes January 2015 Implementation
H	**Total cost of acquiring software**	**$107,850**	**$271,800**	**(Row C + Row E) * Row F * Row G**
I	Number of Specialist Referrals by Participating PCPs	3,970	5,964	Tables 3.1 and 3.2
J	Percentage of Technology Applicable Referrals	40%	80%	Assumed, see narrative for additional information
K	Number of Technology Applicable Referrals	9,528	57,255	Row G * Row I * Row J
L	Cost per Use of Technology	$5	$5	Doc2Doc fee per use
M	Provider Reimbursement for Referral	$30	$30	$10 to PCPs, $20 to RCCOs. Based on Doc2Doc model
N	**Total Cost of Consultation**	**$333,480**	**$2,003,923**	**Row K * (Row L + Row M)**
O	**Total Costs**	**$441,330**	**$2,275,723**	**Row H + Row N**

[1] Includes the following eligibility groups: Adults 65 and Older, Disabled Adults 60-64, Disabled Individuals up to Age 59, Categorically Low-Income Adults, Expansion Adults up to 60% FPL, Expansion Adults up to 100% FPL, Baby Care Adults, Adults without Dependent Children, and Working Adults with Disabilities.

Table 2.C - Savings				
Row	**Item**	**FY 2013-14**	**FY 2014-15**	**Source**
A	Total Visits Potentially Deferred	9,528	57,255	Table 2.B Row K
B	Percent of Visits Deferred	30%	60%	Assumed, see narrative for additional information
C	Average Expenditure per Specialist Visit Deferred	($71.31)	($71.31)	Based on FY 2012-13 MMIS Claims Data
D	**Estimated Savings**	**($203,833)**	**($2,449,710)**	**Row A * Row B * Row C**

Table 3.1 - Provider and Visit Estimates FY 2014-15			
Row	**Item**	**Estimate**	**Source**
A	Total Medicaid Clients FY 2014-15	939,581	FY 2014-15 R-1: "Medical Services Premiums Request" page EB.1 (totals exclude "Non Citizens" and "Partial Dual Eligibles")
B	Total Medicaid Clients Enrolled in the ACC FY 2014-15	535,894	FY 2014-15 R-1: "Medical Services Premiums Request" Page EI.9
C	Percent of Medicaid Clients in the ACC FY 2014-15	57.04%	Row B / Row A
D	Total Specialty Visits FY 2012-13	283,934	FY 2012-13 MMIS claims data
E	Estimated Specialty Visits in FY 2014-15	334,069	Assumed 8.47% annual growth rate - the growth rate of physician services expenditure in Medicaid from FY 2011- 12 to FY 2012-13.
F	Estimated Monthly Specialty Visits in FY 2014-15 Referred by Participating Providers	3,970	Row C * Row E * Table 2.B Row C / 12

Table 3.2 - Provider and Visit Estimates FY 2015-16			
Row	**Item**	**Estimate**	**Source**
A	FY 2015-16 Average Monthly Medicaid Enrollment	998,384	FY 2014-15 R-1: "Medical Services Premiums Request" Exhibit B (totals exclude "Non Citizens" and "Partial Dual Eligibles")
B	FY 2015-16 Average Monthly ACC Enrollment	655,894	FY 2014-15 R-1: "Medical Services Premiums Request" Exhibit I
C	Percentage ACC Enrollment	65.70%	Row A / Row B
D	Estimated Specialty Visits in FY 2015-16	363,133	Table 3.1: Row E * 1.847
E	Estimated Monthly Specialty Visits in FY 2015-16 Referred by Participating Providers	5,964	Row C * Row D * Table 2.B Row C / 12

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Community Provider Rate Increase

Priority Number: R-11

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/24/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2014-15
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,788,354,644	-	5,765,397,597	56,841,628	62,500,297
	FTE	-	-	-	-	-
	GF	1,065,743,206	-	1,249,445,789	20,079,070	21,347,084
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	714,343,710	968,533	1,048,988
	RF	2,936,892	-	2,000,000	-	-
	FF	2,655,950,399	-	3,329,766,014	35,794,025	40,104,225
(2) Medical Services Premiums	**Total**	4,736,824,877	-	5,323,832,795	49,892,416	55,304,907
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	16,686,301	17,831,226
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	506,497	586,952
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	32,699,618	36,886,729
(3)Behavioral Health Community Programs; Medicaid Mental Health Fee for Services Payments	**Total**	4,801,046	-	4,803,917	91,878	97,628
	FTE	-	-	-	-	-
	GF	2,400,523	-	2,401,959	45,939	48,814
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	2,400,523	-	2,401,958	45,939	48,814
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Comprehensive Services for 4,471.2 Medicaid Full Program Equivalents (FPE)	**Total**	-	-	338,015,700	5,131,765	5,193,295
	FTE	-	-	-	-	-
	GF	-	-	153,608,493	2,334,892	2,365,657
	GFE	-	-	-	-	-
	CF	-	-	30,798,715	461,981	461,981
	RF	-	-	-	-	-
	FF	-	-	153,608,492	2,334,892	2,365,657
NEW ITEM (7) Office of Community Living; (A) Program Costs, Adult Supported Living Services for 692 General Fund FPE and 3,417.5 Medicaid FPE	**Total**	46,728,721	-	47,042,236	859,627	1,012,730
	FTE	0.0	-	-	-	-
	GF	27,324,717	-	27,481,475	489,219	565,770
	GFE	0	-	-	-	-
	CF	0	-	-	-	-
	RF	0	-	-	-	-
	FF	19,404,004	-	19,560,761	370,408	446,960

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
NEW ITEM (7) Office of Community Living; (A) Program Costs, Family Support Services	Total	-	-	3,255,842	99,932	99,932
	FTE	-	-	-	-	-
	GF	-	-	3,255,842	99,932	99,932
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	-	-	-
NEW ITEM (7) Office of Community Living; (A) Program Costs, Children's Extensive Support Services for 659 Medicaid FPE	Total	-	-	18,785,189	281,778	281,778
	FTE	-	-	-	-	-
	GF	-	-	9,392,594	140,889	140,889
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	9,392,595	140,889	140,889
NEW ITEM (7) Office of Community Living; (A) Program Costs, Case Management for 692 General Fund and 8,547.7 Medicaid FPE		-				
	Total	-	-	26,610,248.0	438,457.0	464,252.0
	FTE	-	-	-	-	-
	GF	-	-	14,454,444	236,468	249,366
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF			$12,155,804	$201,989	$214,886
NEW ITEM (7) Office of Community Living; (A) Program Costs, Eligibility Determination and Waiting List Management	Total	-	-	2,987,431	44,811	44,811
	FTE	-	-	-	-	-
	GF	-	-	2,968,066	44,521	44,521
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	-	-	-	-	-
	FF	-	-	19,365	290	290
NEW ITEM (7) Office of Community Living; (A) Program Costs, Preventive Dental Hygiene	Total	-	-	64,239	964	964
	FTE	-	-	-	-	-
	GF	-	-	60,597	909	909
	GFE	-	-	-	-	-
	CF	-	-	3,642	55	55
	RF	-	-	-	-	-
	FF	-	-	-	-	-

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

Cash or Federal Fund Name and COFRS Fund Number: Medical Services Premiums: $197,939 Hospital Provider Fee Cash Fund Section 25.5-4-402.3 (4) and $308,558 Adult Dental Cash Fund; Office of Community Living: Client Cash Sources.

Reappropriated Funds Source, by Department and Line Item Name: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- The Department requests $56,841,628 total funds, including $20,079,070 General Fund in FY 2014-15.

Link to Operations

- Provider reimbursement for most Medicaid services does not change over time absent increases or decreases to appropriation by the General Assembly. Subsequently, rates for many services do not change based on the costs of providing the service. Provider costs can increase with inflation and other economic factors, or decrease with new technology and efficiencies.
- In FY 2012-13, the General Assembly appropriated funds to partially restore reimbursement to prerecession levels as providers experienced multiple rate reductions since FY 2009-10.

Problem or Opportunity

- For some services, reimbursement is insufficient to maintain provider participation in the long run.
- An inconsistent, fixed fee schedule that has not been updated to account for changes in costs and potential efficiencies can create incentives for providers to utilize higher cost, less effective, and less efficient services.

Consequences of Problem

- Reduced provider participation reduces clients' access to health care. Reduced access to health care can, in turn, result in poor client outcomes and subsequent higher costs for the State.
- Incentives for providers created by insufficient and/or inconsistent reimbursement can result in utilization of services that are inefficient, less effective, and more costly. As with access issues, there are negative impacts for client outcomes and fiscal impacts for the State.

Proposed Solution

- The Department requests $56,841,628 in total funds for FY 2014-15 to increase provider rates by 1.5%. Of this amount, 1% would be an across-the-board increase for certain eligible providers. The Department would reserve funding equal to a 0.5% rate increase to better align reimbursement for select services in a coordinated and targeted manner.
- Investing in adequate provider rates and aligning payment with high value services would result in better outcomes for clients and lower costs for the State.

Department Priority: R-11
Request Detail: Community Provider Rate Increase

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Community Provider Rate Increase	$56,841,628	$20,079,070

Problem or Opportunity:

Investing in adequate provider rates and aligning payment with high-value services is a critical component of ensuring clients have sufficient access to care, quality outcomes are achieved, and services provided are cost-effective.

Many services provided to Medicaid clients are paid at a fixed level that does not change unless the General Assembly explicitly approves an increase or decrease to reimbursement. Throughout the recession, provider rates were reduced repeatedly. However, in FY 2012-13 the General Assembly partially restored provider rates, bringing provider rates closer to prerecession levels. For many services, a gap remains and some providers continue to be reimbursed below historical levels. Inadequate reimbursement is unsustainable in the long run as it would likely limit access to care for Medicaid clients. Subsequently, limited access to care can result in poor quality outcomes and higher costs for the State as conditions that could have been prevented exacerbate in the absence of early intervention.

In addition to addressing inadequate reimbursement, there is an opportunity for the Department to establish policy that incentivizes the use of high value services and disincentivizes low-value procedures. Reimbursement for most services does not change, even though the cost of providing those services increases over time with inflation and other economic factors. Further, reimbursement for a service does not change relative to alternative services that may have shown to produce better client outcomes at a lower long term cost. Consequently, the Medicaid fee schedule does not truly incentivize providers to provide the most clinically effective, cost efficient services. In fact, because the fee schedule has not changed to accommodate the aforementioned factors, incentives to bill high volume, low efficacy procedures likely exists. This is not a problem that can be resolved with an across-the-board rate increase.

Proposed Solution:

The Department requests $56,841,628 total funds, $20,079,070 General Fund, for FY 2014-15 to increase provider rates by 1% for eligible providers and to use funding equal to a 0.5% rate increase in order to provide targeted increases to specific services.

In aggregate, the increases would address adequacy of payment. Additionally, the Department would use targeted rate increases to specifically address the underlying incentive structure inherent in the Medicaid fee schedule, in order to promote utilization of high quality, cost effective procedures that ultimately improve client outcomes and reduce expenditures for the State.

The Department has formed an internal workgroup to establish a framework for targeting rates to achieve these goals. The expertise of the stakeholder community would be valuable; the Department would actively seek stakeholder feedback throughout the process to gain a better understanding of which areas can be most beneficially impacted through targeted rate increases given resource constraints.

Anticipated Outcomes:

Implementing a provider rate increase would reduce the financial strain and risk to client access that accompanied several years' worth of rate reductions. Additionally, targeted increases would more appropriately align incentives, encouraging positive outcomes for clients and allowing the Department to pay for value rather than volume of services. Access issues related to inappropriate reimbursement rates, particularly important with the Medicaid expansion and exacerbated in rural areas, would be partially alleviated.

Providing adequate reimbursement to providers encourages participation in Medicaid and therefore increases client access, which aligns with the Department's Objective 3 in the FY 2013-14 Strategic Plan.

Assumptions and Calculations:

Although these rate increases would affect most Medicaid providers, a number of providers would be exempted from rate increases or receive different rate increases. These distinctions include:

- A portion of physician and EPSDT services are not eligible for an increase in rates due to rates already being increased under Section 1202 of the Affordable Care Act. A portion of expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract.
- Class I and Class II nursing facility rates are determined in accordance with statutory guidelines which has the effect of increasing reimbursement to most providers each year, based on providers' cost. Therefore, the Department is not requesting funding to increase nursing facility rates. In addition, the Department would exempt hospice rates, which are set in part as a function of nursing facility rates and in part as a result of federal requirements.
- Physical health managed care programs, including risk-based health maintenance organizations such as the Program of All-Inclusive Care for the Elderly (PACE), would receive rate increases based on whether the services covered under their contracts received rate increases.
- Behavioral health organizations (BHO) would not receive direct rate increases as part of this change request. BHO rates are set in accordance with federal regulation and actuarial standards. BHO rates generally increase in response to provider cost, and the Department cannot apply a direct increase to the rates.
- The Department would exempt reimbursement to pharmacies from the rate increase. Pharmaceutical reimbursement has transitioned to a methodology that reflects the actual costs of purchasing and

dispensing medications. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology is directly tied to a moving price statistic that increases reimbursement as provider costs increase.

- The Department exempts rates for services provided under the home and community based services (HCBS) waiver for children with autism because of the cap on client expenses. An increase in rates would reduce the amount of services that clients are able to receive. For this reason, the Department has not applied rate reductions to this program in prior years and would not apply a rate increase to the reimbursement of these services.
- Rates for rural health clinics (RHCs) are based on actual cost or the Medicare upper payment limit. RHCs have previously not been subject to rate decreases or increases due to the unique manner in which these rates are calculated.

The Department's request also includes rate increases for programs administered by the Office of Community Living.

See Appendix A for detailed calculations.

Table 1a: FY 2014-15 - Amounts Eligible for Rate Increase by Funding Source
(Includes Budget Actions Not Yet Approved)

Long Bill Group	Total Funds	General Fund	Cash Funds	Federal Funds
(2) Medical Services Premiums				
Acute Care	$2,716,767,935	$831,003,827	$31,805,002	$1,853,959,106
Community Based Long Term Care	$394,213,970	$195,661,321	$643,918	$197,908,731
Program for All-Inclusive Care for the Elderly	$101,998,967	$50,999,483	$0	$50,999,484
Service Management	$112,249,758	$34,334,908	$1,314,100	$76,600,750
FY 2014-15 R-7: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase	$2,626,699	$1,313,350	$0	$1,313,350
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	($1,933,750)	($966,875)	$0	($966,875)
FY 2014-15 R-10: Primary Care Specialty Collaboration	$237,497	$74,061	$3,479	$159,957
Total Medical Services Premiums	**$3,326,161,076**	**$1,112,420,075**	**$33,766,499**	**$2,179,974,502**
Impact of 1.5% Rate Increase	**$49,892,416**	**$16,686,301**	**$506,497**	**$32,699,618**
(3) Behavioral Health Community Programs				
Mental Health Fee-for-Service	$6,125,216	$3,062,608	$0	$3,062,608
Impact of 1.5% Rate Increase	**$91,878**	**$45,939**	**$0**	**$45,939**

Table 1a: FY 2014-15 - Amounts Eligible for Rate Increase by Funding Source (Continued)
(Includes Budget Actions Not Yet Approved)

Long Bill Group	Total Funds	General Fund	Cash Funds	Federal Funds
(7) Office of Community Living				
Adult Comprehensive Services	$338,015,700	$153,608,493	$30,798,715	$153,608,492
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	$4,102,000	$2,051,000	$0	$2,051,000
Total	**$342,117,700**	**$155,659,493**	**$30,798,715**	**$155,659,492**
Impact of 1.5% Rate Increase	**$5,131,765**	**$2,334,892**	**$461,981**	**$2,334,892**
Adult Supported Living Services	$47,042,236	$27,481,475	$0	$19,560,761
FY 2014-15 R-7: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase	$9,887,594	$4,943,797.00	$0	$4,943,797
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	$378,627	$189,314	$0	$189,313
Total	**$57,308,457**	**$32,614,586**	**$0**	**$24,693,871**
Impact of 1.5% Rate Increase	**$859,627**	**$489,219**	**$0**	**$370,408**
Family Support Services	$3,255,842	$3,255,842	$0	$0
FY 2014-15 R-14: Family Support Services Funding Restoration	$3,406,321	$3,406,321	$0	$0
Total	**$6,662,163**	**$6,662,163**	**$0**	**$0**
Impact of 1.5% Rate Increase	**$99,932**	**$99,932**	**$0**	**$0**
Children's Extensive Support Services	$18,785,189	$9,392,594	$0	$9,392,595
Impact of 1.5% Rate Increase	**$281,778**	**$140,889**	**$0**	**$140,889**

Table 1a: FY 2014-15 - Amounts Eligible for Rate Increase by Funding Source (Continued)
(Includes Budget Actions Not Yet Approved)

Long Bill Group	Total Funds	General Fund	Cash Funds	Federal Funds
Case Management	$26,610,248	$14,454,444	$0	$12,155,804
FY 2014-15 R-7: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase	$2,335,543	$1,167,772	$0	$1,167,771
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	$284,673	$142,337	$0	$142,336
Total	**$29,230,464**	**$15,764,553**	**$0**	**$13,465,911**
Impact of 1.5% Rate Increase	**$438,457**	**$236,468**	**$0**	**$201,989**
Eligibility Determination and Waiting List Management	$2,987,431	$2,968,066	$0	$19,365
Impact of 1.5% Rate Increase	**$44,811**	**$44,521**	**$0**	**$290**
Preventive Dental Hygiene	$64,239	$60,597	$3,642	$0
Impact of 1.5% Rate Increase	**$964**	**$909**	**$55**	**$0**
Total Impact	**$56,841,628**	**$20,079,070**	**$968,533**	**$35,794,025**

Table 1b: FY 2015-16 - Amounts Eligible for Rate Increase by Funding Source
(Includes Budget Actions Not Yet Approved)

Long Bill Group	Total Funds	General Fund	Cash Funds	Federal Funds
(2) Medical Services Premiums				
Acute Care	$3,094,437,840	$918,775,429	$37,544,371	$2,138,118,041
Community Based Long Term Care	$447,093,487	$223,546,744	$0	$223,546,744
Program for All-Inclusive Care for the Elderly	$8,499,914	$4,249,957	$0	$4,249,957
Service Management	$135,685,552	$41,503,439	$1,588,461	$92,593,652
FY 2014-15 R-7: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase	$5,253,399	$2,626,699	$0	$2,626,700
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	($3,802,439)	($1,901,220)	$0	($1,901,219)
FY 2014-15 R-10: Primary Care Specialty Reform	($173,987)	($52,647)	($2,714)	($118,626)
Total Medical Services Premiums	**$3,686,993,766**	**$1,188,748,401**	**$39,130,118**	**$2,459,115,248**
Impact of 1.5% Rate Increase	**$55,304,907**	**$17,831,226**	**$586,952**	**$36,886,729**
(3) Behavioral Health Community Programs				
Mental Health Fee-for-Service	$6,508,559	$3,254,280	$0	$3,254,279
Impact of 1.5% Rate Increase	**$97,628**	**$48,814**	**$0**	**$48,814**

Table 1b: FY 2015-16 - Amounts Eligible for Rate Increase by Funding Source (Continued)
(Includes Budget Actions Not Yet Approved)

Long Bill Group	Total Funds	General Fund	Cash Funds	Federal Funds
(7) Office of Community Living				
Adult Comprehensive Services	$338,015,700	$153,608,493	$30,798,715	$153,608,492
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	$8,204,000	$4,102,000	$0	$4,102,000
Total	**$346,219,700**	**$157,710,493**	**$30,798,715**	**$157,710,492**
Impact of 1.5% Rate Increase	**$5,193,295**	**$2,365,657**	**$461,981**	**$2,365,657**
Adult Supported Living Services	$47,042,236	$27,481,475	$0	$19,560,761
FY 2014-15 R-7: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase	$19,715,830	$9,857,915.00	$0	$9,857,915
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	$757,254	$378,627	$0	$378,627
Total	**$67,515,320**	**$37,718,017**	**$0**	**$29,797,303**
Impact of 1.5% Rate Increase	**$1,012,730**	**$565,770**	**$0**	**$446,960**
Family Support Services	$3,255,842	$3,255,842	$0	$0
FY 2014-15 R-14: Family Support Services Funding Restoration	$3,406,321	$3,406,321	$0	$0
Total	**$6,662,163**	**$6,662,163**	**$0**	**$0**
Impact of 1.5% Rate Increase	**$99,932**	**$99,932**	**$0**	**$0**
Children's Extensive Support Services	$18,785,189	$9,392,594	$0	$9,392,595
Impact of 1.5% Rate Increase	**$281,778**	**$140,889**	**$0**	**$140,889**

Table 1b: FY 2015-16 - Amounts Eligible for Rate Increase by Funding Source (Continued)

Long Bill Group	Total Funds	General Fund	Cash Funds	Federal Funds
Case Management	$26,610,248	$14,454,444	$0	$12,155,804
FY 2014-15 R-7: Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase	$3,868,410	$1,934,205	$0	$1,934,205
FY 2014-15 R-8: Developmental Disabilities New Full Program Equivalent	$471,510	$235,755	$0	$235,755
Total	**$30,950,168**	**$16,624,404**	**$0**	**$14,325,764**
Impact of 1.5% Rate Increase	**$464,252**	**$249,366**	**$0**	**$214,886**
Eligibility Determination and Waiting List Management	$2,987,431	$2,968,066	$0	$19,365
Impact of 1.5% Rate Increase	**$44,811**	**$44,521**	**$0**	**$290**
Preventive Dental Hygiene	$64,239	$60,597	$3,642	$0
Impact of 1.5% Rate Increase	**$964**	**$909**	**$55**	**$0**
Total Impact	**$62,500,297**	**$21,347,084**	**$1,048,988**	**$40,104,225**

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Administrative Contract Reprocurements
Priority Number: R-12

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	4,778,023,804	-	5,369,576,703	4,296,940	-
	FTE	358.1	-	395.1	-	-
	GF	1,047,004,091	-	1,048,611,796	1,148,457	-
	GFE	469,842,084	-	469,842,084	-	-
	CF	602,045,033	-	692,151,319	976,968	-
	RF	4,673,734	-	3,768,913	-	-
	FF	2,654,458,862	-	3,155,202,591	2,171,515	-
(1) Executive Director's Office, (A) General Administration, General Personal Services	**Total**	24,611,523	-	28,512,863	57,168	-
	FTE	358.1	-	395.1	-	-
	GF	8,410,879	-	10,245,685	28,584	-
	GFE	-	-	-	-	-
	CF	2,599,660	-	2,693,382	-	-
	RF	1,736,842	-	1,768,913	-	-
	FF	11,864,142	-	13,804,883	28,584	-
(1) Executive Director's Office, (D) Eligibility Determinations and Client Services, Customer Outreach	**Total**	5,523,166	-	5,760,824	486,245	-
	FTE	-	-	-	-	-
	GF	2,575,246	-	2,543,792	243,123	-
	GFE	-	-	-	-	-
	CF	186,338	-	336,620	-	-
	RF	-	-	-	-	-
	FF	2,761,582	-	2,880,412	243,122	-
(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	**Total**	6,745,159	-	7,151,142	1,191,335	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	3,357,390	-	3,560,382	592,515	-
	RF	-	-	-	-	-
	FF	3,387,769	-	3,590,760	598,820	-

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
(2) Medical Services Premiums	Total	4,736,824,877	-	5,323,832,795	1,753,499	-
	FTE	-	-	-	-	-
	GF	1,036,017,966	-	1,035,822,319	876,750	-
	GFE	469,842,084	-	469,842,084	-	-
	CF	593,882,063	-	683,541,353	-	-
	RF	2,936,892	-	2,000,000	-	-
	FF	2,634,145,872	-	3,132,627,039	876,749	-
(4) Indigent Care Program, Children's Basic Health Plan Administration	Total	4,319,079	-	4,319,079	808,693	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	2,019,582	-	2,019,582	384,453	-
	RF	-	-	-	-	-
	FF	2,299,497	-	2,299,497	424,240	-

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

Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee (24A) and Children's Basic Health Plan Trust (11G)

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: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: R-12
Administrative Contract Reprocurements
FY 2014-15 Change Request

Cost and FTE

- The Department requests $4,296,940 total funds, including $1,148,457 General Fund, $976,968 cash funds, and $2,171,515 federal funds, for enrollment broker, eligibility determinations and enrollment services (EEMAP), and consumer-directed attendant support services (CDASS). This funding is only for FY 2014-15 and does not require any additional FTE.

Link to Operations

- The Department conducts a number of contractor-delivered services, including:
- Enrollment broker for Medicaid clients, which enrolls and disenrolls qualified Medicaid clients in an appropriate program;
- Eligibility determinations and enrollment services (EEMAP) for all Medicaid and CHP+ clients, ensuring only eligible individuals are enrolled in the Medicaid program; and
- CDASS, which allows long-term care clients to receive less-expensive, community-based care at the hands of a care provider of the client's choice.

Problem or Opportunity

- The current contracts for these services expire in 2015, and the Department is required to competitively reprocure each of the contracts.
- To assure a smooth transition between vendors, the Department must overlap contract periods and temporarily assign a transition manager to oversee each transition. Past transitions that did not include overlapping contracts resulted in delayed service delivery, longer processing periods, clients having to resubmit information, and loss of client data.

Consequences of Problem

- If this request is not approved, clients may experience delayed services, longer processing periods, or be forced to resubmit data, which means delayed or absent services, leading to poorer outcomes and higher costs. In some cases, it may violate federal law if clients are unable to obtain services.

Proposed Solution

- The Department requests: $2,514,857 total funds for enrollment broker and EEMAP services and $1,782,083 total funds for consumer-directed attendant support services (CDASS).
- If approved, this request would fund a one-time increase to the lines associated with these contracts to allow for a transitional overlap between vendors with a temporary transition manager for each contract who would be charged with ensuring the transition occurs in a timely and successful manner.
- The incoming vendor would be able to transition into the contractual obligations with assistance from the outgoing vendor, and affected clients should notice little to no change in service delivery.

Department Priority: R-12
Request Detail: Administrative Contract Reprocurements

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Administrative Contract Reprocurements	$4,296,940	$1,148,457

Problem or Opportunity:

The Department is required to reprocure three administrative service contracts in 2015 and is requesting funding to assure that the transition of these contracts between vendors does not affect service delivery for clients. The current contracts for these services expire in FY 2014-15, and the Department is required to competitively reprocure each of the contracts.

The Department contracts with external vendors to provide administrative services for Colorado Medicaid and Child Health Plan *Plus* (CHP+) clients. These services include enrollment broker (a component of customer outreach), eligibility determinations and enrollment services (also referred to as Eligibility and Enrollment for Medical Assistance Programs, or EEMAP), and consumer-directed attendant support services (CDASS). The enrollment broker vendor contacts all newly eligible Medicaid clients to inform them of Medicaid plan choices, enrolls clients who choose the Primary Care Physician Program (PCPP) or a health maintenance organization (HMO) plan, and enrolls and disenrolls clients from managed care plans in accordance with Medicaid rules. Similar to counties, the vendor conducting eligibility determinations and enrollment ensures only eligible individuals are enrolled in the Medicaid and CHP+ programs; however, the vendor is solely responsible for processing and disposition of all mailed-in Medicaid and CHP+ applications, administration of the CHP+ customer call center and website, handling of CHP+ appeals and grievances, and processing CHP+ disenrollment files, enrollment fees, and buy-in program premiums. Because EEMAP covers both Medicaid and CHP+ populations, it is a single contract split between two line items. Due to the similar nature between the enrollment broker and EEMAP contracts, as well as the fact both are currently held by the same vendor, the Department plans to merge the two into a single contract during the reprocurement process. For certain clients who require long-term services and supports, the CDASS vendor trains these clients on how to select an attendee to provide in-home personal care, homemaker, and health maintenance services. The vendor also acts as a financial management service, paying the attendees for services rendered.

Proposed Solution:

The Department requests $4,296,940 total funds – comprised of $1,148,457 General Fund, $976,968 cash funds, and $2,171,515 federal funds – to fund a transitional overlap period for each contract and assign two temporary transition managers during contract reprocurement: one to oversee the merging contracts for enrollment broker and eligibility determinations and enrollment services (or EEMAP), and one for the CDASS contract. This funding is one-time (only for FY 2014-15) and does not require any additional FTE.

To assure a smooth transition between the outgoing and incoming vendors, the Department must overlap contract periods. As a best practice, the Department believes that transition to a new vendor should begin three to six months prior to the end-date of the incumbent vendor's contract. The new vendor will be responsible for leading, coordinating, and implementing the transition plan, with assistance from the Department. The goal is for the new vendor to demonstrate to the Department, prior to implementation, that their operations are ready to begin and services are set to be rendered. Past transitions that did not include overlapping contracts resulted in several negative consequences. When the current non-emergent medical transportation (NEMT) contract was reprocured, the incoming vendor began transition activities late. The vendor's new computer system deployed to coordinate all vendor activities, including NEMT, launched without being fully functional, resulting in service delays for the first few months of the contract period.

In addition to overlapping contract periods, the Department must also assign a temporary transition manager to oversee each new contract transition. When a new contractor is selected, the Department does not have the staffing resources to properly manage all the tasks of both the incoming and outgoing contractor. The transition manager is needed to perform basic project management, facilitating communication between the new and incumbent contractor, and verifying that the new contractor is operationally ready to perform. In the Department's previous transition for its eligibility determinations and enrollment services (or EEMAP) vendor, months after the current vendor took over the contract, the Department discovered that several thousand client applications and documents, which were mailed to the outgoing vendor, were left sitting in boxes. No review or determination of these cases was made. Other boxes contained applications and documentation that had been entered but not filed or categorized, which continues to create issues with locating records for internal reviews and external auditing. This type of mistake, affecting client eligibility, is categorically unacceptable and must not be allowed to happen again.

If this request is not approved, clients may have difficulty enrolling in a plan, and the Department risks client eligibility determinations and enrollment not being completed within an appropriate time frame. As a result, clients may experience longer processing periods or be forced to resubmit data, which results in delayed or absent services, leading to poorer outcomes and higher costs. In some cases, it may violate federal law if clients are unable to obtain services due to processing complications. Additionally, CDASS clients may experience a disruption in their services, which leads to poorer outcomes and higher costs.

Anticipated Outcomes:

If approved, this request would fund a one-time increase to the line items associated with these contracts to allow for a transitional overlap between the outgoing and incoming vendors. This request would also increase the Department's Personal Services line item to fund a temporary transition manager for each new

contract transition who would be charged with ensuring the transition occurs in a timely and successful manner. As a result, the incoming vendor would be able to transition into the contractual obligations with assistance from the outgoing vendor, while maintaining optimal health care access and outcomes for the clients and demonstrating sound stewardship of financial resources.

This request is in line with all five objectives of the Department's performance plan. By mitigating disruptions between outgoing and incoming eligibility and enrollment vendors, the Department is ensuring those who are eligible for Medicaid or CHP+ are enrolled. By mitigating disruptions between outgoing and incoming NEMT vendors, the Department is ensuring those who need medical attention receive it when they need it, instead of when their condition has worsened and becomes much more expensive to treat. By mitigating disruptions between outgoing and incoming CDASS vendors, the Department is ensuring certain clients requiring long-term services and supports receive the appropriate level of care in their homes instead of a facility, which is significantly more expensive.

Assumptions and Calculations:

This request is composed of three parts, one for each service contract being reprocured. Of the $4,296,940 total funds requested, $2,514,857 is for enrollment broker and eligibility determinations and enrollment services, and $1,782,083 is for CDASS. The Department's calculations are provided in the appendix.

Traditionally, the Department determines start-up costs to be 10% of the five-year contract amount – which is the same as 50% of a single-year amount of the contract – and spreads it out over the life of the contract. This approach can be problematic, as it requires vendors to take a loss in the short-term, which may discourage qualified vendors from bidding on the contract. Because an incoming vendor will not be incurring any operational costs during the transition period, the Department believes 25% of the FY 2013-14 contract amount will be sufficient to fund necessary start-up costs related to capital and administration. The Department applied this methodology to each of the three contracts being reprocured. However, the actual costs would be determined based on the contractor's response to the Department's request for proposals. The Department would use the standard budget process to adjust for any differences between the incurred expenditure and the estimate.

Enrollment Broker and Eligibility Determinations and Enrollment Services (or EEMAP)

The Department estimates that the total additional funding need for enrollment broker and eligibility determinations and enrollment services is $2,514,857 total funds, including $257,415 General Fund, $976,968 cash funds, and $1,280,474 federal funds (see Table 4, Row I of the appendix).

Enrollment broker and eligibility determinations and enrollment services is a function of similar contracts within three separate appropriations: "Customer Outreach," which funds outreach and enrollment services to Medicaid clients, "Centralized Eligibility Vendor Contract Project," which funds eligibility and enrollment services for Medicaid clients, and "Children's Basic Health Plan Administration," which funds eligibility and enrollment services for CHP+ clients and families. Currently, both enrollment broker and EEMAP contracts are held by the same vendor, and the Department has elected to merge these contracts during the reprocurement process. Because there will only be one new contract, only one temporary transition manager is needed for this transition.

The Department determined the additional cost during the transition period to be 25% of the FY 2013-14 contract amount plus the cost of the temporary transition manager. Table 4 of the appendix details the FY 2013-14 contracts for enrollment broker and eligibility determinations and enrollment services, as well as the transition funding need for each portion of the contract.

The Department would fill the temporary transition manager position at the General Professional IV level. The current monthly salary at the General Profession IV level is $4,764.

Consumer-Directed Attendant Support Services (CDASS)

The Department estimates that the total additional funding need for its CDASS contract is $1,782,083 total funds, including $891,042 General Fund and matching federal funds (see Table 6, row D of the appendix).

The Department determined the additional cost during the transition period to be 25% of the FY 2013-14 contract amount plus the cost of the temporary transition manager. The Department will fill the temporary transition manager position at the General Professional IV level, for which the monthly salary is $4,764.

Table 1: Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	Enrollment Broker and Eligibility Determinations and Enrollment Services (or EEMAP)	$2,514,857	$257,415	$976,968	$1,280,474	Table 4, Row I
B	Consumer-Directed Attendant Support Services (CDASS)	$1,782,083	$891,042	$0	$891,041	Table 5, Row D
C	**FY 2014-15 Additional Funding Request**	**$4,296,940**	**$1,148,457**	**$976,968**	**$2,171,515**	**Row A + Row B**

Table 2: Request by Line Item						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	(1) Executive Director's Office, Personal Services	$57,168	$28,584	$0	$28,584	Table 3, Row A
B	(1) Executive Director's Office, Customer Outreach	$486,245	$243,123	$0	$243,122	Table 3, Row D
C	(1) Executive Director's Office, Centralized Eligibility Vendor Contract Project	$1,191,335	$0	$592,515	$598,820	Table 3, Row F
D	(2) Medical Services Premiums	$1,753,499	$876,750	$0	$876,749	Table 3, Row H
E	(4) Indigent Care Program, Children's Basic Health Plan Administration	$808,693	$0	$384,453	$424,240	Table 3, Row J
F	**Total Request**	**$4,296,940**	**$1,148,457**	**$976,968**	**$2,171,515**	Sum of Rows A through E

Table 3: Request by Line Item Detail						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	**(1) Executive Director's Office, Personal Services**	**$57,168**	**$28,584**	**$0**	**$28,584**	Row B + Row C
B	Transition Manager: Enrollment Broker and EEMAP	$28,584	$14,292	$0	$14,292	Table 4, Row H
C	Transition Manager: CDASS	$28,584	$14,292	$0	$14,292	Table 5, Row C
D	**(1) Executive Director's Office, Customer Outreach**	**$486,245**	**$243,123**	**$0**	**$243,122**	Row E
E	Enrollment Broker Transition Costs	$486,245	$243,123	$0	$243,122	Table 4, Row E
F	**(1) Executive Director's Office, Centralized Eligibility Vendor Contract Project**	**$1,191,335**	**$0**	**$592,515**	**$598,820**	Row G
G	EEMAP Transition Costs	$1,191,335	$0	$592,515	$598,820	Table 4, Row F
H	**(2) Medical Services Premiums**	**$1,753,499**	**$876,750**	**$0**	**$876,749**	Row I
I	CDASS Transition Costs	$1,753,499	$876,750	$0	$876,749	Table 5, Row B
J	**(4) Indigent Care Program, Children's Basic Health Plan Administration**	**$808,693**	**$0**	**$384,453**	**$424,240**	Row K
K	CHP+ Admin Transition Costs	$808,693	$0	$384,453	$424,240	Table 4, Row G
L	**Total Request**	**$4,296,940**	**$1,148,457**	**$976,968**	**$2,171,515**	Row A + Row D + Row F + Row H + Row J

Table 4: Enrollment Broker and Eligibility Determinations and Enrollment Services (or EEMAP)						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
	FY 2013-14 Base Contract Amounts					
A	Enrollment Broker	$1,944,980	$972,490	$0	$972,490	
B	EEMAP: Centralized Eligilibty Vendor Contract Project	$4,765,339	$0	$2,370,058	$2,395,281	
C	EEMAP: CHP+ Administration	$3,234,773	$0	$1,537,811	$1,696,962	
D	**FY 2013-14 Contract Amount Total**	**$9,945,092**	**$972,490**	**$3,907,869**	**$5,064,733**	Sum of Rows A through C
	FY 2014-15 Transitional Funding Need by Contract					
E	Enrollment Broker: Transition Need	$486,245	$243,123	$0	$243,122	Row A × 25%
F	EEMAP: Centralized Eligilibty Vendor: Transition Need	$1,191,335	$0	$592,515	$598,820	Row B × 25%
G	EEMAP: CHP+ Administration: Transition Need	$808,693	$0	$384,453	$424,240	Row C × 25%
H	Transition Manager	$28,584	$14,292	$0	$14,292	Table 6 Row C
I	**FY 2014-15 Additional Funding Request**	**$2,514,857**	**$257,415**	**$976,968**	**$1,280,474**	Sum of Rows E through H

Table 5: Consumer-Directed Attendant Support Services (CDASS)						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes**
A	FY 2013-14 Contract Amount	$7,013,997	$3,506,999	$0	$3,506,998	
B	Transition Need	$1,753,499	$876,750	$0	$876,749	Row A × 25%
C	Transition Manager	$28,584	$14,292	$0	$14,292	Table 6 Row C
D	**FY 2014-15 Additional Funding Request**	**$1,782,083**	**$891,042**	**$0**	**$891,041**	Row B + Row C

Table 6: Transition Manager (General Professional IV)			
Row	**Item**	**Monthly Rate**	**Notes**
A	Salary	$4,764	Range Minimum as of July 2013
B	Effective Months	6	Assumed
C	**Total Per Transition Manager**	**$28,584**	Row A × Row B

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Funding for Utilization Review Services
Priority Number: R-13

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	9,382,809	-	10,053,110	1,691,977	1,691,977
	FTE	-	-	-	-	-
	GF	2,279,886	-	2,298,646	838,378	838,378
	GFE	-	-	-	-	-
	CF	305,844	-	461,089	-	-
	RF	-	-	-	-	-
	FF	6,797,079	-	7,293,375	853,599	853,599
(1) Executive Director's Office, Utilization and Quality Review Contracts, Professional Services Contracts	**Total**	9,382,809	-	10,053,110	1,691,977	1,691,977
	FTE	-	-	-	-	-
	GF	2,279,886	-	2,298,646	838,378	838,378
	GFE	-	-	-	-	-
	CF	305,844	-	461,089	-	-
	RF	-	-	-	-	-
	FF	6,797,079	-	7,293,375	853,599	853,599

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

Cash or Federal Fund Name and COFRS Fund Number: Federal funds: Title XIX
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: N/A

COLORADO
Department of Health Care Policy and Financing

Priority: R-13
Funding for Utilization Review Services
FY 2014-15 Change Request

Cost and FTE

- The Department requests $1,691,977 total funds, including $838,378 General Fund and $853,599 federal funds to the Department's Utilization and Quality Review Contracts Long Bill group.

Link to Operations

- The Department conducts utilization review of Medicaid services, including review of clients who receive long-term services and supports (LTSS) and review of prescription drug therapy. These services are delivered by contracted vendors.

Problem or Opportunity

- The Department's budget for utilization review for LTSS remains unchanged since 2002, despite increases both in caseload and scope of work.
- The increase in clients and requirements causes delays in service delivery. As prospective clients wait, their medical conditions may worsen and require a greater amount of care and be more expensive to treat.
- The Department's current budget for drug utilization review does not allow for analysis of complex prescription drug cases. Clients may be receiving unnecessary or duplicative drug regimens that could be modified to reduce the cost and improve the health of the client.

Consequences of Problem

- Clients who require long-term services and supports or necessary drug reviews are subject to longer processing periods, potentially necessitating more costly health care services.
- If cases are not processed within an appropriate period of time, the Department could face federal fines or litigation filed on behalf of clients for services not received in a timely manner.
- Without additional funding for LTSS utilization reviews, the Department does not believe it would be able to procure another vendor after the current contract expires on June 30, 2014.

Proposed Solution

- The Department requests $1,313,360 total funds for LTSS utilization review and $378,617 total funds for drug utilization review. These would be ongoing increases to the funding for these contracts.
- This request would allow for more resources to process LTSS applications and reviews, resulting in faster decisions, elimination of the current backlog, and clients receiving services before their condition worsens and becomes more costly.
- This request would also allow for thorough analysis of complex prescription drug cases to be performed, ensuring clients are not receiving unnecessary or duplicative drug treatment while ensuring all costs are appropriate and necessary.

Department Priority: R-13
Request Detail: Funding for Utilization Review Services

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Funding for Utilization Review Services	$1,691,977	$838,378

Problem or Opportunity:

The Department is requesting funding to reinforce and further develop utilization review processes within long-term care and prescription drug services.

Long-Term Care Utilization Review

Utilization review of LTSS is done by two types of vendors: 1) a Quality Improvement Organization (QIO) that performs a number of clinical reviews on LTSS clients, including on Pre-Admission Screening and Resident Review (PASSR – types I and II), prior authorization review (PAR), Children's Extensive Support (CES) reviews, and technologically dependent and medically complex (TDMC) reviews, and 2) single entry points (SEPs), which are comprised of 20 counties and three private entities, that perform non-clinical assessments and identify local resources to match services to a client's needs.

Since 2002, the Department's appropriation for utilization review for LTSS has remained unchanged, despite increases in caseload and scope of work. Between 2002 and 2013, Medicaid caseload grew 131%, while federal audits conducted over this same period led to several additional requirements vendors must perform throughout the review process. The increase in clients and review requirements demands more resources to complete reviews. As a result, vendors are forced to pull resources from other efforts to ensure utilization reviews are completed within 60 days, as per federal requirements. Consequently, some private vendors and counties have threatened to back out of the contract and cease providing utilization review services.

In 2009, the Department learned that, because SEPs do not qualify as a QIO, reviews conducted by SEPs are not eligible for an enhanced 75% federal match, as had been previously assumed. This reduced the total funds appropriation for SEPs from $1,049,948 to $524,974 – or by one half.

In 2013, the legislature provided funding to eliminate the existing waitlist for the CES program. As a result, the Department anticipates CES caseload will grow from 373 to 925 – or 148%.

The Department has recently learned it is out of compliance with federal requirements relating to PASRR I reviews, which are less complex than PASRR II. Currently, of the approximately 18,000 clients requiring PASRR I reviews, approximately 50% are automatically approved. When a client is automatically approved, an actual review is not performed. Federal requirements now demand that PASRR I clients be reviewed annually, prohibiting any further automatic approvals. The Department expects that this federal requirement will double the current PASRR I review annual caseload, as some clients require more than one review per year. Should the Department deviate from this requirement, the federal government could impose fines.

The Department is currently pursing approval from the Centers for Medicare and Medicaid Services (CMS) to receive an enhanced 75% federal match on TDMC reviews, which currently receive the standard 50% match. If approved, as the Department anticipates, the enhanced match may be retroactively applicable for two years.

The Department determined it must increase the contract amounts for long-term care utilization review to ensure clients continue to receive appropriate services for quality of life in accordance with federal regulations.

Drug Utilization Review

The Department's drug utilization review line is composed of four parts: 1) the Drug Utilization Review (DUR) vendor, 2) an electronic reference used for the reviews, 3) the Pharmacist Incentive Program, and 4) the Drug Effectiveness Review Project (DERP). Currently, due to funding limitations, drug utilization reviews are performed by Department staff, while the DUR vendor analyzes the data and offers a clinical interpretation. This arrangement provides severe limitations to the types of cases that can be reviewed.

The Department has one pharmacy staff who conducts retrospective reviews of prescription drug utilization, whereas the DUR vendor includes two pharmacists and one analyst who receive the reviews from the Department, analyze the reviews, provide a clinical interpretation, and create a presentation consisting of narrative, evidence, and recommendations that is presented quarterly to the DUR Board. The DUR vendor does four, in-depth, drug-class reports per year and frequently identifies areas for clinical efficiencies and cost savings.

Currently, case review is inconsistent in some areas and non-existent in others. Cases involving drugs prescribed to treat multiple sclerosis, chronic pain, or psychiatric disorders are reviewed by Department Pharmacy staff. Many of these cases are complex and would benefit from additional review by experts in the respective fields. Cases involving drugs prescribed to treat cancer are not currently reviewed. The DUR vendor has access to specialists and could provide additional review of these drugs. The level of expertise required to perform these reviews cannot be afforded by the current appropriation for drug utilization review. In addition, the Department would like to have experts available for Medicaid providers to use to consult about complex clients. The Department does not have that expertise in-house and the DUR vendor can provide experts for the peer-to-peer consultations. Without these services, clients with these diagnoses may receive unnecessary or duplicative drug treatment, due to a lack of analysis of their

prescription regimens by clinical experts. Reviewing these cases could reduce cost and improve the health of the client.

The Department's current DUR contract appropriation is $166,000 total funds. At this level, the funding does not allow for analysis of complex prescription drug cases, as the amount is less than the cost of employing a single physician full time.

Proposed Solution:

The Department requests $1,691,977 total funds, including $838,378 General Fund and $853,599 federal funds, to increase funding for its Long-Term Care Utilization Review program and Drug Utilization Review program.

Of the total requested amount, the Department requests $1,313,360 total funds, including $649,069 General Fund and $664,291 federal funds for its Long-Term Care Utilization Review program. This request does not require any additional FTE. The Department's calculations are shown in Table 2 in the appendix. The requested funds will enable the Department to increase the QIO and SEP contracts for LTSS utilization review so that the contracts are able to fund the amount of work they demand and retain the contracting vendors to ensure federally required reviews are performed. SEPs that have had to pull resources away from local resource development, which is a primary function they serve, will be able to resume this activity which will benefit clients who rely on these services. For example, Friends of Man, a volunteer-based charity in Littleton, is a local resource that a SEP might work with to help a client acquire items such as a portable wheelchair ramp or hearing aids using donation funding.

If this request is not approved, the Department risks losing its vendors for utilization review of clients who receive LTSS. Further, the Department believes it would be unable to procure another vendor at the current appropriation. These reviews are federally required to be performed; if the Department is unable to do so, the Department is subject to being fined by the federal government. Further, if these reviews are not performed, these clients may not receive appropriate or necessary services and may require more costly emergency services.

The Department requests $378,617 total funds, including $189,309 General Fund and $189,308 federal funds to increase funding for its Drug Utilization Review program. The requested funds would allow the DUR vendor, currently the University of Colorado, to hire personnel with the required expertise, ideally two physicians, to perform review of complex prescription drug cases – such as cancer, multiple sclerosis, chronic pain, and psychiatric disorders – in a way that the Department is currently unable to review these cases. These funds will also increase the base price of the contract to allow the vendor to assume a role in reviewing the cases the Department currently reviews, which will allow Department pharmacy staff to concentrate on other important issues, such as working with the RCCOs and pharmacy community on the development of a more robust Medication Therapy Management (MTM) program within the Accountable Care Collaborative (ACC) and adding additional drug classes for reports.

If this request is not approved, complex prescription drug reviews will continue to be reviewed by Department staff or not at all. The Department believes there are many potential efficiencies that can be

achieved with the data yielded from review of complex drug cases. Additionally, Department pharmacy staff will continue to be heavily devoted to review of these drug cases and will not be able to pursue development of other pharmacy-related projects, such as a potential MTM program within the ACC.

Anticipated Outcomes:

If approved, this request would allow for more resources to process LTSS utilization reviews, resulting in more timely decisions, elimination of the current CES backlog, and clients receiving services before their condition potentially worsens and becomes more costly. Further, this request would allow the Department to retain its vendors and allow counties to focus more on local resource development. This request also allows analysis of complex prescription drug cases, ensuring necessary, cost-effective, and non-duplicative drug treatment. The Department believes review of complex drug cases may produce savings by reducing unnecessary costs for treatment. The Department would account for any savings achieved through the regular budget process.

This request would also help the Department achieve four of the stated goals on the Department's Five-Year Strategy Map. This request would allow the Department to improve health outcomes by ensuring LTSS clients receive regular reviews so that they can get the appropriate level of care they require. Clients taking complex prescription drug regimens will have their cases reviewed to make certain they are on the most appropriate drug plan. This request would also allow the Department to increase access to health care by having LTSS clients reviewed regularly to ensure they are receiving a level of care commensurate with their condition. Additionally, this request would allow the Department to contain health care costs by making sure LTSS and prescription drug clients are not receiving unnecessary or duplicative care and, instead, are receiving necessary care to mitigate further complications. Finally, this request would allow the Department to improve the long-term care service delivery system by funding the Long-Term Care Utilization Review contracts at a level that is consistent with the amount of work the contractors are required to perform.

Assumptions and Calculations:

The Department requests $1,313,360 total funds for Long-Term Care Utilization Review and $378,617 total funds for Drug Utilization Review (see Table 1 in the appendix), which are housed in the Department's Utilization and Quality Review Contracts line item. These would be ongoing increases to the funding for these contracts.

Long-Term Care Utilization Review

To calculate the additional funding need for review of LTSS clients, the Department analyzed data provided by its QIO vendor relating to the current contract. By analyzing actual caseload and required hours per review of each review type in FY 2012-13, the Department estimated the cost of the contract to be $1,220,826 total funds, which is an increase of $620,826 total funds over the current contract. This data is summarized in Table 3 of the appendix. A similar actuals-based table is provided for the SEPs, who should earn a flat rate for reviews conducted (see Table 4). The Department acknowledges an increase from $524,974 to $1,837,500 is significant; however Table 5 illustrates a comparison between SEP functions in utilization review and Medical Services Premiums. Since FY 2002-03, the SEP portion of the

utilization review appropriation has been reduced by one half, whereas the SEP portion of Medical Services Premiums has increased by almost 85%.

Long-term care (or LTSS) utilization review is divided between a QIO contractor and 23 separate SEPs at the county level. Table 2 in the appendix details the estimated contract costs for both the QIO and the SEPs, the current allocations within the Department's appropriation for each, an uncommitted amount that exists in the line, and the FY 2014-15 additional funding need to increase the contracts to the requested level. PASSR reviews performed by the QIO qualify for an enhanced match of 75%, and the Department believes that TDMC reviews will be approved for a 75% match. The Department is currently pursuing approval from CMS to apply an enhanced federal match for TDMC reviews and is assuming such approval will be granted in its calculations for this request.

Drug Utilization Review

To calculate the additional funding need for the Department's DUR vendor contract, the Department analyzed similar contracts by other states. The least expensive contract was held by Arkansas for approximately $430,000, while the most expensive was held by Washington for approximately $700,000. Through this analysis, the Department determined the DUR base contract amount should first be increased by $34,000 total funds to $200,000 to allow the vendor to assume a role in reviewing the cases the Department's Pharmacy staff currently reviews, which will allow Department staff to concentrate on other pharmacy projects (see Table 7, Row B). To expand the scope of prescription drug review to include complex prescription drug cases – such as those for cancer, multiple sclerosis, chronic pain, and psychiatric disorders – the Department also requests $344,617 total funds to allow the vendor to employ two physicians to conduct these reviews, as well as oversee and help manage all drug review cases conducted by the vendor and the Department. Combined, the base increase and cost of two physicians are estimated to increase the cost of the contract by $378,617 totals funds, including $189,309 General Fund and $189,308 federal funds, to $544,617 total funds (see Table 7, Row D).

Table 1: Summary					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**Notes**
A	Long-Term Care Utilization Review	$1,313,360	$649,069	$664,291	Table 2 Row H
B	Drug Utilization Review	$378,617	$189,309	$189,308	Table 6 Row C
C	**FY 2014-15 Additional Funding Request**	**$1,691,977**	**$838,378**	**$853,599**	**Row A + Row B**

Table 2: Long-Term Care Utilization Review					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**Notes**
A	Estimated Cost of QIO Contract	$1,220,826	$367,561	$853,265	Table 3, Row F
B	Estimated Cost of SEP Contracts	$1,837,500	$918,750	$918,750	Table 4, Row A
C	Combined Estimated Cost of LTCUR	$3,058,326	$1,286,311	$1,772,015	Row A + Row B
D	Current Appropriation for QIO	$600,000	$180,031	$419,969	
E	Current Appropriation for SEPs	$524,974	$262,487	$262,487	
F	Current Uncommitted Appropriation	$619,992	$194,724	$425,268	
G	Combined Current Appropriation for LTCUR	$1,744,966	$637,242	$1,107,724	Row D + Row E + Row F
H	**FY 2014-15 Additional Funding Request**	**$1,313,360**	**$649,069**	**$664,291**	**Row C - Row G**

Table 3: FY 2012-13 QIO Activity (and estimated costs)									
Row	**Review Type**	**Reviews**	**Hours**	**Hours per Review**	**Hourly Cost**	**Total Funds**	**General Fund**	**Federal Funds**	**Notes**
A	Pre-Admission Screening and Resident Review (PASRR) I	24,264	9,477	0.39	$67.80	$642,583	$160,646	$481,937	75% FFP
B	PASRR II	1,217	3,700	3.04	$62.87	$232,633	$58,158	$174,475	75% FFP
C	Prior Authoirzation Review (PAR)	8,681	2,283	0.26	$54.00	$123,276	$61,638	$61,638	50% FFP
D	Children's Extensive Support (CES)	655	1,457	2.22	$86.58	$126,142	$63,071	$63,071	50% FFP
E	Technologically Dependent and Medically Complex (TDMC)	56	910	16.25	$105.71	$96,192	$24,048	$72,144	75% FFP
F	**Total**	**34,873**	**17,827**	**N/A**	**N/A**	**$1,220,826**	**$367,561**	**$853,265**	**Sum Rows A through E**

Table 4: FY 2012-13 SEP Activity (and estimated costs)					
Row	**Reviews**	**Cost per Review**	**Total Funds**	**General Fund**	**Federal Funds**
A	24,500	$75.00	$1,837,500	$918,750	$918,750

Table 5: SEP Funding 10-Year Perspective					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**Notes**
	SEP Utilization Review (LTC Utilization Review)				
A	FY 2002-03 Budget	$1,049,948	$262,487	$787,461	
B	FY 2012-13 Budget	$524,974	$262,487	$262,487	
C	**Percent Growth**	**-50.00%**	**0.00%**	**-66.67%**	**(Row B ÷ Row A) - 1**
	SEP Service Delivery (Medical Services Premiums)				
D	FY 2002-03 Budget	$14,628,776	$7,314,388	$7,314,388	
E	FY 2012-13 Budget	$26,976,561	$13,488,280	$13,488,280	
F	**Percent Growth**	**84.41%**	**84.41%**	**84.41%**	**(Row E ÷ Row D) - 1**

Table 6: Drug Utilization Review - University of Colorado Contract					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**Notes**
A	FY 2013-14 Contract Budget	$166,000	$83,000	$83,000	
B	Estimated Cost of New Contract	$544,617	$272,309	$272,308	Table 7 Row D
C	**FY 2014-15 Additional Funding Request**	**$378,617**	**$189,309**	**$189,308**	**Row B - Row A**

Table 7: Estimated Cost of New University of Colorado Contract					
Row	**Item**	**Total Funds**	**General Fund**	**Federal Funds**	**Notes**
A	Current Contract Amount	$166,000	$83,000	$83,000	
B	Contract Base Increase	$34,000	$17,000	$17,000	Expand scope of work and reporting requirements
C	Add Personnel (Two (2) Physicians)	$344,617	$172,309	$172,308	Physician I range minimum as of July 2013 plus benefits
D	**Total**	**$544,617**	**$272,309**	**$272,308**	**Sum of Rows A through C**

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Family Support Services Funding Restoration
Priority Number: R-14

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/24/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	6
		Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	0	0	3,255,842	3,406,321	3,406,321
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	0	0	3,255,842	3,406,321	3,406,321
	GFE	0	0	0	0	0
	CF	0	0	0	0	0
	RF	0	0	0	0	0
	FF	0	0	0	0	0
NEW ITEM (7) Office of Community Living; (A) Program Costs, Family Support Services	**Total**	0	0	3,255,842	3,406,321	3,406,321
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	0	0	3,255,842	3,406,321	3,406,321
	GFE	0	0	0	0	0
	CF	0	0	0	0	0
	RF	0	0	0	0	0
	FF	0	0	0	0	0

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

Cash or Federal Fund Name and COFRS Fund Number: N/A

Reappropriated Funds Source, by Department and Line Item Name: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: Pursuant to HB 13-1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, the line items impacted by the request will be reflected in the Department of Health Care Policy and Financing.

Cost and FTE

- $3,406,321 General Fund in FY 2014-15, FY 2015-16 and beyond, 0.0 FTE, 4.6% Increase (Family Support Services line item).

Link to Operations

- The Family Support Services Program (FSSP) provides funding for flexible and responsive services and supports to families who provide care for a family member with a developmental disability in the home. Examples of these services include assistive technology; home/vehicle modifications; medical and dental expenses; professional services such as counseling; respite care; and transportation.
- FSSP funding is allocated to Community Centered Boards (CCBs). The CCBs determine the amount of services and supports an individual or family requires. Services provided under FSSP are identified in each family's Individualized Family Support Plan; families then select services from providers in the community.

Problem or Opportunity

- FSSP funding has been reduced over a period of several years to address budget shortfalls and over-expenditures in other program areas for individuals with intellectual and developmental disabilities.
- There are 5,945 individuals with developmental disabilities on the waiting list for FSSP requesting services as soon as available or by June 30, 2015. The demand for services exceeds available funding.

Consequences of Problem

- Individuals with intellectual and developmental disabilities in Colorado are experiencing delays in receiving needed FSSP services by remaining on the waiting list.

Proposed Solution

- The Department requests General Fund to restore FSSP funding to the FY 2009-10 levels. Funds are allocated to CCBs to be used as a pool of funds to serve those in need of support services not provided under other programs; therefore, funding does not directly correlate to the number of FPE that can be served.
- FSSP will provide families with the most need and who are caring for a child or individual with a disability the support they need for services that are above and beyond those typically incurred by a family for child rearing or daily expenses.
- FSSP supports families in their role as primary caregivers to provide individuals with developmental disabilities the support needed to enable them to enjoy typical lifestyles in the community.

Department Priority: R-14
Request Detail: Family Support Services Funding Restoration

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Family Support Services Funding Restoration	$3,406,321	$3,406,321

Problem or Opportunity:

The Family Support Services Program (FSSP) provides the support needed for individuals with developmental disabilities to remain at home in their own family setting and prevent out-of-home placement. The FSSP program provides flexible and responsive services and supports to families who provide care for a family member with a developmental disability. Eligible FSSP services are generally expenses that are above and beyond those typically incurred by a family for child rearing or daily living expenses.

As set forth at section 27-10.5-401, C.R.S., "It is the intent of the general assembly that the service delivery systems for individuals with developmental disabilities emphasize community living for persons with developmental disabilities and provide supports to individuals that enable them to enjoy typical lifestyles. One way to accomplish this is to recognize that families are the greatest resource available to individuals who have a developmental disability and that families must be supported in their role as primary caregivers. The general assembly finds that supporting families in their effort to care for their family members at home is more efficient, cost-effective, and humane than maintaining people with developmental disabilities in out-of-home residential settings." This statute establishes the guiding principles and basic parameters for providing support through the FSSP program.

Services provided under FSSP are tailored to the individual and family's needs. The specific commitment for services is identified in the each family's Individualized Family Support Plan. The family then selects their services from providers in their community. The following are examples of the types of services that can be provided to eligible persons and all family members living in the household:

- Assistive technology (mobility aids, adaptive equipment, communication devices)
- Home/vehicle modifications (ramps, lifts, widened door frames)
- Medical and dental expenses (not otherwise covered by other sources such as Medicaid or private insurance)
- Other individual expenses (special diets, specialized clothing)

- Parent and sibling support (counseling, special resource materials and publications, cost of memberships, child care and sitter services for siblings, behavioral intervention)
- Professional services (counseling, occupational therapy, speech therapy, physical therapy)
- Respite care (temporary care of the person with the developmental delay/disability)
- Transportation (mileage costs related to providing care and support)

In Colorado, the Community Centered Boards (CCB) are responsible for determining the level of support a person requires and how much funding is necessary to meet their needs. CCBs manage the FSSP waiting list. For the FSSP program, eligibility determinations are made by the local CCBs in consultation with the family and others, as appropriate. State rules provide that all ages are eligible to receive services, as long as the eligible person lives with his or her family in the household and the services relate to the impact of the developmental disability. Services and supports are to be targeted toward families that are most in need according to the locally determined criteria. In conjunction with their Family Support Councils, the CCBs develop a written process to apply the five parameters defined below to ensure that families most in need are served with State funds:

- Child's disability/overall care needs: The type of disability or condition and the need for, and complexity of, medical or personal care needs of the child. The need for, frequency, and amount of direct assistance required to care for the child. The types of services needed that are above and beyond what is typically needed for any child.
- Child's behavior: The degree to which the child's behavior is disruptive to or impacts the day-to-day operation of the family, the level of supervision required to keep the child and others safe, and the type and amount of services required to address these behaviors.
- Family composition and stability: The composition of the family, such as a single working parent, the number of siblings, disabilities of siblings, or other family members with disabilities. The level of stability of the family, such as pending divorce, age of parents, and medical condition of parents.
- Access to support networks: The level of isolation or lack of support networks for the family, such as not having extended family nearby, living in a rural area, or availability of providers.
- Access to resources: The family's access to other resources, such as family income, insurance coverage, and other public benefits.

FSSP funding was reduced over several years to address State budget shortfalls and projected over-expenditures in other programs for individuals with intellectual and developmental disabilities. The appropriation was $6,405,926 in FY 2009-10 to serve a minimum of 1,226 families, and is now $3,255,842 in FY 2013-14. FPE is no longer included with the appropriation. The high demand for services through the Family Support Services Program, evidenced by 5,945 families on the FSSP waiting list, far exceeds the available funding.

Proposed Solution:

This request is for $3,406,321 General Fund in FY 2014-15, and beyond to raise FSSP funding to the FY 2009-10 level plus the 4% provider rate increase approved for FY 2013-14.

The alternative is to continue to fund FSSP at the current level. The waiting list reflects 5,945 individuals with developmental disabilities and their families awaiting FSSP services as soon as available or by June 30, 2015. This alternative does not address the unmet needs of the families currently on the waiting list or growth in the number of families that will need services in the coming years. The waiting list for Family Support Services grew 28.8% from 4,679 families in June 2010 to 5,945 families in June 2013. Without Family Support Services, some families may not be able to continue their provision of natural services and supports. Families may be pushed into more restrictive and/or more costly services and assistance.

This request impacts the Department of Health Care Policy and Financing (HCPF). As a result of HB 13 1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, HCBS programs for persons with developmental disabilities included in this request will be managed and supervised by HCPF. A statutory change is not required for this request.

The request is consistent with the HCPF's Strategic Plan Objective 3 - Increase Access to Health Care. FSSP provides funding to those determined most in need, including those people most in need of medical and dental services not available through other means. FSSP covers expenses not covered by Medicaid, other medical or health insurance, or other programs. Examples of expenses funded through FSSP are: medications prescribed by a physician, syringes, feeding tubes, suctioning equipment, catheters, lodging and food expenses incurred during out-of-town medical treatment, or long distance telephone calls to arrange or coordinate medical services.

Anticipated Outcomes:

Family Support Services for individuals with developmental disabilities enables individuals to continue to live in the community by providing financial resources to help alleviate the pressure on primary caregivers. Approval of this request would enable more families to receive needed financial support. FSSP funds provide the flexibility to quickly adjust to changing events in the life of the family. The FSSP assists the family to meet additional costs associated with the family member's developmental disability. For example, FSSP can assist with the cost of providing care to the individual with a developmental disability over the age of twelve while allowing the primary caregiver to work outside the home, or provide for paid short-term personal care services due to a parent's inability to provide services related to a temporary health issue. Assisting families in these ways helps to stabilize the families; can prevent unwanted out-of-home placement, supports ongoing community integration of the family; and reduces reliance upon "systems" by providing options for one-time or short-term services and supports.

Family Support Services offer:

- A high degree of flexibility and timeliness of response in addressing the wants/needs of eligible families with no ongoing commitment of funds.
- Access to a special reserve of funding on a case-by-case per request basis.
- Locally established processes for prioritization of funds and limitations based on local needs or values.
- Time-limited infusion of services and supports to provide families relief.

Assumptions and Calculations:

Summary of Request FY 2014-15	**Total Funds**	**General Fund**
Total Request	$3,406,321	$3,406,321
NEW ITEM (7) Office of Community Living; (A) Program Costs, Family Support Services	$3,406,321	$3,406,321

The Family Support Services Program appropriations have fluctuated significantly since FY 2007-08. Funds are allocated to CCBs to be used as a pool of funds to serve those in need of support services that cannot be or are not being provided through other programs. The Division does not authorize enrollments or FPE for specified clients for FSSP. Expenditures per family vary widely and are often one-time in nature rather than ongoing. Therefore, the amount of funding does not have a direct correlation to the number of clients that can be served with the funds. The following table shows the history of the FSSP appropriations.

Family Support Services Program Appropriation History

Fiscal Year	Number of Appropriated FPE	Total Appropriated Funds	Amount Per Appropriated FPE
FY 2007-08	1,176	$6,461,550	$5,494.52
FY 2008-09	1,226	$2,168,085	$1,768.42
FY 2009-10	1,226	$6,405,926	$5,225.06
FY 2010-11	None Designated	$3,070,208	N/A
FY 2011-12	None Designated	$2,169,079	N/A
FY 2012-13	None Designated	$2,169,079	N/A
FY 2013-14	None Designated	$3,255,842	N/A

This request is to raise the FSSP appropriation to the FY 2009-10 funding level including the 4% provider rate increase approved for the FY 2013-14 appropriation for total of $6,662,163 ($6,405,926 + $256,237 = $6,662,163). This is an appropriation increase of $3,406,321 General Fund. Expenditures per family vary widely and many are one-time in nature rather than ongoing. Therefore, it is difficult to calculate a number of people or families that will be served or removed from the FSSP waiting list through this request. However, funding this request is anticipated to result in a reduction of the FSSP waiting list for services and supports. The FSSP waiting list history is as follows:

Family Support Services Waiting List	
Fiscal Year	**Waiting List**
FY 2007-08	4,740
FY 2008-09	4,717
FY 2009-10	4,679
FY 2010-11	5,198
FY 2011-12	5,477

Family Support Services Waiting List	
Fiscal Year	**Waiting List**
FY 2012-13	5,931
FY 2013-14	5,941*
FY 2014-15	5,945*

** Includes families indicating that they need services as soon as available and by FY 2013-14, or by FY 2014-15. Growth of new families needing services has not been projected into these waiting list numbers.*

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Long-Term Services and Supports for Individuals with Complex Medical Conditions
Priority Number: R-15

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/24/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information		FY 2013-14		FY 2014-15		FY 2015-16
		1	2	3	4	5
	Fund	Appropriation FY 2013-14	Supplemental Request FY 2013-14	Base Request FY 2014-15	Funding Change Request FY 2014-15	Continuation Amount FY 2015-16
Total of All Line Items	**Total**	8,492,552	-	6,660,552	125,000	-
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	62,500	-
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	62,500	-
(1) Executive Director's Office (A) General Administration General Professional Services and Special Projects	**Total**	8,492,552	-	6,660,552	125,000	-
	FTE	-	-	-	-	-
	GF	2,507,418	-	1,547,418	62,500	-
	GFE	-	-	-	-	-
	CF	568,500	-	562,500	-	-
	RF	-	-	-	-	-
	FF	5,416,634	-	4,550,634	62,500	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

Cost and FTE

- The Department requests $125,000 total funds, $62,500 General Fund in FY 2014-15.

Link to Operations

- The Department's Hospital Back-Up program serves as placement for medically-complex clients who can be discharged from a hospital but require high level skilled nursing facility care.
- The program fails to incorporate modern medical and technological advances to their best use to allow clients with more severe conditions to receive care in alternative settings.
- The Hospital Back-Up program is currently the only option for providing this level of care, creating a gap in the continuum of care as there may be more appropriate alternatives available.

Problem or Opportunity

- The Hospital Back-Up program provides treatment designed for the highest-acuity patients but lacks incentives for providers to do more than maintain patients' health.
- Although ventilator weaning success rates can range from 38% to 67%, the Hospital Back-Up program does not actively incentivize ventilator weaning.
- The Department has pediatric clients who require these services but currently may not access them.
- The current design of the program does not include mechanisms for incentivizing providers to contain costs or induce optimal patient outcomes.
- The Department does not have clinical staff, so a program addressing the gaps in the continuum of care is more complex than the Department can undertake without third-party study and outreach.

Consequences of Problem

- The Department pays approximately $250,000 per client per year to Hospital Back-Up program providers, who are required to provide the highest level of service despite some patients having a lower level of need (as required by rule).
- Because there are no intermediate options, clients may become long-term ventilator-dependent when their ventilator use might otherwise be reduced and perhaps ultimately eliminated.

Proposed Solution

- The Department requests $125,000 in one-time funding to hire a contractor to analyze the current Hospital Back-Up program and address gaps in coverage offered by current programs.
- The contractor would examine performance-based reimbursement mechanisms predicated on client outcomes and explore "mobile health homes" that follows clients to more appropriate placement.
- An infrastructure that supports inter-facility communication and cooperation would reduce the number of hospital readmissions and improve overall health outcomes.

Department Priority: R-15
Request Detail: Long-Term Services and Supports for Individuals with Complex Medical Conditions

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Long-Term Services and Supports for Individuals with Complex Medical Conditions	$125,000	$62,500

Problem or Opportunity:

The Department's Hospital Back-Up (HBU) program provides treatment designed for the highest-acuity patients but lacks incentives for providers to do more than maintain clients' health. Therefore, in order to pursue optimal health goals for its clients, the Department recommends reforming the HBU program to provide a continuum of options for every level of health need that a client might possess, while also constantly striving for the health improvement of clients with a focus on quality of life enhancement.

Originally proposed to reduce medical costs, the HBU program serves as a placement for ventilator-dependent and medically-complex clients who need to be discharged from a hospital but require a higher level of skilled nursing care than is currently available in any other clinically appropriate setting. The HBU program provides treatment to only the highest acuity patients, often focusing on life support systems such as mechanical ventilators rather than life-improving programs such as ventilator weaning. The program is currently the only option for this level of care but, designed over twenty years ago with no incentives to move patients to lower-acuity settings, does not always incorporate modern medical and technological advances to their best use to allow individuals with severe conditions to receive care in alternative settings, or to improve medical conditions to the point that such intensive care is no longer necessary to sustain their lives.

Numerous areas within the program would benefit from redesign so that patients can enjoy optimal health outcomes and the Department can reduce avoidable costs. The ideal system supports an infrastructure that facilitates communication and cooperation among acute care hospitals, the HBU program providers, skilled nursing facilities, home and community based long-term care, and other alternatives in levels of care, which would reduce the number of hospital readmissions after discharge through a more cohesive continuum of care that ensures patients receive appropriate care at all times. Such communication between different levels of health care providers along the continuum of care would also ensure that clients attain the optimal level of health care for their needs quickly, reducing risks involved with placement in settings that are higher-acuity than necessary. For example, communication between skilled nursing facilities, HBU

program providers, and acute care hospitals could lessen incidences such as clients receiving early tracheotomies in acute care and hospital settings that might have been avoided by waiting as little as ten days to give patients the opportunity to self-wean from ventilators, avoiding complications involved with the procedure as well as the need for extra medical care and stress to the client.

The HBU program's client population is small and complex, making it very difficult to evaluate. True evaluation would require expertise in the medical conditions that are most common in the population, as well as the full scope of care options available and how best to incentivize facilities to achieve optimal health outcomes. Because the Department does not have clinical staff and the design of the program requires clinical-based outcomes and benchmarks, addressing the programmatic design and deficiencies of the HBU program is a more complex venture than the Department is able to efficiently accomplish without third-party expertise and outreach.

Proposed Solution:

The Department requests $125,000 total funds, $62,500 General Fund, in one-time funding in FY 2014-15 to hire a contractor to analyze the current design of the HBU program and address issues associated with potential gaps in coverage offered by the Department's existing programs. Because the population served by the HBU program is so complex, program redesign requires outside expertise. The contractor would examine performance-based reimbursement mechanisms predicated on client outcomes and would explore the implementation of a "mobile health home" model that follows ventilator-dependent and medically-complex clients from a hospital or HBU program provider to more appropriate placement. Additionally, the contractor would assist the Department with extensive stakeholder outreach to ensure this vulnerable population's needs are fully addressed.

An incentive program that focuses on patient outcomes would foster strict standards of quality and ensure that every effort would be made at the provider level to connect patients with the appropriate level of care for their needs. For example, although ventilator weaning success rates can range from 38% to 67%, the HBU program does not actively incentivize ventilator weaning. When appropriate, however, ventilator weaning can greatly improve patient quality of life while at the same time reducing such risks as long-term ventilator dependence and ventilator-related pneumonia, and is therefore a goal worth pursuing in the interest of client health and well-being. A program that rewards providers for accomplishing ventilator weaning for their clients, while following safe practice procedures and standards of quality, would hold all providers to the same expectations of excellence in achieving optimal health outcomes and quality of life for each patient.

Further, gaps exist in the current continuum of medical care that a well-designed HBU program could potentially address. Some patients, such as pediatric clients, who require a level of care appropriate for the HBU program are not currently able to access services outside of the hospital setting. Likewise, a comprehensive training program for client family members would enable clients to enjoy more success in home-based care and reduced likelihood of hospital readmission, resulting in drastic improvements in quality of life and health. Evaluation and redesign of the HBU program would fulfill such goals as more efficient guidelines for cost negotiation or standardized costs, incorporation of the most modern technologies available for complex wound care, and standards of care to ensure that patients achieve the

best health outcomes possible. A full analysis would identify all areas where improvement could reduce health care costs, support better health outcomes, and ensure more efficient delivery of long-term care service.

Anticipated Outcomes:

The contractor would provide the information necessary to reach the ultimate goal of a redesigned HBU program that focuses on cost containment and patient outcomes by connecting each client with the right level of care for that client's needs, rather than the client remaining in a high-acuity setting indefinitely. This course of action furthers the Department's Performance Plan objectives of containing health care costs, improving health outcomes, and improving the long-term care service delivery system by resolving inefficiencies inherent in the current HBU program.

Medicaid patients would achieve optimal patient outcomes and quality of life through treatment that focuses on improving health conditions to the point that clients could transition to lower acuity settings, simultaneously allowing the Department to significantly reduce the current cost of approximately $250,000 per client per year for each patient that successfully transitions to a lower acuity setting. Further health benefits and cost reduction would stem from fewer incidences of hospital readmission after discharge as well as intermediate health options that focus on the gradual reduction and possible elimination of ventilator use, lowering the risk of ventilator related pneumonia and long-term ventilator dependence. Once a new system is in place, the Department would account for any savings achieved using the regular budget process. However, because it may take several years to implement, the Department has not included any estimate of savings in this request.

Assumptions and Calculations:

Based on past contracting experience, the Department assumes a contract rate of $125 per hour and approximately 1,000 hours for a total request of $125,000 to develop a robust proposal for redesign of the HBU program and assisting the Department with stakeholder engagement activities.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing

Request Title: New Operational and Membership Funds for the Division for Developmental Disabilities

Priority Number: R-16

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/24/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 6 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	1,764,066	-	1,738,183	172,002	172,002
	FTE	-	-	-	-	-
	GF	733,525	-	789,074	86,001	86,001
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	86,001	86,001
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	1,764,066	-	1,738,183	172,002	172,002
	FTE	-	-	-	-	-
	GF	733,525	-	789,074	86,001	86,001
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	86,001	86,001

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A

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

Schedule 13s from Affected Departments: N/A

Other Information: Pursuant to HB 13-1314, the Division for Developmental Disabilities will be transitioned from the Department of Human Services to HCPF as of March 1, 2014. Therefore, the line items impacted by the request will be reflected in the Department of Health Care Policy and Financing.

COLORADO
Department of Health Care Policy and Financing

Priority: R-16
New Operational and Membership Funds for the Division for Developmental Disabilities
FY 2014-15 Change Request

Cost and FTE

- $172,002 total funds, including $86,001 General Fund in FY 2014-15 and beyond

Link to Operations

- The Division for Developmental Disabilities (DDD) is the state office that provides leadership and oversight for the direction, funding and administration of long term care services in the community for children and adults with developmental disabilities.

Problem or Opportunity

- The Division needs funding to participate in the State Employment Leadership Network (SELN), which provides access to resources for improving employment outcomes for people with developmental disabilities who are enrolled in day services; and, in National Core Indicators (NCI), which provides public developmental disabilities agencies the ability to measure and track their own performance, compare results across states and establish national benchmarks.
- The Department does not have the resources to fund training and travel for staff presence at national conferences and public forums to address updates to rules and policies; for staff training and professional development; or the full number of Program Quality Reviews needed for ongoing provider surveys, licensing or certification.

Consequences of Problem

- Ongoing efforts to improve employment outcomes for people with disabilities may be impeded without access to the tools offered by SELN.
- Colorado received one-time NCI grant funding for FY 2013-14, and without continued funding, will miss the opportunity to further capitalize on the NCI data measurement project.
- The Division has been unable to provide appropriate representation at national trainings and conferences; and program quality provider surveys have not been funded at adequate levels.

Proposed Solution

- The Department requests $35,000 for SELN membership, which advances integrated employment that can enhance an individual's sense of self-worth, increase economic well-being and allow greater independence by improving their daily living skills.
- The Department requests $69,102 for NCI membership, which will be instrumental in the identification of service delivery trends, policy planning and strategic development.
- Funding of $67,900 is requested for training and travel costs that will enhance employee professional development and program management, for Program Quality Review travel costs for 4 FTE, and staff presence at public forums and national conferences.

Department Priority: R-16
Request Detail: New Operational and Membership Funds for the Division for Developmental Disabilities

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
New Operational and Membership Funds for the Division for Developmental Disabilities	$172,002	$86,001

Problem or Opportunity:

Pursuant to HB 13-1314, administration of long-term services and supports in the Division for Developmental Disabilities will transfer effective March 1, 2014 from the Department of Human Services to HCPF, Office of Community Living, as the Division of Intellectual and Developmental Disabilities. For purposes consistency and clarity, the Division will most often be referred to by its current name, the Division for Developmental Disabilities (DDD, or the Division) throughout this request. DDD is the state office that provides leadership and oversight for the direction, funding and administration of long term care services in the community for children and adults with intellectual and developmental disabilities. There are 36 FTE allocated to the Division for Developmental Disabilities.

The Division requires funding to participate in two strategic networks:

1) The State Employment Leadership Network (SELN), which provides access to resources for improving employment outcomes for people with developmental disabilities who are enrolled in day services; and,
2) National Core Indicators (NCI), which provides public developmental disabilities agencies the ability to measure and track their own performance, compare results across states and establish national benchmarks.

Additionally, the DDD does not have the resources to sufficiently fund training and travel for staff presence at national conferences and public forums to address updates to rules and policies; for staff training and professional development; or the full number of Program Quality Reviews needed for ongoing provider surveys, licensing or certification.

State Employment Leadership Network:
DDD funded membership in SELN in 2006, but could not continue funding due to budget restraints. As a result, the DD Council took up the funding as a way to continue to focus attention on Supported

Employment and to receive technical assistance from a group that has a nationwide perspective. However, the DD Council will not continue funding membership in the SELN because its Five Year Plan will be updated and employment will not likely be a priority. Additionally, the Council has lost $41,000 due to sequestration and funds for SELN will not be available.

Participation in SELN provides training and collaboration opportunities to improve outcomes in employment, including individual customized employment. The Division is currently engaged in a performance management strategy to increase the number of participants receiving Supported Employment.

Currently, DDD examines the performance measure titled *Participants Receiving Supported Employment in Group and Individualized Settings.* The goal of this measure is to increase the number of participants receiving Supported Employment in group and individualized settings to 23% among those adults in the community with developmental disabilities who are enrolled in day services. Performance trends from calendar year 2012 to the first six months of 2013 have shown improvement, ranging from 19.3% to 22.4% in 2012, and peaking at 24.5% as of June 2013. The DDD has surpassed the 23% goal for improving Supported Employment outcomes and has exceeded the national Supported Employment average of 20.3%.

Recently, a more targeted performance measure was introduced titled *Participants Receiving Supported Employment in Individualized Settings.* This measure focuses on efforts to customize employment opportunities and serve individuals in the most integrated setting possible. The goal of this measure is to increase the number of participants receiving Supported Employment in individualized settings to 13% among those adults in the community with developmental disabilities who are enrolled in day services. This goal was set based on data obtained through the SELN. Performance trends from calendar year 2012 to the first six months of 2013 have been stable, ranging from 8.5% to 9.3%. Participation in SELN will be an important tool to meet this goal.

National Core Indicators:

The NCI core indicators are standard measures used across the states to assess the outcomes of services provided to individuals and families, including employment, rights, service planning, community inclusion, choice, and health and safety. Colorado was invited by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) to participate in the NCI project. In turn, Colorado received one-time grant funding in the amount of $29,820 to assist DDD in covering the costs of the first year of data collection and will join approximately 35 other states already participating in this project. DDD received notification in May 2013 that Colorado was accepted to participate in the NCI program. Colorado will be participating in the 2013-14 data collection cycle that runs during FY 2013-14.

The data collected as part of this project would supplement and complement the Division's efforts to measure performance outcomes centered on employment. Data obtained through participation in NCI will also expand the Division's ability to capture other personal outcomes including service planning, community inclusion, choice and health and safety. Colorado's participation in the NCI project has been vetted through DD system stakeholders, including families, advocates, providers and Community Centered Boards (CCBs) and has received favorable support.

Training and Travel Costs:
The Division does not have the resources to fund DDD staff presence at public forums to provide up-to-date information sharing with stakeholders, Community Centered Boards (CCBs) and the public. These meetings are critical as public and stakeholder input is required before new or modified waiver operations and other associated changes can be implemented. The Division has the responsibility to gather public and stakeholder input related to rules and policy changes.

Due to funding constraints in the Operating Expenses line, DDD has been unable to provide appropriate Division representation at National trainings and conferences that provide information on national trends, upcoming and ongoing federal initiatives related to Home and Community Based Services waivers and financial management tools. This has resulted in the DDD staff being behind on the most current national trends, data and training opportunities that are instrumental to staff development of program expertise. Staff training and development is needed to assist with professional development to improve productivity, cost-effectiveness and quality of program administration.

Program Quality Surveys have not been funded at adequate levels. Therefore, staff has not been able to conduct the appropriate number of surveys, which may result in the Division being out of compliance with the provider survey schedule included in the HCBS Waiver.

Proposed Solution:

This request is for $172,002 total funds, including $86,001 General Fund, in FY 2014-15, FY 2015-16 and beyond, 0.0 FTE, for the Operating Expenses line item as outlined below. The request does not require a statutory change. The request includes:

- $35,000 for the membership fee for the State Employment Leadership Network (SELN);
- $69,102 for participation in National Core Indicators (NCI) data collection and measurement project;
- $67,900 for travel costs to 8 public forums to address updates to rules, policies and procedures; training costs for registration fees, materials, and travel expenses; Program Quality Review travel costs to conduct initial and ongoing provider surveys and provider licensing or certifications.

The request will impact the Department of Health Care Policy and Financing (HCPF). Pursuant to HB 13-1314, administration of long-term services and supports in the Division for Developmental Disabilities will transfer effective March 1, 2014 from the Department of Human Services to HCPF, Office of Community Living, as the Division of Intellectual and Developmental Disabilities.

State Employment Leadership Network:
The requested funding will allow DDD to continue SELN membership and maintain access to resources that will help to create and maintain community connections and stability for the well-being of individuals with intellectual and developmental disabilities through employment. Integrated employment can enhance an individual's sense of self-worth, increase economic well-being and allow them to gain greater independence by improving their daily living skills. The sharing of strategy and information on best

practices around Supported Employment will make the Division more knowledgeable in their efforts to impact the current performance measure.

Annual membership is required for participation in all network events. The membership will be managed by the Division for Developmental Disabilities (DDD) and includes opportunities for stakeholders statewide to participate in membership benefits. Membership in SELN impacts service delivery by providing networking, training and technical assistance opportunities directly to Supported Employment service providers. Service delivery providers learn about best practices and innovative strategies for customizing employment from peers across the nation. This results in higher quality service provision and positive employment outcomes for people receiving Supported Employment services, with a focus on individualized, customized employment. Also, participation in SELN positively impacts the DDD staff workload as staff has access to immediate training and technical assistance which increases expertise, along with nationwide best practices, decreasing the need for staff to conduct independent research. Additionally, staff benefits from the expertise of the national SELN team in anticipating future trends, requirements and expectations of federal agencies so as to design programs and policies accordingly.

The consequences of not funding this request is that DDD would not participate in SELN. While ongoing efforts to improve employment outcomes for people with developmental disabilities would continue without the resources that SELN offers, progress could be impeded or significantly slowed without access to these tools.

National Core Indicators:
NCI would be instrumental in facilitating collaboration between state developmental disabilities (DD) agencies on the identification of service delivery trends, policy planning and development of mutual strategies to improve the well-being of those receiving services. Performance data on service outcomes make it possible to determine the success of DDD services and programs in the lives of the DD community.

The alternative is to not fund this request. The State of Colorado would miss the opportunity to continue participation in the NCI data measurement project. The collection of valid and reliable data and cross collaboration between Colorado, other state DD agencies and the developmental disability network is vital to the successful identification of service delivery trends, policy planning, and the development of mutual strategies to improve the well-being of those receiving services.

Training and Travel Costs:
The request will fund DDD staff training, in-state travel for staff to participate in public forums to receive public input and discuss updates or changes at the DDD, out of state travel for national conferences and travel for Program Quality staff to conduct initial and ongoing provider surveys and provider licensing or certifications for providers of services identified in the Medicaid Home and Community Based Services (HCBS) waivers.

Service delivery and program performance is directly linked to the ability of DDD staff to communicate with stakeholders. DDD staff presence and participation in public forums that elicit public input is a requirement prior to the implementation of new or modified waiver operations. Staff participation in public forums is also an essential step in keeping CCBs, providers, parents and stakeholders informed with the

latest information regarding developmental disabilities programs as well as understanding the needs of the DD community.

DDD participation in federally sponsored trainings and conferences will support the success of the Division because it will provide staff with the most up-to-date information on federal rules and regulation changes, best practices, national trends and new and ongoing federal initiatives. In addition, professional development for DDD staff would improve not only technical aptitude and skills, but would also improve non-technical and interpersonal activities such as supervisory training. A skilled supervisor can help improve morale, lower turnover and reduce grievances. Program quality surveys provide performance data on service outcomes that make it possible for DDD to determine the extent to which the valuable services provided and state laws are manifest in the lives of those served.

The alternative is to not fund this request, limiting the Division's participation in public forums, staff training and development to administer long term care programs, and program quality reviews.

Anticipated Outcomes:

State Employment Leadership Network (SELN):

The outcomes of funding and participation in SELN will be measured by the performance measure related specifically to supported employment – *Participants Receiving Supported Employment in Group and Individualized Settings and Participants Receiving Supported Employment in Individualized Settings.* The DDD will also measure outcomes based on feedback and input provided through the evaluations that are completed following the SELN Webinars and Employment Roundtables. The Department will know if the membership in SELN has been successful by monitoring the SELN/Employment Workgroup's implementation of the work plan and successful completion of the action steps therein. The SELN/Employment Workgroup is comprised of a cross representation of DD stakeholders.

National Core Indicators (NCI):

Participation in the NCI project would improve the performance of the programs in the Division by utilizing nationally recognized standardized outcome measures to better measure and evaluate the performance and effectiveness of the developmental disabilities (DD) system in Colorado. The data obtained through this project will assist the Department in identifying service gaps or DD systems issues, and support improvements to policy, processes and quality improvement efforts as well as federally required quality and evaluation activities for the Medicaid waiver programs.

The funding request indirectly relates to the Performance Measure "*Participants Receiving Supported Employment in Group and Individualized Settings.*" The data obtained will provide valuable information by which providers can identify areas for improvement so appropriate remedies can be implemented, such as person centered training.

Training and Travel Costs:

This funding will allow the Division to provide required ongoing staff presence at public forums to communicate program information essential to stakeholders. DDD staff attendance at national trainings and conferences will provide staff with essential implementation information related to new federal rules

and regulations and federal initiatives that will be at the forefront of internal planning, policy, and procedural discussions. Appropriate funding levels for ongoing program quality provider surveys of services provided under the Home and Community Based Services waivers will provide the data necessary to strengthen the services that improve the lives of persons with disabilities. Professional development for employees will improve productivity, quality and management of programs to further strengthen Colorado's ability to administer key long term services and supports programs.

Assumptions and Calculations:

State Employment Leadership Network (SELN)

This membership fee is determined by SELN, a joint program of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Institute for Community Inclusion at the University of Massachusetts Boston (ICI).

National Core Indicators (NCI)

The total costs of $69,102 to participate in the NCI data measurement project include:

- $13,380 Annual Participation Fee – this fee covers the analysis of the data and preparation of state and national reports.
- $40,000 Face-to-Face Consumer Survey and Data Entry– this includes face-to-face interviews with 400 survey participants and data entry for the same, estimated to cost $100 per participant.
- $3,422 Mail-In Adult Family, Family Guardian, and Child Family Surveys.
- $1,800 Business Reply Envelope (BRE) Return Survey charges from Mail-In Adult Family Survey, Family Guardian Survey, and Child Family Surveys – it is estimated that of the 3,600 surveys sent to participants, up to 77% will be returned. The postage charge for each returned BRE is $0.65.
- $10,500 Data Entry and Survey Processing costs for returned Adult Family Survey, Family Guardian Survey, and Child Family Survey – it is estimated that it will cost approximately $3,500 per survey category to process and complete data entry.

Training and Travel Costs:

The total costs of $67,900 to increase Operational Funds for DDD are:

- $9,600 Travel Costs – this includes costs for a minimum of 4 FTE to travel statewide to attend approximately 8 public forums to address updates and/or changes to rules, policies and procedures. This is estimated to cost $300 per employee.
- $34,000 Training Costs – this includes training costs for 34 FTE, estimated to cost $1,000 per participant. This amount of $1,000 would cover various training registration fees and materials, conference registration fees and travel expenses.
- $24,300 Program Quality Reviews - this includes travel costs for 4 FTE to conduct initial and ongoing provider surveys and provider licensing or certifications, for providers of services identified in the Medicaid Home and Community Based Services waivers. This includes a total of 45 hotel overnights per staff person estimated at $84 per night and daily meal per diem estimated at $51 per day.

Schedule 13
Funding Request for the 2014-15 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Computer Replacement and Office Software
Priority Number: R-17

Dept. Approval by: Josh Block 11/1/13 Date

OSPB Approval by: 10/29/13 Date

- [x] Decision Item FY 2014-15
- [ ] Base Reduction Item FY 2014-15
- [ ] Supplemental FY 2013-14
- [ ] Budget Amendment FY 2014-15

Line Item Information	Fund	FY 2013-14 1 Appropriation FY 2013-14	FY 2013-14 2 Supplemental Request FY 2013-14	FY 2014-15 3 Base Request FY 2014-15	FY 2014-15 4 Funding Change Request FY 2014-15	FY 2015-16 5 Continuation Amount FY 2015-16
Total of All Line Items	**Total**	1,764,066	-	1,738,183	322,982	322,982
	FTE	-	-	-	-	-
	GF	733,525	-	789,074	161,491	161,491
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	161,491	161,491
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**Total**	1,764,066	-	1,738,183	322,982	322,982
	FTE	-	-	-	-	-
	GF	733,525	-	789,074	161,491	161,491
	GFE	-	-	-	-	-
	CF	131,410	-	63,057	-	-
	RF	23,910	-	23,910	-	-
	FF	875,221	-	862,142	161,491	161,491

Letternote Text Revision Required? Yes: ☐ No: ☑ **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: N/A
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

COLORADO
Department of Health Care Policy and Financing

Cost and FTE

- The Department requests $322,982 total funds, $161,491 General Fund and $161,491 federal funds; this is an 18.6% increase to the Department's appropriation for Operating Expenses.

Link to Operations

- In order to continue operating efficiently, the Department replaces outdated computer equipment and renews software licenses with Governor's Office of Information Technology (OIT) oversight.
- Replacing computers and updating software avoids unnecessary delays and downtime and reduces software and hardware compatibility issues with stakeholders, clients, and vendors.

Problem or Opportunity

- The Department has no dedicated funding for replacing computers or annual licensing of an office software suite like the Microsoft Enterprise Agreement (EA).
- When funding is appropriated for new staff, the Department receives a one-time appropriation for hardware and software; this does not allow for license renewals or hardware replacement.
- The Department aims to replace computers after five years, requiring approximately 90 computers replacements annually; the Department cannot consistently achieve this goal because there is no dedicated funding for this purpose.

Consequences of Problem

- Without dedicated funding for computer replacements, the Department risks having to use outdated computers, which cause inefficiencies due to hardware failure, slow speeds and downtime, decreasing vendor support, and risking incompatibility with new technology and external entities.
- Without dedicated funding for office software licensing, the Department cannot maintain and update office software to take advantage of new functionality that increase efficiencies, benefiting Medicaid client care and Department business function.
- Because the Department has no dedicated funding for this purpose, expenditure for computer replacements limit the Department's ability to use its operating funds for other priorities such as stakeholder outreach.

Proposed Solution

- The Department requests $120,871 to ensure computers are consistently replaced every five years and thus avoid the inefficiencies introduced by outdated computers.
- The Department requests $202,111, ongoing, to ensure adequate and consistent funding of the Department's EA – this allows for maintaining essential office software, updating to the latest version for new functionality, and working closely with OIT to ensure IT security.

Department Priority: R-17
Request Detail: Computer Replacement and Office Software

Summary of Incremental Funding Change for FY 2014-15	Total Funds	General Fund
Computer Replacement and Office Software	$322,982	$161,491

Problem or Opportunity:

The Department currently lacks dedicated funding for repairing and replacing computer and network hardware and renewing software licenses. As a result, the Department's hardware and software environment is inadequately maintained, exposing the Department to the inefficiencies caused by aged hardware and outdated software

The Department maintains computers for all staff and other hardware necessary for a functional computing and networking environment such as monitors, printers, internet protocol (IP) phones, routers, switches, and power supplies. These resources are integral in daily business functions, and the Department aims to regularly repair or replace aged or damaged hardware to avoid the wide-spread inefficiencies of aged hardware such as crashes, downtime, lost data, unpredictable behavior, and compatibility issues.

The Department has licenses for Microsoft Office for all staff as a general-purpose office software suite and additional licenses for specialized software such as Microsoft Office Project and statistical analysis software such as SAS. Microsoft Office is central to daily operational functions such as preparing documents and presentations and analyzing data. Specialized software is utilized by staff for essential Department operations, such as advanced project management capabilities and statistical analysis. The Governor's Office of Information Technology (OIT) oversees all purchases of hardware and software and all these purchases are made according to pricing agreements between OIT and its vendors.

When the Department receives appropriations to hire additional staff, it receives one-time funding for the necessary initial hardware and software purchases for the staff, but does not receive dedicated, ongoing funding for the repair and replacement of the hardware or renewal of the software licenses. The Department has set aside existing operating funds to repair and replace hardware and renew software licenses; however, with other priorities for the Department's operating budget, the Department has been unable to set aside enough existing operating funds to consistently achieve this goal.

This lack of ongoing funding has resulted in the Department waiting to replace hardware and software until absolutely necessary. This means waiting until hardware is broken or aged past its expected lifetime to

repair or replace it, resulting in unplanned downtime while new hardware is installed or extended periods of time with substandard hardware. This also means using outdated software, such as outdated releases of Microsoft Office software, resulting in network instability and security problems due to decreasing vendor support of older products, and lost opportunities for efficiencies afforded by new software functionality. The Department's lack of dedicated funding for hardware and software replacement has also resulted in one-time requests such as the Department's FY 2012-13 S-7 "Server Upgrade and SharePoint Assessment," in order to supplement the operating funds when necessary.

Proposed Solution:

The Department requests an increase of $322,982 total funds (an 18.6% increase over the Department's FY 2014-15 Operating Expenses base request), ongoing, to replace Department computers on a five-year schedule and to maintain updated licensing for Microsoft Office for all staff. This solution relieves the strain on the operating budget described above and will allow the Department to consistently keep all the hardware and software resources fully functional and current. Keeping hardware functional and current avoids inefficient use of staff time due to the delays and workarounds inherent with aged hardware. Keeping software licenses current avoids compatibility issues between outdated and current versions of the software and increases functionality in updated versions of the software. The Department would continue to use its existing operating budget for other needed hardware replacements and software licenses that are not common to all Department staff.

If this request is not approved, the Department will continue to function within a substandard hardware and software environment, exposing the Department to the inefficiencies caused by aged hardware and outdated software. This strain will worsen beginning this fiscal year due to additional need including nine new FTE added to the Department by FY 2013-14 R-6 "Additional FTE to Restore Functionality," 34 new FTE added by HB 13-1314, which transfers the Division for Developmental Disabilities from the Department of Human Services to the Department, 19 new FTE added by SB 13-200, and a computer lab recently created to help fulfill county training functions under HB 12-1339. Since computers and the Microsoft Office software licenses are integral resources to the Department's daily operations and service delivery, it remains a high priority and would compete with other priorities in the operating budget, such as stakeholder outreach, or require continued one-time requests to supplement the operating budget.

Anticipated Outcomes:

If funding is approved, the Department would be able to implement a five-year replacement policy; this would allow the Department to replace its oldest computers annually, so that every computer is replaced when it becomes five years old. Further, the Department would be able to keep its Microsoft Office software licenses current for all staff each fiscal year. For both computers and Microsoft Office software, the Department expects to utilize OIT oversight and pricing agreements.

The success of this approach can be measured by decreases in requests made by the Department to OIT for hardware issues, increased efficiencies at the end-user level through utilization of updated software, and decreases in one-time budget requests to supplement operating funds for hardware and software purposes.

Assumptions and Calculations:

Table 1 in the attached appendix gives an overview of the funding requested. The Department assumes the Centers for Medicare and Medicaid Services (CMS) will provide a 50% federal financial participation (FFP) rate for costs.

Tables 2 and 3 in the attached appendix provide detailed calculations of the estimated cost of the Department's computer replacement plan. The Department assumes one computer is needed per staff member and assumes the total number of staff equals all current permanent and temporary staff (based on the August 2013 payroll) plus permanent staff to be added to the Department this fiscal year. The Department also assumes that computers are needed in the Department's computer labs for testing and training, and are needed for an on-hand inventory to accommodate events such as a sudden computer break or short-term increase in temporary staffing. The Department assumes that computers will be replaced on a staggered five-year basis and that replacement computers would be laptops, per current Department policy, with a price based on the average cost of current OIT-approved laptops.

Table 4 in the attached appendix provides detailed calculations of the estimated cost for software licensing. To calculate the funding request for Microsoft Office software, the Department assumes one license will be needed for each computer. The Department assumes that the Microsoft Office 365 product will be used, with a price based on current OIT pricing agreements. In addition to the per user licensing costs, there are multiple other components to the Microsoft Office 365 solution, including annual Bridge Access licensing costs for network functionality, and annual Exchange Management and SharePoint development costs for ongoing maintenance and development.

Table 1 - Total Request for FY 2014-15 and Ongoing					
Item	**Total Funds**	**General Fund**	**Federal Funds**	**FFP**	**Explanation**
Annual computer replacement cost	$120,871	$60,435	$60,436	50%	From Table 2, Row C
Annual Microsoft Office cost	$202,111	$101,056	$101,055	50%	From Table 4, Row F
Total Request	**$322,982**	**$161,491**	**$161,491**	**50%**	

Table 2 - Annual Computer Replacement Cost			
Row	**Item**	**Amount**	**Explanation**
A	Average cost of laptop	$1,162.22	Per current OIT pricing agreements
B	Number of computers to replace annually	104	From Table 3, Row J
C	**Annual computer replacement cost**	**$120,871**	**Row A * Row B**

Table 3 - Department Computer Need		
Row	**Item**	**Number of Computers Needed**
	Staff computers	
A	Current permanent staff	353
B	Approved additional permanent staff[1]	67
C	Current temporary staff	38
D	**Subtotal: Staff computers**	**458**
	Computer labs and other computers	
E	Department human resources testing & training computer lab	12
F	HB 12-1339 county training computer lab	30
G	On-hand inventory computers	20
H	**Subtotal: Computer labs and other computers**	**62**
I	**Total number of Department computers (Row D + Row H)**	**520**
J	**Number of computers to replace annually on 5-year replacement schedule (Row I / 5)**	**104**

[1] Includes positions to be filled per FY 2012-13 R-5 "Medicaid Fee-for-Service Payment Reform," HB 12-1281, FY 2013-14 R-6 "Additional FTE to Restore Functionality," FY 2013-14 R-11 "HB 12-1281 Departmental Differences Reconciliation," Denver Health nursing state plan amendment, SB 13-167, SB 13-200, SB 13-242, and HB 13-1314 as well to be removed per SB 13-267

Table 4 - Annual Microsoft Office Software Cost			
Row	**Item**	**Amount**	**Explanation**
	Per-user licensing costs		
A	Annual cost per Microsoft Office 365 license	$240	Per OIT pricing agreements
B	Annual cost per Bridge Access license	$14.06	Per OIT pricing agreements
C	Total number of licenses needed	520	From Table 3, Row I (One license per computer needed)
D	**Total annual licensing cost**	**$132,111**	**(Row A + Row B) * Row C**
E	Annual Exchange management and SharePoint development cost	$70,000	Per OIT pricing agreements; single annual cost for the Department
F	**Total annual Microsoft Office software cost**	**$202,111**	**Row D + Row E**