Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-01 Medical Services Premiums

Dept. Approval By: _____

OSPB Approval By: _____

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**$307,654,186**	**$810,719,647**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	$118,712,084	$276,890,478
	CF	$983,543,298	$0	$984,608,781	$111,034,880	$182,792,648
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	$77,907,222	$351,036,521

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**$307,654,186**	**$810,719,647**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	$118,712,084	$276,890,478
	CF	$983,543,298	$0	$984,608,781	$111,034,880	$182,792,648
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	$77,907,222	$351,036,521

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2019-20, FY 2020-21, and FY 2021-22 Budget Request

November 2019

TABLE OF CONTENTS

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $21.0 million under the FY 2019-20 appropriation in total funds, including an increase of $47.0 million in General Fund. The decrease in total funds is driven primarily by decreases in caseload – the Department reduced the caseload forecast for almost every eligibility category. The most significant changes in the caseload projection is for the expansion adults (a decrease of 7.09%). The increase in General Fund is driven primarily by increases in per capita costs. The Department increased the per capita cost forecast for almost every eligibility category. The most significant change in the per capita cost projection is for the elderly and individuals with disabilities categories (an increase of 8.7%).
- Community-Based Long-Term Care – The current request is approximately $5.8 million under the FY 2019-20 appropriation in total funds, including a reduction of $1.8 million in General Fund. The reduction is primarily driven by reductions in projected enrollment in community-based long-term care programs and utilization of private duty nursing.

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. The Department's request identifies, and in some cases amends, the fiscal impact of various State and federal policy changes 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 reduction's fiscal impact can 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.

2. 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% federal medical assistance percentage (FMAP) while Family Planning Services receive a 90% FMAP. Breast and Cervical Cancer Program (BCCP) services are matched at 65% FMAP. Medicaid expansion populations receive a different match rate than existing populations. Expansion Adults to 133% and the MAGI Adults populations, for instance, receive a 91.5% FMAP in FY 2019-20 and a 90.0% FMAP in FY 2020-21 and ongoing as the federal match for these populations falls from 93% to 90% in January 2020. The former CHP+ population that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of approximately 65% with an additional 23 percentage point FMAP increase through September 30, 2019; the enhanced FMAP is expected to be 79.38% in FY 2019-20, 67.88% in FY 2020-21, and 65.00% in FY 2021-22 ongoing.

3. 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 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.

4. The State's FMAP for Medicaid services is 50% in FY 2019-20. Data from the Colorado Population Forecast, the U.S. Census, and the Legislative Council is used to estimate the FMAP for FY 2020-21 and FY 2021-22 at 50.00%. These changes are outlined in Exhibit R. Medicaid administrative costs will also continue to receive 50.00% Federal Financial Participation (FFP). If the FMAP changes from Department estimates, the Department would submit a supplemental funding request to account for the change in federal funds. More information can be found about the FMAP estimates in Exhibit R.

5. The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until December of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously. The FY 2018-19 actuals contained within this request reflect data for FY 2018-19 as of August 15, 2019.

6. In FY 2016-17, the Department overcollected approximately $132 million in drug rebates. The Department anticipates that FY 2017-18, FY 2018-19, and FY 2019-20 drug rebate payments from manufacturers will be less to account for the overcollection in the previous fiscal year.

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 the caseload forecast is complete, 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 person with disabilities 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 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 expenditure data 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 that 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 and 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
- Other Medical Services
- Acute Home Health

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: Children's Home-and Community-Based Services Waiver
- 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: Children with Life Limiting Illness

- Home-and Community-Based Services: Spinal Cord Injury
- Private Duty Nursing
- Long-Term Home Health
- 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
- Accountable Care Collaborative
- Prepaid Inpatient Health Plan Administration

Financing:

- Healthcare Affordability and Sustainability Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing
- Outstationing Payments
- Other Supplemental Payments

Note that for services in the Community Based Long-Term Care, 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 current year expenditure from page EA-2. 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 request year expenditure from page EA-3. 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 out year expenditure from page EA-4. 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 typically around 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service (FFIS) each year and is based on a statewide per capita earnings formula that is set in federal law. In October 2014, the FMAP for Medicaid services increased to 51.01% and then ramped down each year until it returned to 50.00% beginning October 1, 2017. For more information about historic FMAP and FMAP changes, see Exhibit R.

Certain populations and services receive different FMAPs than the new standard 50.00% that begins October 2017, summarized in the table below. Clients who transitioned from CHP+ to Medicaid under SB 11-008 and SB 11-250 receive the CHP+ FMAP, which is approximately 65%. Section 2105(b) of the Social Security Act further modifies the enhanced FMAP for CHP+ clients, including clients who transitioned from CHP+ to Medicaid and are funded under Title XXI, by an additional 23 percentage points, effective October 1, 2015 through September 30, 2019. The enhanced FMAP steps down to 11.5 percentage points effective October 1, 2019 before returning to 65% effective October 1, 2020, per the HEALTHY KIDS Act. Therefore, FMAP for clients who transitioned from CHP+ to Medicaid receive 79.38% FMAP in FY 2019-20, 67.88% in FY 2020-21, and 65.00% in FY 2021-22. Clients in the BCCP program also receive a 65% match. The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 93% beginning January 1, 2019, which falls to 90.00% beginning January 1, 2020, resulting in a final FMAP of 91.50% for these populations for FY 2019-20 and 90.00% for FY 2020-21 and FY 2021-22. However, any Community-Based Long-Term Care waiver services for these individuals must be claimed at the standard match as they are not eligible to receive the enhanced FMAP. A sub-group of MAGI Adults, non-newly eligible individuals with disabilities, receive the ACA expansion FMAP for 75% of their expenditure and the standard FMAP for the remaining 25%, resulting in an effective FMAP of 81.13%, 80.00%, and 80.00% for FY 2019-20, FY 2020-21, and FY 2021-22 respectively. The Disabled Buy-In population receives the standard match for expenditure net of patient premiums.

Calculation of expenditure by financing type can be found in Exhibit A and calculation of FMAP can be found in Exhibit R.

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
FY 2019-20	79.38%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP program	Please see Exhibit F
	91.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	81.13%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2020-21	67.88%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	90.00%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	80.00%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2021-22	65.00%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	90.00%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	80.00%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2019-20	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2020-21	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2021-22	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	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.

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. Most 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 typically receives a 65.00% FMAP. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the state's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund.

- Family Planning: The Department receives a 90% FMAP available for all documented family planning expenditure. 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%. Please see Exhibit F for calculations.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the number 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. 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 the recommended services without cost-sharing.

- Non-Emergency Medical Transportation (NEMT): These services receive the administrative federal financial participation (FFP) rate of 50% rather than the various service FMAP rates. This entry adjusts the fund splits between federal and state funding to properly account for this service receiving FFP.

- 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 6 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). FMAP for these clients remains at the same level as if the clients had enrolled in Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%. Section 1205(b) of the Social Security Act increases the enhanced FMAP by an additional 23 percentage points, effective October 2015 through September 2019 and stepping down to 76.5% until October 2020. Therefore, FMAP for this population for FY 2019-20, FY 2020-21, and FY 2021-22 is expected to be 79.38%, 67.88%, and 65.00% respectively.

- 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) 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. The Department received permission from the Centers for Medicare and Medicaid Services (CMS) to continue receiving a higher match rate for this population, including

Section 1205(b) of the Social Security Act, similar to the population under SB 11-008 "Aligning Medicaid Eligibility for Children". Therefore, FMAP for this population for FY 2019-20, FY 2020-21, and FY 2021-22 is expected to be 79.38%, 67.88%, and 65.00% respectively.

- MAGI Parents/Caretakers 69% to 133% FPL: This population began participation in Medicaid in FY 2009-10 and is funded with a combination of federal funds and HAS Fee. 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 MAGI Parents/Caretakers 69% to 133% of the federal poverty line receive a 100% federal match rate through the end of CY 2016, effective January 1, 2014, with ramp down every year until it reaches 90% effective January 1, 2020. See Exhibit J for additional information and detailed calculations.

- MAGI Adults: This population began participation in Medicaid in FY 2011-12 and was previously labeled Adults without Dependent Children (AwDC). The population is funded with a combination of federal funds and HAS Fee. SB 13-200 amended the Medicaid eligibility criteria for MAGI Adults 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 from CY 2014 through CY 2016 with ramp down every year until it reaches 90% effective January 1, 2020. However, waiver services for this population receive the standard FMAP and not the enhanced FMAP per CMS. Calculations and information regarding this population can be found in Exhibit J.

- Continuous Eligibility for Children: HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, beginning March 2014, even if the family experiences an income change during any given year. The Department has the authority to use the HAS Fee Cash Fund to fund the State share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives the standard federal financial participation rate. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department has broken this population out in its respective service categories to better show the impact of continuous eligibility for children. Calculations and information regarding this population can be found in Exhibit J.

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

- Non-Newly Eligibles: MAGI Parents/Caretakers 69% to 133% FPL and MAGI Adults are funded with a combination of federal funds and HAS Fee. As explained above under those categories, the Affordable Care Act provides both populations with a 100% federal match rate, effective January 1, 2014, though it ramps down over time beginning in CY 2017. A caveat of this enhanced federal match rate is that the expansion population cannot have been eligible for Medicaid services prior to 2009 (or else those individuals are not considered part of the Medicaid expansion population). A subset of the population may have been eligible for Medicaid services prior to 2009 under disability criteria, had the clients chosen to provide asset information when they applied for Medicaid services. For this population, the Department is unable to prove that these clients would not have been eligible for Medicaid services prior to 2009 if they had provided asset information, and therefore cannot claim the full enhanced expansion FMAP on their expenditure. These clients are now eligible for Medicaid under the expansion, and receive FMAP determined by a resource proxy with the State portion funded through the HAS Fee, as required by statute. The Department can claim 75% of the expenditure for Non-Newly Eligible clients at the enhanced expansion FMAP and the remaining 25% at standard FMAP. Please refer to Exhibit J for calculations and additional details.

- MAGI Parents/Caretakers 60% to 68% FPL: Parents/Caretakers over 60% FPL are funded with a combination of federal funds and HAS Fee. As explained above, the Affordable Care Act provides MAGI Parents/Caretakers 69% to 133% FPL with a 100% federal match rate, effective January 1, 2014, with a ramp down beginning January 1, 2017. Due to new MAGI conversion rules (please refer to the Caseload Narrative for additional details), the non-expansion eligibility category MAGI Parents/Caretakers to 68% FPL now includes FPL levels over 60%. The MAGI Parents/Caretakers to 68% FPL clients who have FPL levels over 60% are funded with HAS Fee for the State's contribution, rather than General Fund, as required by statute. Please refer to Exhibit J for calculations and additional details.

- Adult Dental Benefit Financing: SB 13-242 created a limited dental benefit for adults in the Medicaid program, implemented 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. Please refer to Exhibit F for calculations and additional details.

- HB 16-1408 State Plan Autism Treatment: CMS denied the Department's request to expand the Children with Autism Waiver, which was authorized through HB 15-1186. CMS directed the Department to provide behavioral therapy services deemed medically necessary under EPSDT. HB 16-1408 increased the General Fund offset for these services, funded through the Colorado Autism Treatment Fund. Effective with the November 2016 request, the Department accounts for the state plan costs under Acute Care rather than under Community Based Long-Term Care Services.

- 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 federal financial participation (FFP) and certain individuals with limited resources qualify as a "Qualified Individual", which receives 100% FFP. In aggregate, the Department estimates that approximately 17.58% of the total will receive no FFP, 76.91% of the total will receive 50% FFP, and 5.51% will receive 100% FFP. These assumptions are held constant in FY 2019-20, 2020-21, and in FY 2021-22.

- Tobacco Quit Line: The Tobacco Quit Line is administered by the Department of Public Health and Environment (DPHE); the Department pays for the share of costs for the quit line related to serving Medicaid members. The costs are administrative and therefore receive FFP rather than the applicable FMAP by eligibility category.

- Upper Payment Limit Financing: Offsets General Fund as a bottom-line adjustment to total expenditure. 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 expenditure in excess of the current reimbursement methodology. Prior to FY 2017-18, these payments were made with certified public expenditure. Going forward, these payments are to be made with General Fund. The FY 2019-20, FY 2020-21, and FY 2021-22 estimates account for payments under the new RMTS methodology, with retroactive payments built into the estimate for FY 2019-20.

- Hospital Supplemental Payments: Hospital payments are increased for Medicaid hospital services through a total of five supplemental payments, three 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 payments is to increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL), and to create hospital quality incentive payments that reward hospitals for enhanced quality, health outcomes and cost effectiveness.

- 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.

- Physician Supplemental Payments: Federal funds are drawn to reimburse Denver Health and the Memorial Health Systems in Colorado Springs for physician services provided in excess of the current reimbursement methodology. The Department retains 10% of the federally matched dollars as a General Fund offset. The FY 2019-20, FY 2020-21, and FY 2021-22 totals are based on the total amounts Denver Health and Memorial Health Systems were able to certify in prior fiscal years.

- Hospital High Volume Payment: Colorado public hospitals that meet the definition of a high volume Medicaid and Colorado Indigent Care Program (CICP) Hospital qualify to receive an additional supplemental reimbursement for uncompensated inpatient hospital care for Medicaid clients. To meet the definition of a high volume Medicaid and CICP Hospital a hospital must be: licensed as a General Hospital by the Department, classified as a state-owned government or non-state owned government hospital, a High Volume Medicaid and CICP hospital, defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000 and whose Medicaid and CICP days combined equal at least 30% of their total inpatient days, and maintain the hospital's percentage of Medicaid inpatient days compared total days at or above the prior State Fiscal Year's level. Historically, Memorial Health has been the only hospital to qualify for this payment.

- 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. The FY 2019-20, FY 2020-21, and FY 2021-22 estimates are based on the amounts assumed in the February 15, 2019 forecast.

- Intergovernmental Transfer for Difficult to Discharge Clients: Privately owned nursing facilities are eligible for receiving supplemental Medicaid reimbursements for costs incurred treating medically complex clients, such that the sum of all Medicaid reimbursement remains below the Upper Payment Limit for privately-owned nursing facilities. To be eligible for these payments, nursing facilities must be privately owned; enter into an agreement with the discharging hospital regarding timelines and initial plans of care for the affected medically complex patients; and provide long-term care services and supports in the least restrictive manner for medically complex clients residing in an inpatient hospital setting for whom no other suitable discharge arrangements are available. The transfer is an annual payment of $1,000,000 total funds, increasing to $1,400,000 in FY 2018-19 and ongoing, with the State share being transferred through Denver Health & Hospital Authority. The State Plan Amendment (SPA) associated with this program has been approved by CMS and the Department began making payments in FY 2017-18.

- Denver Health Ambulance Payments: Federal funds are drawn to reimburse Denver Health for ambulance services in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund; the Department retains 10% of the federally matched dollars as a General Fund offset. The FY 2019-20, FY 2020-21, and FY 2021-22 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Emergency Transportation Provider Payments: Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. Because these providers receive public funds, the Department has an opportunity to obtain a federal match on expenditures made by public entities. Implementation of a certified public expenditure (CPE) program for public ground EMT providers would allow the Department to make supplemental payments to public (EMT) providers for EMT services to Medicaid clients Pursuant to 42 CFR § 433.51, public funds may be considered as the State's share in claiming federal financial participation when the public funds are certified by the contributing public agency as representing expenditures eligible for federal financial participation. EMT service providers eligible to participate in this program would receive supplemental reimbursement payments by completing a federally approved cost report form. The supplemental reimbursement payment is based on claiming federal financial participation on CPEs that have already been incurred by the public provider. To be eligible for the reimbursement, the CPE cannot be claimed at any other time to receive federal funds under Medicaid or any other program. The supplemental reimbursement amount is determined by a methodology approved by Centers for Medicare and Medicaid Services (CMS).

- University of Colorado School of Medicine Payment: Originally approved under SB 17-254, the Colorado Legislature approved a transfer of $77 million funds from the University of Colorado School of Medicine (UCSOM) to the Department for FY 2019-20, FY 2020-21, and FY 2021-22, to gain access to federal matching funds. The Department then would reimburse UCSOM approximately $155 million through a UPL payment for physician services.

- Cash and Reappropriated Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash and reappropriated fund transfers. Starting in FY 2016-17, the General Fund offset from the Old Age Pension Health and Medical Care Fund comes entirely from reappropriated funds based on JBC approval of JBC staff recommendations. This methodology ensures that the full $10 million authorized by Colorado's constitution can be allocated to people who qualify for services from the Old Age Pension Medical Program and that these funds are not tied up in another line.

  The table below shows the impact by cash fund for FY 2019-20, FY 2020-21, and FY 2021-22.

Cash and Reappropriated Funds	FY 2019-20	FY 2020-21	FY 2021-22
Tobacco Tax Cash Fund (SB 11-210)	$2,038,515	$2,021,580	$2,021,580
Healthcare Affordability and Sustainability Fee Cash Fund (SB 13-230) - Upper Payment Limit Backfill	$15,700,000	$15,700,000	$15,700,000
Old Age Pension Health and Medical Care Fund (SB 13-200)	$9,769,438	$9,769,438	$9,769,438
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$27,708,413**	**$27,691,478**	**$27,691,478**

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1997-98 through FY 2020-21. 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 through EB-6 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2008-09 through FY 2018-19.

A description of the forecasting methodology for Medicaid caseload, including all adjustments, is 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. Per capita trends can be affected by changes in caseload, utilization of services, and service costs.

For FY 2002-03 through FY 2008-09, expenditure for the Prenatal State-Only program are included in the Non-Citizens aid category. The Prenatal State-Only program allows legal immigrants that entered the United States after August 22, 1996 to have State funded

prenatal care and Emergency only Medicaid benefits for labor and delivery. This expenditure is included in the MAGI Pregnant Adults aid category beginning in FY 2009-10. HB 09-1353 was passed in FY 2009-10, which allowed legal immigrants that have lived in the United States less than five years to qualify for Medicaid as pregnant adults, Medicaid children, or CHP+ clients, provided there is available funding. Funding for Medicaid pregnant adults was available July 2010. The population that was Prenatal State-Only now represents pregnant adults that are eligible under HB 09-1353. This expenditure is still included in the MAGI Pregnant Adults aid category. Funding for Medicaid children was available July 2015.

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 in 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, I, and J and caseload information from Exhibit B.

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 expenditure 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 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. 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 and out-year per capita costs, although the Department adjusts the selected trend where necessary.

Percentages selected to modify per capita costs are calculated to assess the percentages considering 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 2019-20 and FY 2020-21. The selected trend factors for each year, with the rationale for selection, are as follows:

Aid Category	FY 2019-20 Per Capita Selection	FY 2020-21 Trend Selection	Justification
Adults 65 and Older (OAP-A)	4.61%	1.15%	The Department selected a lower trend relative to the February request. For the request and out years, the Department selected a positive trend to account for large increases in co-insurance expenditure for this category.
Disabled Adults 60 to 64 (OAP-B)	3.28%	0.82%	The Department selected a lower per capita trend to the February request. The Department anticipates the per capita of this population will continue to grow.

Aid Category	FY 2019-20 Per Capita Selection	FY 2020-21 Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	3.67%	0.92%	The Department selected a higher per capita trend relative to the February request. Use of prescription drugs and physician services is high in this population. CMS projects per capita drug spending will increase between 4% and 6% annually from 2016 through 2024.
Disabled Buy-in	4.23%	1.03%	The Department selected a higher per capita trend relative to the February request. The positive trend for this population is primarily driven by prescription drugs, physician services, and inpatient hospital expenditure.
MAGI Parents/ Caretakers to 68% FPL	1.14%	0.57%	The Department selected a lower per capita trend relative to the February request. The Department anticipates the per capita of this population will grow based on increases physician services expenditure.
MAGI Parents/ Caretakers 69% to 133% FPL	2.22%	1.11%	The Department selected a higher per capita trend relative to the February request. The Department anticipates the per capita of this population will continue to grow based on historical growth in per capita costs.
MAGI Adults	0.98%	0.49%	The Department selected a higher per capita trend relative to the February request. The Department anticipates the per capita of this population will continue to grow at a very low rate.

Aid Category	FY 2019-20 Per Capita Selection	FY 2020-21 Trend Selection	Justification
Breast and Cervical Cancer Program	11.66%	5.83%	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.
Eligible Children (AFDC-C/ BCKC-C)	4.51%	1.13%	The Department selected a lower per capita trend relative to the February request. The Department selected a positive trend based on the growth in physician services and inpatient hospital expenditure. The Department anticipates the per capita of this population will continue to grow.
SB 11-008 Eligible Children	1.61%	0.81%	The Department selected a higher per capita relative to the February request. The Department has selected a positive trend in the request and out years based on increases to physician service expenditure.
Foster Care	2.13%	1.07%	The Department selected a lower per capita trend relative to the February request. The Department selected a positive trend based on the growth in physician service and inpatient hospital expenditure. The Department anticipates the per capita of this population will continue to grow.
MAGI Pregnant Adults	1.11%	0.56%	The Department selected a higher per capita relative to the February request.
SB 11-250 Eligible Pregnant Adults	1.11%	0.56%	The Department selected a higher per capita trend relative to the February request. The trend for this category is tied to MAGI Pregnant Adults, as the Department assumes similar utilization within these populations.

Aid Category	FY 2019-20 Per Capita Selection	FY 2020-21 Trend Selection	Justification
Non-Citizens	1.23%	0.62%	The Department selected a lower per capita relative to the February request. The Department anticipates the per capita of this population will continue to grow.
Partial Dual Eligibles	2.90%	1.45%	The Department selected a higher per capita trend relative to the February request. The Department has selected a flat trend as per capita growth is expected to level out. This population's growth in per capita cost is driven primarily by large expenditure in co-insurance.

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:

- FY 2019-20 R-13 Community Provider Rate Increase (1.0% Across-the-Board), incorporates the acute care impact of the 1.0% across-the-board increases approved during the 2019 legislative session. The rate increases are effective as of July 1, 2019.
- FY 2019-20 R-13 Community Provider Rate Increase (Targeted Maternity), incorporates maternity rate increases to 80% of the Medicare rates. The rate increases are effective as of July 1, 2019.
- FY 2019-20 R-13 Community Provider Rate Increase (Targeted Transportation), incorporates transportation rate increases for specific Emergency and Non-Emergency Transportation services. The rate increases are effective as of July 1, 2019.
- FY 2019-20 R-13 Community Provider Rate Increase (Other Targeted Rate Increases), incorporates rate increases for specific Trachea Prothesis, Polysomnography, and Aquatic Therapy services. The rate increases are effective as of July 1, 2019.
- FY 2019-20 R-13/JBC Action Community Provider Rate Increase (Targeted Anesthesia), incorporates transportation rate reductions to 120% of the Medicare benchmark for Anesthesia Services. The rate increases are effective as of July 1, 2019.
- FY 2019-20 R-13 Community Provider Rate Increase (Targeted Lab and Pathology), incorporates rate reductions for Lab and Pathology services. The rate increases are effective as of July 1, 2019.
- FY 2019-20 R-13 Community Provider Rate Increase (Targeted Diabetes Test Strips), incorporates rate reductions for Diabetes Test Strips. The rate increases are effective as of July 1, 2019.

- FY 2019-20 R-6 Local Administration Transformation – The Department received $700,000 for FY 2019-20 and $1,966,848 in FY 2020-21 to implement three initiatives that would improve county performance and accountability, increase incentive funding and oversight, remove NEMT administration from county administration responsibilities, and consolidate returned mail processing.
- FY 2019-20 R-12 Medicaid Enterprise Operations, accounts for recoveries resulting from a scan of the Department's entire data warehouse looking for recoverable overpayments and cost-avoidance opportunities that have never been identified by recovery contractors.
- FY 2019-20 R-15 Operational Compliance and Program Oversight, accounts for savings that will result from eligibility audits.
- JBC Action: Increasing Dental Cap to $1500, accounts for the increased costs related to increasing the annual cap on dental expenditure for adults from $1000 to $1500.
- JBC Action: Medicaid Fraud Inspectors, adjusts for the additional savings that the Department will achieve as a result of the Department of Law hiring additional staff to investigate fraudulent activity at Medicaid.
- Annualization of Copay 5% of Income, adjusts for the additional amount the Department will need to pay providers to comply with a federal rule stating that copays cannot exceed 5% of a Medicaid client's income. The legacy MMIS was unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new interChange system, implemented March 1, 2017, will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department needs to reimburse providers for the full cost of the service without subtracting copay for these clients.
- Annualization of SB 17-267 Sustainability of Rural Colorado – Increased Copays, accounts for the decrease in the Department's payment for services due to collection of greater copays. SB 17-267 stipulates copays for pharmacy must be at least double the average amount paid by recipients in state fiscal year FY 2015-16 and copays for hospital outpatient services must be at least double the amount required to be paid as specified in Department rules as of January 1, 2017, subject to federal law. As of January 1, 2018, copays for pharmacy are $3.00 and are $4.00 for hospital outpatient services.
- Annualization of SB 17-091, Allow Medicaid Home Health Services in the Community, expands where home health services can be received. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional acute home health services in the community. The Department demonstrated compliance with this rule starting July 1, 2017 through SB 17-091 which removed language from statute stipulating a home health services must be received "in the home."
- Annualization of State Plan Autism Treatment adds in the cost of providing autism services through EPSDT to Acute Care and removing the impact from Community Based Long-Term Care (CBLTC).
- Annualization of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Adjustment for Children's Extensive Support (CES) Waiver, accounts for the transition of costs previously delivered under the CES waiver to EPSDT per CMS instruction.

- Annualization of HB 18-1328, Redesign of the Children's Habilitation Residential Program (CHRP), this bill moves the administration of the CHRP waiver from the Department of Human Services (DHS) to the Department and is expanding the eligibility criteria to include children with very severe Intellectual and Developmental Disabilities (IDD) needs that are also living at home as well as in foster care. Services that are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) under CHRP will now be paid from Acute Care.
- SB 10-117, Over the Counter (OTC) Medications allows for pharmacists to prescribe certain over-the-counter drugs to Medicaid Clients. The program reduces expenditure by reducing costlier visits to the emergency room or physicians for over-the-counter prescriptions. The Department anticipates necessary MMIS systems edits will be in place by November 1, 2018 to reimburse pharmacists for their prescribing services.
- Annualization of SB 16-027, Medicaid Option for Prescribed Drugs by Mail, allows Medicaid clients to receive maintenance medications through the mail, regardless of physical hardship or third-party insurance status as previously required by SB 08-90. As many maintenance medication prescriptions delivered by mail come in ninety-day supplies, the Department anticipates a shift towards receiving medications in larger supplies. This shift would result in a decrease in prescription drug expenditure due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.
- Annualization of Repay Overcollection of Drug Rebates in FY 2016-17, accounts for adjustments to FY 2017-18 drug rebate collections due to voided pharmacy claims from the legacy system being billed to drug manufacturers in FY 2016-17. Manufacturers did not claim the entirety of their credit in FY 2017-18 and the Department expects to receive $81.3 million less in rebates in FY 2018-19.
- Annualization of HB 18-1322 Long Bill, Provision for 12 Month Supply of Contraceptives, will allow pharmacists to fill a 12-month supply of birth control after an initial 3-month trial dispensing, which will increase the number of total contraceptives dispensed by allowing women to pick up a year-long supply of contraceptives.
- Annualization of FY 2018-19 R-10 Drug Cost Containment Initiatives, The Department was appropriated administrative funds to implement a prior authorization system on physician administered drugs and hire a contractor to help with designing an alternative payment methodology for drugs, particularly those that fall under the categories of high-cost and specialty. The Department anticipates prior authorization of physician administered drugs began in January 2019 and result in decreased utilization.
- Annualization of Outpatient Specialty Drug Carveout, accounts for an emergency rule made by the Department that will be retroactively effective starting in August 2018. The Department is updating the pricing methodology for certain specialty drugs delivered in the outpatient hospital setting. Under the emergency rule, the Department will reimburse hospitals for 50% of actual invoiced drug costs; this percentage increases to 72% if the drugs have a value-based agreement.
- Annualization of FY 2017-18 R-7 Oversight of State Resources – Physician Administered Drugs, incorporates the impact of changing the reimbursement rates of physician administered drugs to an average of 2.5% over the average sales price (ASP) and the cost avoidance associated with members no longer needing to receive this service at higher cost outpatient facilities. Due to more

competitive reimbursement in the physician setting, the Department anticipates patients will be matched to more appropriate drugs and less physicians will advise members to receive drugs in a hospital setting. The Department implemented this methodology earlier than anticipated, on July 1, 2017.

- Annualization of FY 2017-18 R-7 Oversight of State Resources – Client and Provider Investigations, accounts for the expected increase in recoveries due to hiring dedicated staff in the Department's Program Integrity section to investigate client and provider fraud.
- Annualization of Client Over-Utilization Program, accounts for a lock-in program starting July 1, 2018. This initiative originally sought to increase enrollment to 200 clients in the Client Overutilization Program (COUP) by 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 targets the abuse of prescription medication, inappropriate use of emergency room and/or physician services. The Department implemented COUP on July 1, 2018, but anticipates lower enrollment than originally requested.
- Annualization of SB 17-254 Long Bill – Community Provider Rate Increases (1.402% Across-the-Board), incorporates the acute care impact of the 1.402% across-the-board rate increases approved during the 2017 legislative session. Though the Department was not officially appropriated an amount for physician services that are not associated with codes that received a rate increase through HB 16-1408, the adjustment includes an estimated impact for these services. The rate increases are effective July 1, 2017, except for rate increases to services provided under HCBS waivers. Rate increases associated with HCBS waivers are effective October 1, 2017 and are accounted for in Exhibit G.
- Annualization of SB 17-254 Long Bill – Targeted Rate Increase – Transportation, accounts for a 7.01% targeted rate increase to transportation services, including emergency transportation, non-emergency transportation, and non-medical transportation offered under HCBS waivers. The rate increases are effective July 1, 2017, except for rate increases to services provided under HCBS waivers. Rate increases associated with HCBS waivers are effective October 1, 2017 and are accounted for in Exhibit G.
- Annualization of SB 17-254 Long Bill – Targeted Rate Increase – Home Health, factors in targeted rate increases to acute home health services, including skilled nursing, physical therapy, occupational therapy, and speech therapy.
- Annualization of FY 2018-19 R-9 Community Provider Rate Increase (1.0% Across-the-Board), incorporates the acute care impact of the 1.0% across-the-board increases approved during the 2018 legislative session. The rate increases are effective as of July 1, 2018.
- Annualization of FY 2018-19 R-9 Community Provider Rate Increase (Targeted Neonatology), incorporates neonatology rate increases to 92% of 2015 Medicare rates. The rate increases are effective as of July 1, 2018.
- Annualization of FY 2018-19 R-9 Community Provider Rate Increase (6.61% Transportation), incorporates targeted increases of 6.61% to NEMT and EMT services. This percentage is the net effect of funds appropriated in HB 18-1322 Long Appropriation Act and HB 18-1321 Efficient Administration Medicaid Transportation. The rate increases are effective as of July 1, 2018.

- Annualization of Compliance with 21st Century Cures Act – DME Rates Adjustment, incorporates the projected decrease in DME rates. Per section 1903(i)(27) of the Social Security Act, there is a limit on the available FFP for state Medicaid fee-for-service expenditure on DME. The 21st Century Cures Act changed the effective date of this requirement to January 1, 2018. This adjustment is based on the total amount that a contractor determined the Department currently reimburses for DME over Medicare rates. The adjustments were made in FY 2018-19.
- Annualization of Set DME Rates According to Medicare, will tie DME rates for certain services to Medicare rates, which are updated annually on January 1st. The policy intends to mitigate the effects of the DME rate decreases resulting from the 21st Century Cures Act.
- Prospective Payment System (PPS) – Rural Health Center Rate Adjustment, incorporates an expenditure increase due to setting prospective payment system (PPS) rates for several rural health centers that did not previously have PPS rates.
- 2017 JBC Action: PT/OT Supplemental Footnote, allows members to receive more than 48-units of physical therapy or occupational therapy services with prior authorization. The adjustment accounts for reimbursement of services beyond the 48-units.
- R-6 (FY 2012-13), Dental Efficiency, reduces expenditure through refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated and revised.
- 2017 JBC Action: Post-Partum Depression Screening, expands maternal depression screening to be billable three times in the first year postpartum under the child's Medicaid ID.
- FY 2017-18 Legislative Action – Elective Circumcisions, incorporates funding for elective circumcisions that was not previously appropriated through SB 17-254, Long Appropriations Bill.
- Circumcision Rate Increase, accounts for an increase in circumcision rates effective March 2018. Circumcision rates had not been updated since 2011.
- Annualization of Deluxe Vision Frames, accounts for the net effect of allowing deluxe vision frames to be reimbursed for reasons of medical necessity. The estimate accounts for an increase in reimbursement relative to standard frames and the expected decrease in frame breakage due to more durable materials.
- Annualization of End State Renal Disease (ESRD) added as an Emergency Medical Condition, accounts for the effect of adding ESRD as an Emergency Medical Condition. This allows for individuals with ESRD who are eligible for Medicaid through Non-Citizens Emergency Services to receive treatment for ESDR in dialysis centers instead of a hospital setting. This results in a decrease in cost to the state from cost avoided from serving patients with ESRD in the hospital. Annualization of HB 16-1408, Allocation of Cash Fund Revenues from Tobacco MSA, accounts for partially maintaining the rate increases authorized under Section 1202 of the Affordable Care Act for specific services through FY 2016-17.
- Annualization of FY 2017-18 R-6 Delivery System and Payment Reform – Primary Care Increase Continuation, continues the primary provider rate increases approved in HB 16-1408.

- Annualization of HB 17-1353, Implement Medicaid Delivery & Payment Initiatives – Primary Care Incentives, incorporates the payment reform primary care incentives, which transitions the FY 2017-18 continuation of HB 16-1408's primary care rate increase into a primary care incentive payment tied to quality and performance metrics.
- Annualization of FY 2017-18 R-6 Delivery System and Payment Reform – Vaccine, accounts for a reduction to expenditure due to annually setting reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the Center for Disease Control and Prevention (CDC).
- Annualization of FY 2018-19 R-8 Medicaid Savings Initiatives – Prior Authorization Requirements (PAR) Savings, will account for savings in Acute Care expenditure from improved utilization management (UM) by implementing new prior authorization requirements (PAR) for several services that are at risk for over utilization.
- Annualization of FY 2018-19 R-8 Medicaid Savings Initiatives – Public Assistance Reporting Information System (PARIS) Savings, accounts for savings from automating a system in Colorado Benefits Management System (CBMS) to identify individuals on the PARIS interstate match file which identifies Colorado Medicaid enrollees who are also enrolled in another state's Medicaid program. The reductions will come from preventing the MMIS from generating certain capitation payments for clients who do not live in Colorado.
- Annualization of FY 2018-19 R-8 Medicaid Savings Initiatives – Non-Emergent Medical Transportation (NEMT) Savings, allows the Department to reduce the amount it spends on public transportation by taking advantage of a Regional Transportation District (RTD) program that will allow the Department to pay half price for bus passes for members through Medicaid's NEMT service.
- Annualization of FY 2018-19 R-8 Medicaid Savings Initiatives – Discounted Bus Tickets, shows the estimated cost to the Department for taking advantage of half-price RTD bus tickets for Medicaid members.
- Annualization of HB 18-1321, Efficient Administration Medicaid Transportation, requires the Department to create and implement a method for meeting urgent transportation needs within the existing NEMT benefit. The adjustment accounts for the increase in utilization of urgent NEMT trips that are scheduled within 48 hours and the increase in the NEMT broker's administrative costs.
- Annualization of HB 17-1353 Implement Medicaid Delivery & Payment Initiative – Substance Use Disorder (SUD) & Serious Persistent Mental Illness (SPMI) Savings through Integration of Care, accounts for estimated savings associated with integrating behavioral and physical health care, especially better care coordination for populations with substance use disorders and serious and persistent mental illnesses.
- Annualization of SB 18-266, Controlling Medicaid Costs, requires the Department to implement new initiatives to control Medicaid expenditures.
- Annualization of Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Additional detail can be found in Exhibit I.

- Annualization of SB 10-167, Colorado False Claims Act increases enrollment in the Health Insurance Buy-In (HIBI) program. As of December 2018, there were 775 enrollees in the program. The Department expects to increase enrollment by approximately 1% per month through FY 2020-21.
- Annualization of 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 service group to the PACE service category.
- Additional Week 53 Pay Period in FY 2019-20, factors in an additional payment period in FY 2019-20. Payments are typically made on the Monday of each week and there are 53 Mondays in FY 2019-20.

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 2019, the General Assembly passed HB 19-1302 which extended the repeal date of the program to 2029. All Breast and Cervical Cancer Program expenditure receives an enhanced federal match rate of approximately 65.00%. Please refer to Exhibit A and Exhibit R for more specific information on the federal match rate for this program.

Beginning January 2017, the age range for clients receiving cervical cancer screening and treatment was expanded to include ages 21 through 39, based on CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion." This change did not have an impact of the anticipated magnitude, and the previous caseload adjustment for this policy change has now been removed as the policy change is incorporated into the trend.

Per Capita Cost

The Department assumes base per capita growth for this population will be higher than recent years based on per capita expenditure for the population in FY 2018-19. With the implementation of the ACA expansion in January 2014 many clients who were eligible through the Breast and Cervical Cancer Program were re-determined as eligible for the MAGI Adult population instead. Per CMS direction, the Department was unable to claim the enhanced ACA FMAP for those clients while they were still actively receiving cancer treatment, and the Department manually moved them from MAGI Adults to the Breast and Cervical Cancer Program category. Based on analysis of affected clients, the Department determined that the clients included in the manual adjustment were no longer receiving cancer treatment and the Department stopped completing the adjustment as of July 2017. The number of clients in the Breast and Cervical Cancer Program is now much lower, but the per capita costs of clients remaining in the program are higher as they are more likely to use high-cost cancer treatment services as evidenced by the growth in per capita in FY 2018-19. Therefore, the Department adjusted the per capita up for FY 2019-20, FY 2020-21, and FY 2021-22.

Fund Splits

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

Adult Dental Cash Fund-eligible Per Capita Detail

In 2013, the General Assembly passed SB 13-242, which established the Adult Dental Benefit program along with the Adult Dental Cash Fund, funded through the Unclaimed Property Tax Fund. The Adult Dental Cash Fund provides the funding for the State share of the Adult Dental Benefit program, for expenditure that would otherwise be funded by General Fund for the State share. In 2014, the General Assembly passed HB 14-1336 which provided funding for the addition of full dentures as part of the Adult Dental Benefit. The Department previously covered dental services for adults only in emergencies or in the case of co-occurring conditions that required dental services. The Department does not have a way to systematically distinguish between dental services received in the case of emergency or co-occurring conditions and those covered under the Adult Dental Benefit. The Adult Dental Cash Fund-Eligible Dental Services Exhibit on pages EF-6 through EF-8 reports total Dental expenditure for populations that have the State share of expenditure funded with the Adult Dental Cash Fund and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate the expenditure that will be funded by the Adult Dental Cash Fund.

The Department forecasted expected expenditure based on the most recent actuals, which were lower than previously forecasted. Therefore, the Department has lowered the forecast for FY 2019-20, FY 2020-21, and FY 2021-22.

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 moved antipsychotic drugs from the Department of Human Services' portion of the budget to the Medical Services Premiums line item of the Department. This expenditure is now included in the Acute Care service group within the Prescription Drugs service category. Exhibit F, pages EF-11 through EF-12, 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. FY 2014-15 resumed growth due to increases in cost, utilization, and caseload, which continued in FY 2015-16. The Department experienced a slight decrease in FY

2016-17 in gross expenditure. In FY 2017-18, there was another significant decrease in gross aggregate and per-capita expenditure due to the brand name preference of Abilify being removed in April 2017, as well as a large decrease in the unit price of aripiprazole (the generic version of Abilify).

Federal Funds Only Pharmacy Rebates

The Patient Protection and Affordable Care Act (ACA) increased the number 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. 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 number of rebates that are federal funds only. Estimates are based on FY 2018-19 data. The trend chosen to forecast rebates each year is based on the average price increase in 2017 of 267 brand name and generic prescription drugs used to treat chronic and acute conditions.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, to claim the enhanced match, the State must 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 about 95% of the family planning services provided to Medicaid clients. Totals listed on page EF-14 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services (CMS) for enhanced federal funds.

In FY 2016-17, the Department received more rebates attributed to Family Planning than it should have, as the result of a rebate payment error. As such, the Department's total reported expenditures are understated and artificially low in FY 2016-17. The Department has trended forward the FY 2018-19 expenditure by a fraction of previous growth rates to reach FY 2019-20, FY 2020-21, and FY 2021-22 estimates.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) 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 American 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.

In FY 2018-19, the Department began partnerships with several hospitals to implement better coordination of services for IHS clients, which will allow the Department to claim the enhanced federal financial participation on more services than is currently allowable. The Department is expected to enter into several more agreements with hospitals in the beginning of FY 2019-20. Because of the anticipated increase in hospital partnerships, the estimated impact was increased in FY 2019-20, FY 2020-21, and FY 2021-22. The Department has also experienced high growth in FY 2017-18 which is believed to be the result of more accurate billing associated with IHS clients coinciding with the implementation of interChange. The forecast for FY 2019-20, FY 2020-21, and FY 2021-22 was adjusted slightly up relative to the February forecast based on YTD costs.

Expenditure by Half-Year

As an additional reasonability check, this section presents previous fiscal years' 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 per capita by six-month period can be quickly compared, and historic per capita costs may be referenced with page EF-1 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, the 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 2015-16, the Department paid HCBS-LTSS waiver claims for an average of 24,994 clients per month. From July 2018 through the June 2019, the Department paid HCBS-LTSS waiver claims for an average of 30,391 clients per month.

Clients receiving CBLTC services currently have access to 10 HCBS waivers, each targeted to specific populations. Of the 10 waivers administered by the Department, 6 are included in the Medical Services Premiums line item and the remaining 4 fall under the Office of Community Living. The HCBS waivers that are included in the Medical Services Premiums line item are referred to throughout this narrative as HCBS-LTSS waivers. The Persons Living with AIDS adult waiver is no longer active and clients were phased into the

Elderly, Blind and Disabled waiver by the end of FY 2013-14. The Children with Autism (CWA) waiver ended operation on June 30, 2018 and the Consumer Directed Attendant Support (CDASS) State Plan Waiver ended operation effective January 1, 2019. Information for the CDASS State Plan waiver and CWA waiver was included in this request but will be removed in future requests. The waivers included in the Medical Services Premiums line item are:

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[1]
- Disabled Children's Waiver
- Consumer Directed Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver[2]
- Spinal Cord Injury Adult Waiver[3]

Calculation of Community-Based Long-Term Care Waiver 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-LTSS 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 the HCBS-LTSS 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 current methodology includes a forecast for each waiver's enrollment, utilizers, and cost per utilizer. Percentages selected to modify enrollment, utilizer, or per-utilizer costs are calculated to assess the percentages considering 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-LTSS waiver differs in eligibility requirements, demographics, and utilization, different trends are used for each waiver. From FY 2012-13 to FY 2014-15, the Department used enrollment from a static caseload report that identified

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

clients as being attributed to waivers. During FY 2014-15, the Department noticed that enrollment was not trending with utilization and that clients reported as enrolled in some waivers were actually enrolled in other waivers based on their claims utilization. Thus, in FY 2015-16, the Department decided to depict waiver enrollment as the average number of clients per month with an active prior authorization (PAR) for services on each waiver since services under waivers cannot be rendered without an active PAR. When the Department launched interChange, procedures for inputting PARs changed which caused delays in entering and approving PARs. These changes led to concerns about the consistency of the PAR data so the Department returned to using number of clients with paid claims per month measure for waiver enrollment in the FY 2018-19 R-1 forecast. The Department believes, however, that the changes have been adopted by case managers and there are no longer concerns about the reliability of PARs. Therefore, the Department has returned to using average monthly PARs as the enrollment measure for LTSS waivers. The Department believes that this measure is the most accurate depiction of waiver enrollment as services under waivers cannot be rendered without an active PAR.

Since the Department is using an enrollment-based methodology to define caseload, a utilization adjustment must be used prior to developing final projected expenditure. The Department has chosen to incorporate more recent FY 2018-19 data on average monthly utilizers to average monthly enrollments to adjust projected expenditure for each waiver. For all waivers, the average utilization factor from the two previous fiscal years was used to adjust final expenditure in FY 2019-20, FY 2020-21, and FY 2021-22.

The selected enrollment, utilization adjustments, and cost per utilizer trend factors for FY 2019-20, FY 2020-21, and FY 2021-22 with the rationale for selection, are below. In most cases, the Department kept the trends for both enrollment and cost per utilizer steady for each of the three years. In situations where trends differ each year, the variation is noted.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Utilizer Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2019-20 through FY 2021-22: 2.51%	FY 2019-20 through FY 2021-22: 3.00%, 1.50%, 1.50% respectively	Enrollment history is steady, growing at an average of just over 4% each year. FY 2018-19 showed slightly lower than anticipated enrollment and the Department projects future growth will be slightly under the historical average. Per utilizer cost history has grown at a little under 6% on average since FY 2008-09. The Department predicts utilization growth will slow in future years as utilization levels off.
Community Mental Health Supports Waiver	FY 2019-20 through FY 2021-22: 3.29%, 1.65%, 3.17% respectively	FY 2019-20 through FY 2021-22: 0%	Enrollment growth is on a steady incline, growing at around 5% each year. After strong growth in FY 2016-17, enrollment has returned to slightly lower than average levels with slower growth in FY 2018-19. Cost per utilizer decreased in FY 2017-18 amid some interChange-related billing issues but grew by over 8% in FY 2018-19 probably due to retroactive fixes to billing. The Department is predicting that current cost per utilizer will continue in forecasted years.

Waiver	Enrollment Trend Selection	Per Utilizer Trend Selection	Justification
Children's Home and Community Based Services Waiver	FY 2019-20 through FY 2021-22: 7.54%, 3.77%, 7.52%	FY 2019-20 through FY 2021-22: 18.92%, 18.92%, 12.68% respectively	Since the Department has made significant efforts to better manage clients waiting for enrollment, waiver enrollment has increased strongly since FY 2011-12. Since FY 2011-12, average annual enrollment growth is around 4.5% with large increases in the past three fiscal years. Only two services are offered on the waiver: In-Home Supportive Services (IHSS) - Health Maintenance Activities and case management. While IHSS is expensive, it is less costly than Long-Term Home Health services. Very large historical growth in per-utilizer costs were driven by IHSS - Health Maintenance Activities client utilization. Per utilizer costs continue to grow as new people join the waiver and existing waiver enrollees shift to IHSS.
Consumer Directed Attendant Support-State Plan	FY 2019-20 through FY 2021-22: N/A	FY 2019-20 through FY 2021-22: N/A	Effective August 2018, CDASS was made available on the SLS waiver, eliminating the need for the Consumer Directed Support – State Plan Waiver. All previous clients left the waiver as of 1/1/2019 and began receiving services either on the SLS or EBD waiver. The Department saw some run out claims through FY 2018-19 but is not expecting claims into FY 2019-20 or future years.

Waiver	Enrollment Trend Selection	Per Utilizer Trend Selection	Justification
Brain Injury Waiver	FY 2019-20 through FY 2021-22: 10.04%, 5.02%, 9.80% respectively	FY 2019-20 through FY 2021-22: 5.02%, 1.76%, 1.76% respectively	Historically there has been slow and steady growth in BI enrollment. However, since FY 2014-15 enrollment growth rates have been increasing each year. Driven by an increase in providers and the number of beds available for the supported living program (SLP), the Department expects waiver enrollment to grow through the out-year. Historic cost per utilizer growth has been just over 0% annually. FY 2017-18 cost per utilizer was much lower than predicted values, in part due to billing issues providers are experiencing. Through FY 2018-19, the waiver recovered from the billing issue and cost per utilizer is returning to historic levels.
Children with Autism Waiver	FY 2019-20 through FY 2021-22: N/A	FY 2019-20 through FY 2021-22: N/A	The waiver expired June 30, 2018 and the Department is not including any expenditure or enrollments in this forecast.

Waiver	Enrollment Trend Selection	Per Utilizer Trend Selection	Justification
Children with Life Limiting Illness Waiver	FY 2019-20 through FY 2021-22: 7.10%, 3.55%, 6.74% respectively	FY 2019-20 through FY 2021-22: 0.00%, 2.94%, 2.94% respectively	Waiver programmatic changes have improved the program, resulting in large growth. Since FY 2016-17, average annual enrollment growth has been 9%. Cost per utilizer growth has been volatile but negative for recent fiscal years, likely due to billing issues. The Department is forecasting 0% growth in FY 2019-20 with small positive growth as utilization picks up and billing issues continue to be reduced.
Spinal Cord Injury Waiver	FY 2019-20 through FY 2021-22: 43.12%, 9.16%, 9.16% respectively	FY 2019-20 through FY 2021-22: 3.02%	Senate Bill 19-197 "Spinal Cord Pilot Alterative Med" reauthorized the waiver for five more years. After removal of the enrollment cap, annual enrollment growth has averaged 47% in the last three fiscal years. Cost per utilizer has been growing steadily with the increased number of waiver utilizers with stronger growth in the past two years. Cost is primarily composed of consumer directed services like CDASS and IHSS. FY 2018-19 cost per utilizer was dampened likely by the recent large increase in enrollment. Once enrollment growth is fully realized the Department applied a steady trend of just over 3% growth.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-enrollee trend factors, the Department adds total-dollar bottom-line impacts to the projected enrollment or expenditure. The following impacts have been included in the Request for Community-Based Long-Term Care:

Expenditure

- 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. The program has seen enrollment expectations decrease due to issues with payment methodology and low rates; however, with recent access changes, enrollment began to increase. The program is coming to an end and can no longer transition clients beginning on January 1, 2020. To address this, the Department decreased the expected enrollment until it is close to zero in the last year of this request. The Department has decreased the cost per client for some CCT services based on actual utilization of recent clients which also decreased the impact to other areas of the forecast. CCT clients enrolling into LTSS waivers are captured in the enrollment trends. These clients, however, are eligible for five services, in addition to waiver services, to aid in their transitions. This bottom line impact accounts for expenditure on those five transition services that clients have access to during their one year of transitioning.
- FY 2018-19 R-7 HCBS Transition Services Continuation and Expansion/HB 18-1326 Support For Transition From Institutional Settings – The Department's R-7 request, and the accompanying bill, moved services previously available under the CCT program to the HCBS waivers and to the Medicaid State Plan. The CCT grant program had been in operation since April 2013 but will expire on December 31, 2020. HB 18-1326 appropriated 5.0 FTE to administer the new program once the CCT grant ends which will provide community transition services and supports to persons who are in an institutional setting, who are eligible for Medicaid, and who desire to transition to an HCBS setting.
- FY 2018-19 R-8 Assorted Medicaid Savings Initiatives: Non-Medical Transportation Bus Pass Savings – This approved request implemented a discounted public transportation option. Through Regional Transit District (RTD), into the Non-Medical Transportation (NMT) benefit for the adult HCBS non-IDD waivers. The request included savings because the Department assumes some NMT utilizers will switch to the public transportation option from more costly options like taxi.
- FY 2018-19 Across the Board 1.00% Rate Increase – The Joint Budget Committee approved a 1.00% across the board rate increase, effective July 1, 2018. The rate increase applies to waiver services that did not also receive a targeted rate increase in FY 2018-19.
- FY 2018-19 Alternative Care Facility 25% Targeted Rate Increase – The Joint Budget Committee approved a targeted rate increase for Alternative Care Facility (ACF) providers effective October 1, 2018.

- FY 2018-19 Personal Care & Homemaker 5.25% Rate Increase – The Joint Budget Committee approved a targeted rate increase for personal care and homemaker services within the adult HCBS non-IDD waivers of 5.25% effective January 1, 2019. These services therefore did not receive the 1.00% across the board rate increase effective July 1, 2018.
- FY 2018-19 Non-Medical Transportation 6.61% Rate Increase - The Joint Budget Committee approved a targeted rate increase for Non-Medical Transportation (NMT) effective January 1, 2019.
- FY 2019-20 53 Weekly Payment Periods: FY 2019-20 includes one more Monday than other fiscal years. Since claims are processed on Mondays, that means there will be one extra payment period during FY 2019-20 that does not occur in other fiscal years. The Department has included a bottom line impact to estimate the effect of the extra payment period in FY 2019-20 and removed it in FY 2020-21.
- FY 2019-20 1% Across the Board Rate Increase: The Joint Budget Committee approved a 1.00% across the board rate increase, effective July 1, 2019. The rate increase applies to waiver services that did not also receive a targeted rate increase in FY 2019-20.
- FY 2019-20 Adult Day Targeted Rate Increase: The Joint Budget Committee approved a targeted rate increase for adult day providers which is expected to be implemented January 1, 2020. The exact targeted rate increase percentage varies by waiver but ranges from 28% to 50%.
- FY 2019-20 Respite Targeted Rate Increase: The Joint Budget Committee approved a targeted rate increase for respite providers which is expected to be implemented January 1, 2020. The exact targeted rate increase percentage varies by waiver and type of respite but ranges from 12% to 52%.
- FY 2019-20 Mental Health Counseling Targeted Rate Increase: The Joint Budget Committee approved a targeted rate increase for mental health counseling providers which is expected to be implemented January 1, 2020. The exact targeted rate increase percentage varies by service setting but ranges from 70% to 78%.
- FY 2019-20 Long Bill Personal Care & Homemaker Rate Increase: As part of SB 19-207 "FY 2019-20 Long Appropriations Bill", the Joint Budget Committee approved a targeted rate increases of 8.11% for personal care and homemaker services as part of In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS).
- SB 19-238 "Improve Wages and Accountability Home Care Workers": SB 19-238 requires the Department to enforce training requirements for a wage pass through to direct home care workers and to increase the rate for agency-based IHSS and CDASS personal care and homemaker services by 8.11%.
- Brain Injury Supported Living Program (SLP) Rate Change: Through the Department's FY 2017-18 R-9 "Long Term Care Utilization Management" request, the Department received funding for a contractor to complete SLP acuity assessments for Brain Injury (BI) clients in order to eliminate a conflict of interest that existed as providers were completing the acuity assessments while providing services to the same clients. As a result, clients have received new acuity scores which factor into the rates SLP providers receive. This adjustment accounts for the budget impact of these new rates which use the new acuity scores completed by a third-party entity instead of providers.

Hospice

Hospice expenditure for FY 2019-20, FY 2020-21, and FY 2021-22 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – is expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. This expenditure represents approximately 74% of total hospice expenditure in FY 2018-19. 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 in two predominant ways: there is no patient payment component of the per diem rate for hospice services, and the per diem for hospice clients is prescribed at approximately 95% of the per diem rate for Class I Nursing Facility clients. Otherwise, the methodology for forecasting nursing facility room and board expenditure for hospice clients mirrors the Class I Nursing Facility forecast.

Hospice nursing facility room and board total expenditure estimates for a fiscal year are the product of forecasted patient days and forecasted room and board per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year. 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. The Department used a time trend model with monthly control variables to estimate FY 2019-20 patient days; this decreased patient days for the fiscal year relative to the February 2019 forecast. This trend estimate assumes patient days will continue to grow at a slow pace due to an increasingly aging Medicaid population. 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 roughly the same 3% per-year rate[4]. 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.

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 (7) in the footnotes section of the hospice forecast.

[4] Because the distribution of patient days across facilities is likely different between class I nursing facility and hospice services, the aggregate rate for hospice might not grow at exactly 3% as outlined in statute.

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 or three times per week, generally by nurses. In FY 2018-19, Hospice Routine Home Care expenditure was approximately $14.3 million and thus represented 84% of Hospice Services expenditure and 21% of total hospice expenditure. Hospice Routine Home Care expenditure is computed as a product of patient days and the daily rate. The Department arrived at estimates for patient days by trending forward total patient days in FY 2018-19 by 2.79% for FY 2019-20 based on YTD actuals and by 2.79% for FY 2020-21 and FY 2021-22; the trends were selected with the assumption that patient days would continue to grow over time. The Hospice Routine Home Care per diem is forecasted by applying approximately a 3.00% trend to daily rates in FY 2018-19 based on the YTD average rate. Starting on January 1, 2016, the Department was instructed by CMS to implement a tiered rate system for Routine Home Care Services. [5] Patient days incurred in the first sixty days of service are billed a higher rate than days incurred beyond the sixty-day threshold.

The next-largest component of hospice services expenditure is Hospice General Inpatient Care. This expenditure is incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2018-19, the Department paid approximately $2.5 million for Hospice General Inpatient Care. The Department estimated FY 2019-20, FY 2020-21, and FY 2021-22 service costs by trending FY 2018-19 expenditure by the percentage change in growth from FY 2017-18 to FY 2018-19.

The remaining components of hospice services expenditure in total represent approximately $140,000 of expenditure based on FY 2018-19 actual expenditure. There is significant variation in these remaining services by fiscal year. The Department estimated that expenditure would decrease slightly into FY 2019-20 and will increase by about 10% in FY 2020-21 and FY 2021-22. Expenditure for this category has fluctuated significantly over the past few years.

Hospice is not normally affected by bottom line impacts, except through items that also affect Class I Nursing Facilities, such as the HB 13-1152 1.5% permanent rate reduction on Nursing Facility core per-diem. However, the current request includes the estimated impact of a rate increase that affects Hospice services other than Nursing Facility Room and Board: the across the board rate increase, which increases the Hospice rate by 1.00%. This increase does not apply to Nursing Facility Room and Board.

[5] For more information, refer to: https://www.colorado.gov/pacific/sites/default/files/2016%20Hospice%20Rates%20and%20Rules.pdf

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 similar rates. PDN rates are based on the Department's fee schedule, and there is no mechanism forcing them to change. During the FY 2018-19 Legislative Session, PDN services received an across the board rate increase to bring the rate up 1.00%. The rate increases were implemented on July 1, 2019.

As PDN expenditure is the product of the units utilized per client, the number of utilizers, and the rate and the Department expects rates to remain constant, expenditure forecasts for FY 2019-20, FY 2020-21 and FY 2021-22 are primarily based on unit per utilizer and utilizer forecasts for those fiscal years. The unit per utilizer and utilizer forecasts are separated into three pieces: RN; LPN; and grouped RN Group, LPN Group, and Blended Group.

Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior average monthly enrollment and utilization/cost per client trend factors, the Department adds total-dollar bottom-line impacts to projected enrollment or expenditure. The following impacts have been included in the Request for Private Duty Nursing:

<u>Expenditure</u>

- Additional Week 53 Pay Period in FY 2019-20: Factors in an additional payment period in FY 2019-20. Payments are typically made on the Monday of each week and there are 53 Mondays in FY 2019-20.
- FY 2019-20 1% Across the Board Rate Increase: The Joint Budget Committee approved a 1.00% across the board rate increase effective July 1, 2019. The rate increase is built into the rate within the forecast.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN)	FY 2019-20: 3.15% and in FY 2020-21 through FY 2021-22 1.58%	FY 2019-20 2.35% and 0.00% in FY 2020-21 through FY 2021-22:	RN average utilizers per month had grown in the double digits from FY 2008-09 to FY 2014-15. This growth slowed in FY 2015-16, when the annual average utilizers per month growth dropped to 4.52%, but increased again in FY 2016-17 with growth for the year of 13.99%. The growth dropped in FY 2017-18 to 8.60%. The Department anticipates that the growth in FY 2016-17 and FY 2017-18 was driven mostly by implementation of interChange, and that the growth has slowed and start to level off. RN units per client have historically decreased; however, in FY 2016-17, there was growth of 13.63% and in FY 2017-18 the Department saw a growth of -9.03% The Department anticipates that this decrease is caused by implementation of interChange, and the units per client will revert to historical levels of utilization. The Department expects growth in units per client to go back to positive and then level off.

Licensed Practical Nursing (LPN)	FY 2019-20: -1.06% and in FY 2020-21 through FY 2021-22 0.00%	FY 2019-20 2.79% and 0.00% in FY 2020-21 through FY 2021-22:	LPN average utilizers per month have grown mostly in the double-digits over time, with an average of 16.86% per year, reaching a maximum historical growth rate of 43.65% in FY 2013-14. In FY 2017-18, average utilizers per month was 13.00%. Average utilizers per month did not grow as fast as the Department's February expectations. The Department anticipates that LPN utilizers growth in FY 2017-18 is due to implementation of interChange. The Department believes this was a one-time spike and assumes a negative trend in FY 2019-20 to bring the number of utilizers back to a more normal level and assumes. The Department anticipates a decrease in trend and utilizer growth will level off in FY 2020-21 ongoing. LPN units per client have historically decreased, The Department assumes that this larger decrease in utilization was due to implementation issues with InterChange and expects the utilization to revert to historical trends. The Department increased its growth trends to 2.79% and then level off.

Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN	FY 2019-20: 2.95% and in FY 2020-21 through FY 2021-22: 1.48%.	FY 2019-20 3.77%, FY 2020-21 2.22% and FY 2021-22 2.18%.	LPN-group, RN-group, and Blended RN/LPN drove 12.72% of total expenditure in FY 2017-18 and represent the smallest number of average utilizers per month. Due to large growth in FY 2017-18 and slow growth in FY 2015-16 and FY 2016-17, the Department assumes growth will level off in FY 2019-20 with a trend of 2.95% and then decrease in future fiscal years to 1.48%. For the grouped and blended PDN services, the growth of units per client has been positive over the last few years but decreased significantly in FY 2017-18. The Department assumes that this decrease in units per client is due to implementation issues with interChange. For this reason, the Department increased the FY 2019-20 trend and then assumed slower growth for FY 2020-21 and FY 2021-22.

Long-Term Home Health

Long-Term Home Health (LTHH) services are deemed necessary by a medical need and are skilled nursing and therapy services that are generally provided in a client's home. LTHH services are either billed hourly or on a visit basis with a maximum number of hours. There are nine services under LTHH that are for both children under 21 and adults: clients under 21 that have a medical need can access Physical, Occupational, Speech and Language Therapies (PT, OT, and S/LT respectively), and all clients have access to Registered Nursing/Licensed Practical Nursing (RN/LPN), Home Health Aid Basic and Extended (HHA), Registered Nursing – Brief first visit of day and Brief Second or More Visit of Day, and telehealth. LTHH rates are based on the Department's fee schedule. During the FY 2019-20 Legislative Session, LTHH services received a 1.00% across the board rate increase. The Joint Budget Committee approved a 1.00% across the board rate increase, effective July 1, 2019. The rate increase is built into the rate within the forecast.

All but one of the services in LTHH are forecast individually using the average monthly service utilizers, the average units per utilizer, and the rate. The rate is assumed to be constant beyond the current year legislative rate increases. Due to low utilization, telehealth is forecasted by total expenditure.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Home Health Aid Basic and Home Health Aid Extended	Home Health Aid Basic: FY 2019-20 through FY 2021-22: 4.80% Home Health Aid Extended: FY 2019-20 through FY 2021-22: 5.09%	Home Health Aid Basic: FY 2019-20 4.50%, FY 2020-21 0.00%, and FY 2021-22 2.50%. Home Health Aid Extended: FY 2019-20 through FY 2021-22: 0.00%.	HHA Basic and HHA Extended account for the bulk of the total FY 2019-20 expenditure. Average utilizers per month for HHA Basic and Extended have steadily increased linearly since FY 2008-09, with a large increase in FY 2017-18. The Department believes that this trend will continue to increase but is assuming a leveling of client growth. HHA Basic units per utilizer growth has been historically positive which the Department continued in the current forecast. HHA Extended units per utilizers decreased significantly in FY 2017-18 because of billing and systems issues. As a result, the Department decreased the FY 2019-20 trend to reach a more normal level and assumed 0.00% growth from there.

Registered Nursing/Licensed Practical Nurse	FY 2019-20 through FY 2021-22: 2.45%,	FY 2019-20 through FY 2021-22: 0.00%,	Average monthly utilizers have grown linearly since FY 2012-13, with a surge of enrollment in FY 2017-18 driven by prior period claim true-up because of the new claim system implementation. Units per utilizer have grown slightly over time with large growth in FY 2017-18 because of claims repayment from systems issues. To account for this the Department reduced the trend to get to a more normal unit amount and assumed 0.00% growth from there.

RN Brief First of Day and RN Brief Second or more	RN Brief First of Day: FY 2019-20 through FY 2021-22: 0.00% RN Brief Second or more: FY 2019-20 through FY 2021-22: 3.00%.	RN Brief First of Day: FY 2019-20 2.90%, FY 2020-21 0.00%, and FY 2021-22 2.80%. RN Brief Second or more: FY 2019-20 and FY 2021-22:and 0.00%.	For RN Brief First of Day, the Department chose a trend of 0.00% for average monthly utilizers. There was a large increase in the number of utilizers because of the claims system implementation in FY 2017-18 but the Department assumes this will move back to a more normal growth rate. The large increase in utilizers drove the units per utilizer down in FY 2017-18. The Department assumes this will recover to a lower level of growth in the request and out year. Growth in utilizers for Second or More Visit of the day has seen growth for the past few fiscal years. The Department assumed this trend would continue in the request and out years. Because of billing issues associated with the implementation of the new claims system, the Department saw a significant decrease in the number of units per utilizer for RN Brief Second or more. The Department assumes the units per utilizer will recover to a more normal level and assumed a large increase in FY 2019-20 to reach that level. After the recovery, it is assumed growth would be 0.00% as the need per client should be steady.

Physical (PT), Occupational (OT), and Speech/Language Therapy (S/LT)	Physical Therapy: FY 2019-20 through FY 2021-22: 8.60%. Occupational Therapy: FY 2019-20 through FY 2021-22: 7.88%. Speech/Language Therapy: FY 2019-20 through FY 2021-22: 10.28% and 5.14% respectively.	Physical Therapy: FY 2019-20 through FY 2021-22: 0.00% Occupational Therapy: FY 2019-20 through FY 2021-22: 0.00%. Speech/Language Therapy: FY 2019-20 and FY 2021-22: 0.00%.	Growth in all the therapy services has been high over the past few fiscal years. The Department assumes that this growth will start to slow as a new normal is reached. As such, the Department selected positive trends but about half of what historical growth has been recently. Units per utilizers for the therapy services has been steady for the past few years. As such, all but Occupational Therapy (OT) growth was assumed at 0.00%. OT experienced a spike in units per utilizer in FY 2017-18 because of billing issues from the new claims system implementation. The Department assumes 0.00% growth after in all forecasted years. Growth in utilizers for Speech/Language Therapy has seen strong growth for the past few fiscal years. The Department assumed this trend would slow in the request and out years.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior average monthly enrollment and utilization/cost per client trend factors, the Department adds total-dollar bottom-line impacts to projected enrollment or expenditure. The following impacts have been included in the Request for Long-Term Home Health:

Expenditure

- Telehealth Expenditure Adjustment: Due to small cell sizes that prevent the Telehealth forecast from using the same methodology as the other LTHH services, expenditure for Telehealth is adjusted via bottom line impact.
- FY 2015-16 R-7 "Participant Directed Programs Expansion": The Department's FY 2015-16 R-7 request expands access to Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services (SLS) Home- and Community-Based Services (HCBS) waiver. The savings to LTHH are expected from the clients who currently utilize LTHH services in the SLS waiver, who would then shift into using CDASS services instead. CDASS was implemented into SLS effective August 2018 and all 1915(i) clients were transferred to other waivers by February 2019.
- Like Acute Care in Exhibit F, the LTHH exhibit includes a bottom line adjustment to account for the implementation of new federal rules related to home health. Because of SB 17-091 "Allow Medicaid Home Health Services in the Community" and 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional long-term home health services in the community.
- FY 2018-19 R-08 Assorted Medicaid Savings Initiatives – PAR savings: This initiative creates a requirement that adult Long-Term Home Health Services require review and authorization by the Department's utilization management vendor before a client receives services. This will ensure the Department is not paying for duplicative or unnecessary services and will drive savings.
- Additional Week 53 Pay Period in FY 2019-20, factors in an additional payment period in FY 2019-20. Payments are typically made on the Monday of each week and there are 53 Mondays in FY 2019-20.

Enrollment

- N/A

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 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.

Historically, 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 45.2% between FY 1999-00 and FY 2016-17. This is due to Department efforts to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program of 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 changed to a slight negative trend in FY 2011-12 through FY 2013-14. Most recently, patient days increased in FY 2014-15, and have continued to increase through FY 2016-17, while levelling off in FY 2017-18; the Department is closely monitoring this growth.

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 expenditure 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.

HB 13-1152 extended the 1.5% rate reduction of HB 10-1324, SB 11-125, and 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-5 through EH-8 describe calculations of individual components.

The methodology for the Class I request in Exhibit H is as follows[6]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2019-20.
- 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 2019-20. 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 2019-20 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2019-20.
- The product of the estimated Medicaid per diem reimbursement rate for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2019-20.
- Of the estimated total reimbursement for claims incurred in FY 2019-20, only a portion of those claims will be paid in FY 2019-20. The remainder is assumed to be paid in FY 2020-21. The Department estimates that 92.06% of claims incurred in FY 2019-20 will also be paid during FY 2019-20. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2019-20.
- During FY 2019-20, the Department will also pay for some claims incurred during FY 2018-19 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2018-19 to calculate an estimate of outstanding claims to be paid in FY 2019-20.
- The sum of the current year claims and the prior year claims is the estimated expenditure in FY 2019-20 prior to adjustments.

[6] For clarity, FY 2018-19 is used as an example. The estimates for FY 2019-20 and FY 2020-21 are based on the estimate for FY 2018-19, and follow the same methodology.

- 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 2019-20, this includes HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2019-20 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. The following impacts have been included in the FY 2019-20, FY 2020-21, and FY 2021-22 calculations for Class I Nursing Facilities:

- Expenditure for the Hospital Backup Program are included as bottom-line adjustments for FY 2019-20 through FY 2021-22. Please refer to Footnote 6 on page EH-7 for more detail. The Department increased estimates from the February forecast based on YTD actuals and recent growth trends.
- 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 2019-20, FY 2020-21, and FY 2021-22. Footnote 7 on page EH-7 contains additional detail about these recoveries.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.
- The JBC appropriated funding for the Department of Local Affairs to increase housing vouchers for people transitioning from a nursing home to a community setting. The increase in housing vouchers is projected to decrease nursing home costs by lowering patient days and utilization of nursing home services. The savings from this increase in housing vouchers are included as bottom-line adjustments for FY 2019-20 and beyond.

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 five 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 that examines past claims by month of service and month of payment to estimate the claims that will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. IBNR adjustments analyze the prior pattern of expenditure (the lag between when 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, even 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-6. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2018-19 that will be paid in FY 2019-20 and the percentage of claims incurred in FY 2019-20 that will be paid in FY 2020-21 and subsequent years. The Department applies the same factor to the FY 2020-21 and FY 2021-22 estimates.

Patient Days Forecast

The Department observed a slight decrease in patient days in FY 2018-19. There was a variance of –1.23% between FY 2018-19 actuals and the February 2019 forecast. As such, the Department slightly lowered its assumptions in nursing facility utilization to the patient days forecast for FY 2019-20, FY 2020-21, and FY 2021-22. The Department is continuing to expect slow to modest growth in patient days based on a growing elderly population. The revised forecast uses an auto-regressive model using IBNR-adjusted days.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model that accounts for cost of living adjustment (COLA) increases to forecast patient payment. Neither the current period nor the previous period are relevant to this forecast. The only indicators of patient payment are the number of days in the month and the COLA increase for a given year. For this reason, neither a linear nor an autoregressive model was used, as they did not add value to the forecast.

The Department lowered the patient payment forecast slightly from the previous February 2019 forecast but still expects patient payments to increase steadily based on recent increases in COLA and updated patient payment information from FY 2017-18 and FY 2018-19.

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 moderate 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 expired July 1, 2012.
FY 2012-13	HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2013.
FY 2013-14	HB 13-1152 extended the 1.5% rate reduction from the prior year. The rate reduction is permanent.
FY 2014-15	SB 14-130 raises the basic minimum payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to $75.00 monthly; this increase was effective as of July 1, 2014. This amount increases by 3.0% annually on January 1st of each year.

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-1. 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 calculate 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. There is currently one Class II Nursing Facility provider in Colorado: Bethesda Lutheran Communities (Bethesda). Bethesda operates 5 facilities with a total of 27 beds. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. Class II nursing facilities are authorized to receive an annual cost-based rate adjustment, like class I nursing facilities. Due to the opening of a new facility in July 2016, there was an increase in cost over FY 2016-17. This increase continued in FY 2017-18, but the Department expects costs to level off as facility

capacity is reached. For FY 2019-20 the Department decreased the current year forecast due to rate decreases but increased the forecast in each of the forecast years because the Department expects a 2.20% growth in expenditure per-capita in both the request year and the out-year as well as a 4.17% growth in enrollment in the out-year that aligns with historical growth in the program.

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 55 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-A), Disabled Adults 60-64 (OAP-B), and Disabled individuals to 59 (AND/AB). PACE rates are amended once per year, generally on July 1 of each year.

Exhibit H6 contains two distinct summary measures by fiscal year: 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.

The Department has added several PACE providers over the last ten years. Senior Community Care of Colorado (Volunteers of America) began serving clients on August 1, 2008, in Montrose and Delta counties. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. InnovAge (formerly Total Long-Term Care), the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo, and another facility opened in Loveland in November 2015. Most recently, TRU Community Care opened in February 2017 and serves Boulder and Weld counties. One new facility, HopeWest, is expected to open in Spring of 2020 and will serve clients in Mesa county.

Expenditure estimates for PACE for FY 2019-20, FY 2020-21, and FY 2021-22 are the product of two pieces: projected enrollment and cost per enrollee. PACE enrollment was estimated by taking actual enrollment census numbers reported by PACE facilities and applying the average growth in enrollment over the last five months and continuing that trend through FY 2019-20, FY 2020-21, and FY 2021-22. This method was used to estimate future enrollment on an aggregate-provider by-eligibility-type basis. Enrollment caps are not anticipated to limit growth for the forecast period because of the way PACE services are provided: that is, clients are not full-time residents of PACE facilities. Systems issues since CY 2013 have resulted in clients who are eligible for Medicaid and receiving PACE services showing up in the MMIS as not having an enrollment span in the program, causing a delay in monthly capitation payments for these clients. The Department added one bottom line impact to FY 2019-20 that is for retroactive payments made for services rendered in FY 2018-19. The Department is closely monitoring these systems issues going forward. Based on date of service measures, actual

enrollment in PACE programs is less than the enrollment forecasted in the February 2019 request, and as a result, the enrollment forecast in the November 2019 request has decreased from the February 2019 request for the request and out years.

Per-enrollee costs for FY 2019-20 are determined by cross-walking the actual FY 2019-20 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2019-20 enrollment projections. It was previously assumed that per enrollee costs for FY 2019-20 would remain the same as they were in the February request but new rates for FY 2019-20 were determined in August. To account for this, the Department calculated the per-enrollee cost based on two months at the rate stated in the February forecast and at ten months for the remainder of the fiscal year at the new rates. As such, per enrollee costs only represent an estimate to the extent that the exact eligibility type and exact provider distributions for FY 2019-20 are unknown.

SB 19-209 repealed previous statute directing the Department to apply a grade of membership method in determining the upper payment limit methodology. It also requires the Department to meet with PACE organizations to negotiate an appropriate contracted rate for PACE program services for the FY 2020-21 fiscal year. Until the new rates are negotiated, the Department will continue to use the current rate setting methodology, without the Grade of Membership methodology.

The Department notes that the table showing the average cost per enrollee on page EH-15 represents the total net amount spent in a fiscal year on PACE programs divided by the average number of monthly capitations paid in that specific year. These figures include retroactive capitations and recoupments and do not completely reflect the cost of services received in that fiscal year. For example, the average cost per enrollee in FY 2014-15 factors in approximately $12.9 million in retroactive payments, while the average cost per enrollee in FY 2015-16 encompasses approximately $5.4 million in recoupments.

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 Eligible receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligible 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.[7] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare

[7] 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.

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:[8]

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
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%
2014	$426.00	-3.40%	$104.90	0.00%
2015	$407.00	-4.46%	$104.90	0.00%
2016	$411.00	0.98%	$123.70	17.92%
2017	$413.00	0.49%	$134.00	8.33%
2018	$422.00	2.18%	$134.00	0.00%
2019	$437.00	3.55%	$135.50	0.75%

[8] Premium information taken from the Centers for Medicare and Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf Tables V.E1 and IV.B1.

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 2019-20, the Department first inflates the estimated expenditure from FY 2018-19 by the estimated caseload trend for FY 2019-20, as reported in Exhibit B, along with the anticipated growth in Medicare Part B Premiums. The forecast of FY 2020-21 expenditure utilizes the same methodology as the forecast of FY 2019-20. In this request, the Department assumes that the Medicare Part B premium will be $135.50 in CY 2019, $141.10 in CY 2020, and $148.50 in CY 2021.

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 the past, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. 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.

Beginning with the November 2014 Request, the Department estimates expenditure based directly on the contractor's program enrollment estimates to calculate provider and premiums payments for clients enrolled in HIBI. The Department believes this methodology to be more accurate as HIBI enrollment does not bear a direct relationship to Medicaid caseload and enrollment is the primary driver in differences between cost estimates and actuals.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the per capita or trend factors, the Department previously added total-dollar bottom-line impacts to the projected expenditure.

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacted the HIBI program in FY 2017-18 and going forward by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for eligible clients to create cost savings for the State. The contractor estimated approximately 2% growth in enrollment per month for FY 2017-18. The new contract re-procured in July 2017 increased the administration costs for per member per month rate starting in FY 2017-18. The

new cost of administration is a tiered cost structure based off the total enrollment of the program. Savings due to SB 10-167 are captured in the Acute Care exhibit.

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 agencies (SEPs) 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 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 SEP is an agency in a local community through which persons 18 years or older can access needed long-term care services.

The SEP is required to serve clients of publicly funded long-term care programs including nursing facility care, HCBS-LTSS waivers, 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 SEPs 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. SEPs also serve as the utilization review coordinator for all community based long-term care services.

The Department pays SEPs a case-management fee for each client admitted into a community-based service program. SEPs 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 HCBS and nursing facilities.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and to assure SEP 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.

Effective with the November 1, 2007 Budget Request, the Department revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, SEPs 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 SEPs has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, SEPs would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to SEP contracts. The requested increase is based on the expected increase in HCBS-LTSS waiver enrollment, as determined by average monthly enrollment. This figure is therefore consistent with the caseload growth of the HCBS-LTSS waivers in Medical Services Premiums. The Department believes that growth in enrollment is a good proxy for growth in SEP 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 2019-20, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2019-20 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For the request and out-year, the Department uses HCBS waiver enrollment growth to project SEP expenditure growth.

The Department is expecting to see recoveries from SEPs due to previous overpayments. The expected recoveries have been incorporated into Exhibit I2 after the base contract amount. The recoveries will affect total expenditure on SEPs but will not impact the estimated base contracts amount for each fiscal year. The Department is only expecting recoveries in FY 2019-20.

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.

- FY 2018-19 Across the Board 1.00% Rate Increase: The Joint Budget Committee approved a 1.00% rate increase implemented July 1, 2018. The rate increase affects all waiver services and therefore is relevant to Single Entry Point agencies who are providers of waiver services.
- SB 16-192/FY 2018-19 R-17: "Single Assessment Tool" – SB 16-192 requires the state to select a needs assessment tool for persons receiving Long-Term Services and Supports, including persons with intellectual and developmental disabilities. FY 2020-21 costs to CLTBC result from reassessing a sample of Long-Term Services and Supports members in the pilot program. Costs in the affected years include reassessing every Long-Term Services and Supports members with the selected needs assessment tool.
- FY 2019-20 Across the Board 1.00% Rate Increase: The Joint Budget Committee approved a 1.00% rate increase implemented July 1, 2019. The rate increase affects all waiver services and therefore is relevant to Single Entry Point agencies who are providers of waiver services.
- SEP Transition Funds: The Department has included one-time funding in FY 2019-20 to allow for the transitional overlap between SEP vendors to avoid negative impacts on enrollment and services deliveries for Medicaid enrollees. As a best practice to maintain a seamless transition for Medicaid members, the Department would need to overlap contract periods, as the outgoing SEP vendor closes out its work and the incoming SEP vendor ramps up. The overlap in SEP vendor contracts would aid the current and incoming SEP vendors in completing key transition functions before the new SEP vendor begins service provision, so that members do not experience disruptions in care.

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 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.

Because 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. Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were applied 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 only remaining expenditure in the Disease Management program is for the tobacco quit line, administered by the Department of Public Health and Environment (DPHE). The Department pays for the share of costs for the quit line related to serving Medicaid

members. The November 2019 request aligns the Department's projected expenditure with the reappropriated funds in DPHE's budget that are funded by Medicaid.

Accountable Care Collaborative

In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Accountable Entities (RAEs) that receive service FMAP and that are incorporated in the ACC exhibit.

The 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 reached an enrollment total of approximately 1,171,800 by June 2019. The cost savings estimated for this program are included in Acute Care; please see Exhibit F for more information on its impact to Acute Care. The monthly management fees are estimated in the Accountable Care Collaborative exhibit.

The Department implemented Phase II of the ACC, which was requested in the FY 2017-18 R-6 "Delivery System and Payment Reforms" request approved in HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives". Phase II of the ACC includes mandatory enrollment of the Medicaid population into the ACC, which would only exclude clients enrolled in a managed care program such as a health maintenance organization or the Program of All-Inclusive Care for the Elderly (PACE) and the Non-Citizens-Emergency Services and Partial Dual Eligibles eligibility categories. The ACC Phase II also combines the RCCOs and Behavioral Health Organizations (BHOs) into a single entity called a Regional Accountable Entity (RAE). RAEs will be responsible for further integrating behavioral and physical health care to achieve improved outcomes and cost reduction. PMPM for the RAEs will be $15.50, with a portion of the PMPM pushed through from the RAEs to PCMPs. RAEs will receive capitated payments for managed Behavioral Health just as BHOs do currently.

The increased caseload expectations due to mandatory enrollment and the changes to PMPM under ACC Phase II have been built into the ACC forecast trends, based on anticipated enrollment in other managed care programs and caseload, for FY 2018-19 and beyond.

Legislative Impacts and Bottom-Line Adjustments

The November 2016 request included a bottom-line impact to account for movement of clients from the PMPM-based ACC to the new Kaiser-Access health maintenance organization (HMO), a pilot payment reform initiative under HB 12-1281. This bottom-line impact

was removed in the February 2017 forecast with the assumption that the shift of clients to Kaiser-Access was already accounted for in the base FY 2016-17 ACC enrollment trends. On June 30, 2017, the Kaiser-Access HMO ended. The impact of this change is accounted for directly in the forecast of expected ACC enrollment in FY 2017-18, and not as a bottom-line impact.

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. Until FY 2009-10, the Department contracted with only one prepaid inpatient health plan, Rocky Mountain Health Plans. The Department then contracted with three additional prepaid inpatient health plans in FY 2009-10. These included Colorado Access and Kaiser Foundation Health Plan, jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance and Health Independence (CAHI).

Currently, there are no prepaid inpatient health plans, as Rocky Mountain Health Plans ended in November of 2014. The exhibit contains historical information only.

EXHIBIT J - HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for the Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A.

Healthcare Affordability and Sustainability Fee Fund

HB 09-1293 originally established the Hospital Provider Fee Fund to provide for the costs of certain expansion populations on Medicaid, outlined below. SB 17-267 replaced the Hospital Provider Fee Fund with the Healthcare Affordability and Sustainability (HAS) Fee Fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

MAGI Parents/Caretakers 69% to 133% FPL

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. This expansion population receives standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund had funded this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014. Beginning January 1, 2017, the enhanced federal match fell to 95%. On January 1, 2018, it fell to 94%, then on January 1, 2019, it fell to 93%, and on January 1, 2020 it falls to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

For caseload estimates and methodology, please see the Acute Care and caseload sections of this narrative.

MAGI Adults

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund had funded this population in the interim before the population expanded and the enhanced federal match began on January 1, 2014. Beginning January 1, 2017, the enhanced federal match fell to 95%. On January 1, 2018, it fell to 94%, and then to 93% on January 1, 2019 and 90% on January 1, 2020, where it will remain. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee. Clients in this category are not eligible to receive HCBS Waiver services; in cases where it appears that these clients have received waiver services, this expenditure receives the standard match rate and not the expansion match rate. This incidence can occur for numerous reasons, including clients awaiting disability redeterminations that have caused them to be temporarily moved from their usual eligibility category to this one.

Currently, the Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

Non-Newly Eligibles

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the enhanced expansion federal medical assistance percentage (FMAP) that began January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS Fee Fund. The Department has incorporated the resource proxy in this request.

MAGI Parents/Caretakers 60% to 68% FPL

Historically, clients who fell under the Expansion Parents to 133% FPL eligibility category (any client over 60% FPL) were considered expansion clients and the State's share of funding was provided through the Hospital Provider Fee Fund. The MAGI conversion has resulted in some clients with over 60% FPL falling into the MAGI Parents/Caretakers 60% to 68% FPL category. The State share of funding for these clients comes from the HAS Fee Fund, effective July 1, 2017, in compliance with statute.

Continuous Eligibility for Children

HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, even if the family experiences an income change during any given year, contingent on available funding. The Department implemented continuous eligibility for children in March 2014 and has the authority to use the HAS Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department breaks this population out in its respective service categories in Exhibit J to better show the impact of continuous eligibility for children.

Medicaid Buy-in Fund

This fund is administered by the Department to collect buy-in premiums and support expenditure 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 individuals with disabilities with income up to 450% of the federal poverty level to pay premiums 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. The premiums from the Medicaid Buy-in fund are applied first, and then the remaining expenditure is split at standard medical FMAP as federal funds and HAS Fee Cash Fund. For more information on the funding detail for this population, see Calculation of Fund Splits under Exhibit A.

The Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

Hospital Supplemental Payments

The Department increases hospital payments for Medicaid hospital services through a total of five supplemental payments, three 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.

Cash Fund Financing

An offset of $15,700,000 is made from the HAS Fee to offset the loss of federal matching funds due to the decrease in certification of public expenditure for outpatient hospital services resulting from the authorization of the Hospital Provider Fee in HB 09-1293. The HAS Fee replaced the Hospital Provider Fee effective July 1, 2017, under SB 17-267.

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 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 using certification of public expenditure.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditure.

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 expenditure. These offsets started in FY 2001-02. Nursing facilities account for the larger portion of Upper Payment Limit funding. Home health has expenditure that is less by comparison and will experience little impact related to changes in reimbursement rates.

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 if 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 could utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department could 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 used 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. A new line of recoveries, Credit Balance and Audits, was added in the re-procured contract effective July 1, 2017. Based on the Department's FY 2018-19 R-08 "Assorted Medicaid Savings Initiatives", the Department was appropriated two FTE to increase staffing to review trust compliance issues and identify additional recoveries for the Department.

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 re-procured in FY 2017-18. 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.

EXHIBIT M - CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 9 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 expenditure by aid category from the estimated final expenditure by service categories. This is a necessary step because expenditure in the Colorado Operations Resource Engine (CORE) is 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. From that step, the percent of the total represented by service-

specific eligibility categories was computed and then applied to the final estimate of expenditure 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.

The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until December of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously. In addition, the Department is continuing to validate data as it is reported in the new Medicaid Management Information System (MMIS) reporting layer for FY 2016-17, FY 2017-18, and FY 2018-19. This includes known issues with expenditure reported for certain service categories. The data presented in this request is based on information available as of August 15, 2019.

EXHIBIT N - EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2008-09 through FY 2018-19 final actual expenditure is 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 2018-19 final actual total expenditure for Medical Services Premiums, including fund splits, the remaining balance of the FY 2018-19 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 2018-19 and 2019-20 in the chronological order of the requests/appropriations.

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 expenditure. The Cash Flow Pattern is one forecasting tool used to

estimate final expenditure 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 expenditure.

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

EXHIBIT Q - TITLE XIX AND TITLE XXI TOTAL COST OF CARE

This exhibit details the total cost of Medicaid services, including lines outside of Medical Services Premiums, such as service expenses for Medicaid Behavioral Health, the Office of Community Living, Medicaid-funded Department of Human Services (DHS) services, and CHP+, separating Title XIX and Title XXI fund sources, to show the total services cost of providing care to clients. This exhibit also includes a total cost of care per capita exhibit for these combined services, including both Title XIX expenditure and Title XXI expenditure, by eligibility category. Effective with the November 2016 Budget Request, the Department added the request amounts for the current, request, and out years to this exhibit.

EXHIBIT R - FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

This exhibit calculates expected FMAP for the current year, the request year, and the out year. CMS calculates FMAP using Bureau of Economic Analysis (BEA) personal income data and population data for the United States and each state. FMAP is calculated using the following formula:

$$FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2/(\text{Per capita income}_{U.S.})^2 * 0.45)$$

where per capita incomes are based on a rolling three-year average and the FMAP for a given year is taken from the calculation from two years prior.

Due to the nature of this calculation, federal fiscal year FMAP for 2015-16 is calculated using data for calendar year 2013 at the latest. Therefore, the FY 2019-20 FMAP estimate is calculated using historic data from the BEA. This FMAP calculation would only change if the BEA restates its historical data, which can sometimes occur. However, CMS has informed the Department of the FMAP the Department is eligible for beginning October 1, 2018. Therefore, FMAP for FY 2019-20 and past time periods is not subject to change, as CMS does not restate announced FMAP even in cases where the BEA's updated data results in different calculations. The FY 2020-21 FMAP estimate is based on data after calendar year 2018, which the BEA does not forecast. The forecasts for personal income come

from the legislative council's most recent forecast for the U.S. and Colorado, and the population forecasts come from the U.S. census for U.S. data and the Department of Local Affair's most recent forecasts for Colorado.

Forecasts throughout this request use these FMAP estimates rather than holding FMAP constant in the request and out years, as was previously done. In cases where a restatement of the BEA's data would result in a different FMAP than was previously anticipated, the Department would submit a supplemental funding request to account for the change in federal funds.

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 that are not reflected in historical trends. The Department has incorporated these impacts within the appropriate exhibits.

Schedule 13

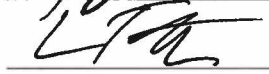
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-02 Behavioral Health Programs

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	**Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$723,074,435**	**$0**	**$896,951,021**	**$41,588,549**	**$100,289,442**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$201,872,261	$0	$236,022,773	$13,337,312	$29,745,373
	CF	$38,385,780	$0	$49,890,718	$7,561,171	$12,796,927
	RF	$0	$0	$0	$0	$0
	FF	$482,816,394	$0	$611,037,530	$20,690,066	$57,747,142

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Capitation Payments	**Total**	**$712,830,202**	**$0**	**$886,698,271**	**$41,091,881**	**$99,558,458**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$199,508,367	$0	$233,656,914	$13,193,752	$29,560,762
	CF	$37,852,285	$0	$49,356,779	$7,390,829	$12,607,635
	RF	$0	$0	$0	$0	$0
	FF	$475,469,550	$0	$603,684,578	$20,507,300	$57,390,061
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	**Total**	**$10,244,233**	**$0**	**$10,252,750**	**$496,668**	**$730,984**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,363,894	$0	$2,365,859	$143,560	$184,611
	CF	$533,495	$0	$533,939	$170,342	$189,292
	RF	$0	$0	$0	$0	$0
	FF	$7,346,844	$0	$7,352,952	$182,766	$357,081

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2019-20 and FY 2020-21 Budget Request

November 2019

TABLE OF CONTENTS

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 behavioral 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 again procured 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. In July 2014, the Department went through another competitive bid process to reprocure the contractors of the five behavioral health regions. As a result of this reprocurement, four of the five prior behavioral health organizations won their respective rebids. The only change was in the northeast region. Access Behavioral Care Northeast began providing services in this region effective July 1, 2014. The Department implemented the Accountable Care Collaborative Phase II, starting July 1, 2018, through HB 17-1353 "Implement Medicaid Delivery and Payment Initiatives". The program integrated behavioral health services and physical health services under one administrative entity called a regional accountable entity. The Department underwent a competitive bidding process to procure contractors for the seven regional accountable entities to be service providers for physical and behavioral health. These changes are effective July 1, 2018.

Each regional accountable entity is responsible for providing or arranging medically necessary behavioral health services to Medicaid-eligible adults 65 and older, individuals with disabilities through 64, MAGI parents and caretakers, MAGI adults, 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, physician care, substance use disorder; 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 regional accountable entities for services for each eligible Medicaid recipient. Payments vary across each regional accountable entity, 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 17-1353, "Implement Medicaid Delivery & Payment Initiatives", authorized the Department to implement performance-based payments for medical providers. The payments are designed to incentivize BHOs to achieve performance-based goals regarding improving health outcomes, coordinating care, and containing costs. The bill also implemented the integration of behavioral health and physical health services under the new Regional Accountability Entity (RAE). Effective July 1, 2018, the Department began working with the new RAEs instead of the BHOs. Although care will be integrated between behavioral health and physical health services under one entity, the Department still pays actuarially sound capitation rates for behavioral health services. Therefore, there will be no changes to the forecasting methodology.
- HB 18-1136, "Substance Use Disorder Treatment", authorized the Department to add residential and inpatient substance use disorder services, and medical detoxification service to the behavioral health program. The Department anticipates that residential and inpatient substance use disorder service and medical detoxification services will begin July 1, 2020 after the Department seeks and receives federal authorization to secure federal financial participation in the program. The Department currently is forecasting the cost of the program based on a report produced by Colorado Health Institute called "Options for Residential and Inpatient Treatment of Substance Use Disorder[1]", which was authorized under HB 17-1351 "Study Inpatient Substance Use Disorder Treatment". The

[1] https://www.coloradohealthinstitute.org/research/options-residential-and-inpatient-treatment-substance-use-disorder

Department will incorporate the costs of the new benefits through the Department's rate setting process for the RAEs and will make corresponding adjustments to estimated expenditure through the regular budget process.

Program Administration

In FY 2005-06, SB 05-112 transferred all Behavioral Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group and they are reflected in the lines for Personal Services, Operating Expenses, and Behavioral 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 antipsychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

Significant Changes between FY 2020-21 R-2 and FY 2019-20 S-2A

FY 2019-20

In the FY 2020-21 R-2, the Department requests a reduction of $6,987,511 in total expenditure compared to the FY 2019-20 S-2A, including a decrease of $312,320 General Fund, $525,668 cash funds, and $6,149,523 federal funds. This is primarily due to a decrease in caseload.

FY 2020-21

In the FY 2020-21 R-2, the Department forecasts a decrease of $10,981,299 in total expenditure compared to the FY 2019-20 S-2A, including a decrease of $1,174,116 General Fund, $908,505 cash funds, and a decrease of $8,898,678 federal funds. This is primarily due to a decrease in caseload.

Behavioral Health Capitation Payments and Medicaid Behavioral 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. Effective July 1, 2014, the behavioral health services contracts were up for reprocurement through a competitive bid process. Four of the five BHOs from the previous rebid won their respective regions with the exception of the northeast region. That region is now managed by Access Behavioral Health – Northeast. The Department underwent a competitive bidding process to procure contractors for the seven regional accountable entities to be service providers for physical and behavioral health. These changes were effective July 1, 2018.

The regional accountable entities are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible members within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each regional accountable entity for each Medicaid client in each Medicaid eligibility category. Retroactive eligibility is covered. Payments vary across regional accountable entities, as well as eligibility categories.

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

The eligible behavioral health populations are:

- Adults 65 and Older
- Individuals with Disabilities
- Low Income Adults
- Expansion Parents & Caretakers
- MAGI Adults
- Eligible Children
- 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 was 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. Beginning July 1, 2014, the Department is using a new financial reporting tool. The Colorado Operations Resource Engine (CORE) is used in place of COFRS and the same overlay methodology is used between CORE and the MMIS.

Description of Methodology

The Department utilizes a capitation trend forecast model. 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 regional accountable entities.

Additionally, the forecast utilizes 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 adjusts 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 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 Community 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 for the base traditional members, the state receives the standard Medicaid federal match with the State's share coming from General Fund. In FY 2018-19 the federal match is 50.00%. Payments for members in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2018-19 is 65.00% and is described separately below. Capitation expenditures are split between traditional members and expansion members. Expansion members are funded from Healthcare Affordability and Sustainability Fee funds. Finally, the reconciliation from prior years for behavioral health capitation overpayments, retractions for capitations paid for members later determined to be deceased, and system issues are also presented (see Exhibit II for reconciliation calculations). A summary of applicable FMAP rates for each of the forecast years is provided below:

Population	FY 2019-20 Match Rate	FY 2020-21 Match Rate	FY 2021-22 Match Rate
Standard Medicaid	50.00%	50.00%	50.00%
Former CHP+ Children	79.38%	67.88%	65.00%
Former CHP+ Prenatal	79.38%	67.88%	65.00%
Expansion Adults	91.50%	90.00%	90.00%
BCCP	65.00%	65.00%	65.00%

The Department also calculates the fund splits for the fee-for-service expenditure in Exhibit BB. The make-up of the fee-for-service population is the same as the capitation program and therefore the same funding mechanisms are used for the same populations mentioned above in the fee-for-service environment (see Exhibit JJ and Exhibit KK for fee-for-service calculations).

Medicaid Behavioral Health Fee-for-Service base traditional members also receive the standard Medicaid federal match with the State's share coming from General Fund. In FY 2019-20 the federal match is 50.00%. Similar to the populations within the capitation payments line, as of July 1, 2014, the Department is breaking out the fee-for-service expenditure by funding source according to population so that it may claim the correct federal match associated with who is obtaining services. 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 members in the Breast and Cervical Cancer Program is managed through the capitation contracts with the regional accountable entities. 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(9), C.R.S. (2015). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the members enrolled in the

program is currently 35.00% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and 65.00% federal funds. The program was reauthorized in FY 2014-15 and sunsets at the end of FY 2018-19, with the potential to extend the program through new legislation. Beginning in FY 2016-17, the Breast and Cervical Cancer Prevention and Treatment Program expanded the age of eligibility for women being screened for cervical cancer from 39 to 21, which impacts the caseload forecast.

Behavioral Health Services for Healthcare Affordability and Sustainability Fee Expansion Members

HB 09-1293 established a funding mechanism for a series of expansion members. The first set of expansion members that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these members were funded through the Healthcare Affordability and Sustainability Fee cash fund. Starting in FY 2011-12, additional expansion populations also received funding through the Healthcare Affordability and Sustainability Fee cash fund. These include individuals with disabilities with income limits up to 450% of the federal poverty level and MAGI Adults, both of which received services through the RAEs as part of their benefit package. Individuals with disabilities with income limits up to 450% are assumed to be similar to other members with disabilities, and expenditure for these members is therefore calculated using the same per-capita rate as other members with disabilities (see exhibit JJ). 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

The former CHP+ populations that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of approximately 65.00%, with an additional 23 percentage point FMAP increase through September 30, 2019; the enhanced FMAP is expected to be 88.00% in FY 2018-19 and 79.38% in FY 2019-20, and 67.88% in FY 2020-21 per the HEALTHY KIDS Act.

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 MAGI Adults, effective January 1, 2014. The Department assumes that federal match rates will apply to each new population as follows: Parents from 60% to 68% FPL will receive the standard Medicaid match rate, with the state share coming from Healthcare Affordability and Sustainability Fee cash fund. Parents from 69% - 133% FPL and newly eligible MAGI Adults will receive the expansion federal match rate. And adults up to 60% FPL will continue to receive the standard Medicaid match. The Department also estimates that the non-newly eligible MAGI Adult population is 81.13%; Because some of these members may have been eligible prior to the expansion, the Department is unable to claim the expansion federal match. Therefore, the Department estimates that it can claim the expansion match on 75% percent of the population and the standard match on the other 25%. As such, the federal match percentage

in FY 2019-10 is 81.13%. Beginning January 1, 2017, all expansion populations will begin a stepdown in federal matching. As a result, the match rate for those populations in 91.50% in FY 2019-20, and 90.00% in FY 2020-21 and ongoing.

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 caseload driven impacts such as the various reconciliations and retractions for members 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 13 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 each of the rate cells which the Department pays a capitation on. The second table displays caseload by all behavioral health eligibility categories that make up the eight rate cells. 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 members 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 each rate cell the Department pays a capitation on. The second table displays per-capita for all behavioral health eligibility categories. However, since the actual per capita from the first table for the combined 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-capita, while the current fiscal year and the request year per-capita 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 Operations Resource Engine (CORE). Expenditures by eligibility category are not available from the CORE. 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 CORE as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the CORE 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 CORE. This calculation estimates actual CORE expenditures across each eligibility category. 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 the Department's budget request for Medical Services Premiums Exhibit B (excepting partial dual eligible members and non-citizens, as discussed above).

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 E.EE-4.

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 members in FY 2009-10; this activity resulted in the 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 members from which to retract and current processes of identification become more effective.

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 E.EE-4 through E.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.

On pages E.EE-6 through E.EE-7, 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 E.EE-1, E.EE-2, and E.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the regional accountable entities 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

Capitations are paid for members 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.

Historically the Department would adjust the forecasted capitation rate to capture retroactive caseload. However, the Department no longer pays capitations for retroactively eligible clients as of July 1, 2018. The Department removed the retroactivity adjustment factor for this and ongoing requests.

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 the 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.

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 HH.

Based on the Department's calculations and rate-setting process and input from the regional accountable entities, the Department's actuaries certify a capitation rate for each RAE and eligibility type as the rate point estimate for each fiscal year.

It is important to note the overall weighted rate 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 regional accountable entities' 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.

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 E.HH-1 and E.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 E.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 E.HH-1 and E.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 E.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 E.HH-3 (see below).

The forecasted rate is adjusted by the partial month adjustment multiplier, calculated on page E.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.

The claims-based rate is also adjusted by the retroactivity adjustment. From Exhibit FF, page E.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 E.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 trend models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. 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.

For FY 2019-20, the Department adjusted the trends to account for the rate change implemented on July 1st, 2019. The table below shows the estimated trends for FY 2020-21.

Aid Category	FY 2020-21 Trend
Adults 65 and Older (OAP-A)	4.95%
	Trend is equal to the average growth from FY 2009-10 to FY 2018-19.
Individuals with disabilities Through 64 (AND/AB, OAP-B)	2.99%
	Trend is equal to the average growth from FY 2009-10 to FY 2018-19.
Low Income Adults	5.30%
	Trend is equal to the average growth from FY 2009-10 to FY 2018-19.
Expansion Parents & Caretakers	5.30%
	Trend is equal to Low Income Adults.
MAGI Adults	5.30%
	Trend is equal to Low Income Adults.
Eligible Children (AFDC-C/BC)	3.68%
	Trend is equal to the Average Growth from FY 2009-10 to FY 2018-19.
Foster Care	3.40%
	Trend is equal to the R-2 FY 2019-20 trend.

Trend Justification

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

EXHIBIT II - RECONCILIATIONS

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When members are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the regional accountable entities through the MMIS. When members are determined to be ineligible for Medicaid benefits retroactively, recoupment of the capitation payments is completed separately. When known, this exhibit also shows the impact of the reconciliation process surrounding all populations.

The ACA mandates that the Internal Revenue Service (IRS) charge a fee, the Health Insurance Provider Fee (HIPF), to covered entities that provide health insurance, based on the amount of revenue that the provider earns. The ACA mandates that the HIPF be paid for based upon the insurer's market share. This mandate excludes insurers that have a certain percentage of revenue that is publicly funded and provides other exclusions based on the number of premiums taken into an account.[2] The Department is issues a refund to the BHOs or RAEs for these costs.

The refund is typically issued one and half years after the revenue being taxed was earned. Since the IRS announced a moratorium on the payment for income earned in CY 2016, the Department did not make a payment in July of FY 2018-19. However, the Department decided to permanently shift the payment schedule and issue the refund for income earned in CY 2017 in FY 2018-19, issue the refund for income earned in CY 2018 in FY 2019-20, and so on. Then the IRS announced another moratorium on the payment for income earned in CY 2018. So, there will be no refund issued in FY 2019-20. These changes resulted in the following Department request: $0 in FY 2019-20, $9,317,988 in FY 2020-21, and an expected request of $9,524,363 in FY 2021-22. The payment is expected to increase in FY 2020-21 because the refund will then be issued based on income earned by the RAEs rather than the BHOs, which have higher profit margins.

Starting in FY 2018-19, the Department is paying incentive payments to the contracted behavioral health providers based on service performance and quality metrics of up to 5% of the total capitation expenditure paid from the previous fiscal year's services.

EXHIBIT JJ – ALTERNATIVE FINANCING POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293), Aligning Medicaid Eligibility for Children (SB 11-008), Eligibility for Pregnant Women in Medicaid (SB 11-250), and Expanding Medicaid

[2] https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

Eligibility in Colorado (SB 13-200) to the Behavioral Health Community Programs fund splits. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. The exhibit also separates out the funding source and the calculation of federal match associated with each category. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Healthcare Affordability and Sustainability Fee Fund 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 members in May 2010. In SB 17-267, The Hospital Provider Fee was changed to the Healthcare Affordability and Sustainability Fee Fund which provides for the costs of the following populations that impact the Behavioral Health budget:

MAGI Parents/Caretakers 60% to 68% FPL

Historically, clients who fell under the Expansion Parents to 133% FPL eligibility category (any client over 60% FPL) were considered expansion clients and the State's share of funding was provided through the Hospital Provider Fee Fund. The MAGI conversion has resulted in some clients with over 60% FPL falling into the MAGI Parents/Caretakers 60% to 68% FPL category. The State share of funding for these clients comes from the HAS Fee Fund, effective July 1, 2017, in compliance with statute.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Low Income Adults in Exhibit DD to forecast the total costs for this population.

MAGI Parents/Caretakers 69% to 133% FPL

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. This expansion population receives standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund had funded this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014. On January 1, 2018, it fell to 94%. Then on January 1, 2019, it fell to 93%, and on January 1, 2020 it falls to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Expansion Parents & Caretakers in Exhibit DD to forecast the total costs for this population.

MAGI Adults

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund had funded this population in the interim before the

population expanded and the enhanced federal match began on January 1, 2014. On January 1, 2018, it fell to 94%. Then on January 1, 2019 if fell to 93% and it will fall to 90% on January 1, 2020, where it will remain. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for MAGI Adults in Exhibit DD to forecast the total costs for this population.

Non-Newly Eligible

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the enhanced expansion federal medical assistance percentage (FMAP) that began January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligible, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS Fee Fund. The Department has incorporated the resource proxy in this request.

The Department uses caseload figures from S-1A Medical Service Premiums, Exhibit J and per capita costs for MAGI Adults in Exhibit DD to forecast the total costs for this population.

Buy-In for Disabled Individuals

This expansion allows for individuals with disabilities with income up to 450% of the federal poverty level to pay premiums 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.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Disabled Individuals in Exhibit DD to forecast the total costs for this population.

Continuous Eligibility for Children

HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, even if the family experiences an income change during any given year, contingent on available funding. The Department implemented continuous eligibility for children in March 2014 and has the authority to use the HAS Fee Cash Fund to fund the state

share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing.

The Department uses caseload figures from R-1 Medical Service Premiums, Exhibit J and per capita costs for Eligible Children in Exhibit DD to forecast the total costs for this population.

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. As with most of the Healthcare Affordability and Sustainability 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 have per-capita costs that will be the same as for the traditional population.

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

Medicaid Behavioral Health Fee-for-Service Payments is a separate budget line item in Behavioral Health Community Programs. Expenditures for this line are calculated in Exhibit KK. The data from Exhibit KK also appear in Exhibit BB, where the fund splits relating to the fee-for-service payments are calculated.

The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid members not enrolled in a regional accountable entity to receive behavioral health services or enrolled Medicaid members to receive behavioral health services not covered by the regional accountable entities. The services are not covered either because the client is not enrolled in a regional accountable entity regional accountable entity or the services are outside the scope of the regional accountable entity contract. Medicare crossover claims are included in the fee-for-service category; these are regional accountable entity regional accountable entity covered services for members enrolled in a regional accountable entity 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 RAE contract or the patient is not enrolled in a RAE.

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.

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-03 Child Health Plan Plus

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$214,184,992**	**$0**	**$214,257,938**	**$8,856,952**	**$20,965,369**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$407,703	$0	$433,335	$25,551,305	$40,311,643
	CF	$44,785,568	$0	$44,808,286	$1,690,167	($2,433,795)
	RF	$0	$0	$0	$0	$0
	FF	$168,991,721	$0	$169,016,317	($18,384,520)	($16,912,479)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Administration	**Total**	**$5,083,274**	**$0**	**$5,083,274**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$16,060	($16,060)	($16,060)
	CF	$1,048,171	$0	$1,037,861	$594,886	$741,285
	RF	$0	$0	$0	$0	$0
	FF	$4,035,103	$0	$4,029,353	($578,826)	($725,225)
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	**Total**	**$209,101,718**	**$0**	**$209,174,664**	**$8,856,952**	**$20,965,369**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$407,703	$0	$417,275	$25,567,365	$40,327,703
	CF	$43,737,397	$0	$43,770,425	$1,095,281	($3,175,080)
	RF	$0	$0	$0	$0	$0
	FF	$164,956,618	$0	$164,986,964	($17,805,694)	($16,187,254)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

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

FY 2019-20, FY 2020-21, and FY 2021-22 Budget Request

November 2019

TABLE OF CONTENTS

CHILDREN'S BASIC HEALTH PLAN

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

Points of Interest

- Federal funding for the CHIP program was reauthorized, retroactive to October 1, 2017. The program has been reauthorized for six years initially then an additional four years, expiring September 30, 2027.
- Federal financial participation was also reauthorized at the additional 23% increase for FFY 2017-18 and FFY 2018-19. Beginning in FFY 2019-20, the federal match rate is reduced by 11.50% and by FFY 2020-21 the federal match rate reduces to 65.00%.
- With the passage of the ACA and the enhanced federal financial participation, the Department has been able to pay for the state's share of costs entirely with cash funds. With the expiration of the enhanced match in FY 2020-21, the Department anticipates that it will need to start funding a portion of the expenses with General Fund. This is due to the exhaustion of the CHP+ Trust fund, which will take place sometime in FY 2020-21.
- In the 2017 legislative session, SB 17-267 "Sustainability of Rural Colorado" was passed and creates the Colorado Healthcare Affordability and Sustainability Enterprise within the Department to manage the Healthcare Affordability and Sustainability (HAS) Fee, which replaces the Hospital Provider Fee assess under current law. Beginning in FY 2017-18, the state share of the populations with FPL greater than 205% will be paid with the HAS Fee.
- Beginning January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Healthcare Affordability and Sustainability (HAS) fee fund. With the implementation of the interChange, the Department is now able to identify discrete FPLs for CHP+ members. Between January 2014 and March 2017, the Department used a distribution of clients over 200% FPL prior to January 2014 to assign clients with that particular income rating code to the appropriate cohorts.
- The Department began paying a disallowance in FY 2014-15 due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-260% FPL range. The final payment was made in Quarter 1 of FY 2017-18. Payment details can be found on page C2-6.

History and Background Information

Children's Basic Health Plan (CBHP), also known as Children's Health Plan *Plus* (CHP+), provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 260% 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 eligible CHP+ populations are:

- Children to 205% FPL (Medical and Dental)
- Children 206%-260% FPL (Medical and Dental)
- Prenatal to 205% FPL
- Prenatal 206%-260% FPL

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.

In FY 2013-14, there was a budget amendment passed (BA-11) to align the CHP+ oral health care benefits with the CHIPRA legislation of 2009. CHP+ dental coverage had been lacking periodontics care, orthodontic care, prosthodontic care, and the required coverage of all medically necessary oral health care. Such services were added to the scope of coverage and the dental program's annual maximum

was increased from $600 to $1000. These changes in the oral health care benefits led to significant increases in the dental rates beginning in FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for inpatient hospital payments and effective October 31, 2016 implemented a new reimbursement schedule for outpatient hospital payments. The Department is now using the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and the Colorado Medicaid Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services.

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). Beginning July 1, 2014, the Department transitioned from COFRS to Colorado Operations Resource Engine (CORE). Historical expenditure through FY 2013-14 is from COFRS and historical expenditure from FY 2014-15 and ongoing is from CORE.

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 has moved to a capitation trend forecast model beginning with the 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 nine categories rather than the previous three (children's medical, children's dental, and prenatal). In addition to viewing the nine eligibility categories separately, the Department has divided up the categories further to analyze each group that has a specific rate. This grouping separates by age as well as FPL. The different age groups apply only to children: 0-1, 2-5, and 6-18. The same FPL brackets apply to both children and prenatal: under 100%, 101%-156%, 157%-200%, 201%-205%, and 206%-260%. These individual analyses are then aggregated in the FPL brackets 0%-205% and 206%-260%. The age groups are each considered separately. By tying forecasted capitation rates directly to each category, the methodology may provide more accurate estimates of expenditures by eligibility category 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 capita costs, the Department has also started incorporating claims distribution and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C8.

Additionally, the Department has incorporated an incurred but not reported methodology similar to the Medicaid Behavioral 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 the 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 includes 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 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 request year expenditure from 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. Capitation expenditures are split between traditional clients and expansion clients. The State share for the traditional clients (0%-205% FPL) is funded from the CBHP Trust fund and the State share for expansion clients (206%-260% FPL) is funded from the Healthcare Affordability and Sustainability Fee Fund (SB 17-267).

The Patient Protection and Affordable Care Act (Sec. 2101 (a)) enhanced the CHP+ FMAP 23 percentage points beginning October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The average for the State Fiscal Year 2018-19 was 88.00%. With the expiration of the enhanced 23 percentage point bump, the projected FMAP for FY 2019-20 is 79.38%. The Department forecasts that the CBHP Trust

Fund will be sufficient for the State share of CHP+ expenditures through FY 2019-20. Beginning in FY 2020-21, the projected FMAP is 67.88%, and the Department expects that it will need to begin funding the program with a combination of General Fund and CHP+ Trust Fund for members to 205% FPL. The Department is also expecting to recover payments in FY 2018-19 for prior year dates of service, but is unsure of the magnitude at this time. Due to state fiscal rules, the Department is unable to offset current year expenditure for prior year recoveries, and therefore, the recoveries are counted as revenue to cash funds.

EXHIBIT C3 - CHILDREN'S BASIC HEALTH PLAN SUMMARY

Exhibit C3 presents a summary of Children's Basic Health Plan caseload and capitation expenditures itemized by eligibility category and a summary of the bottom line adjustments to expenditure, as well as expenditures for CBHP Administration. The net capitation payments include the impacts of the reconciliations for manual enrollments. Exhibit C6 illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT C4 - CBHP CASELOAD

Exhibit C4 contains the caseload history for each of the eligibility categories broken down by poverty level (0%-205% and 206%-260%) and also broken down by age group for children's categories (ages 0-1, 2-5, and 6-18). Each of the tables that comprise Exhibit C4 is described below. Forecast details for CHP+ caseload can be found starting on page 20 of this narrative.

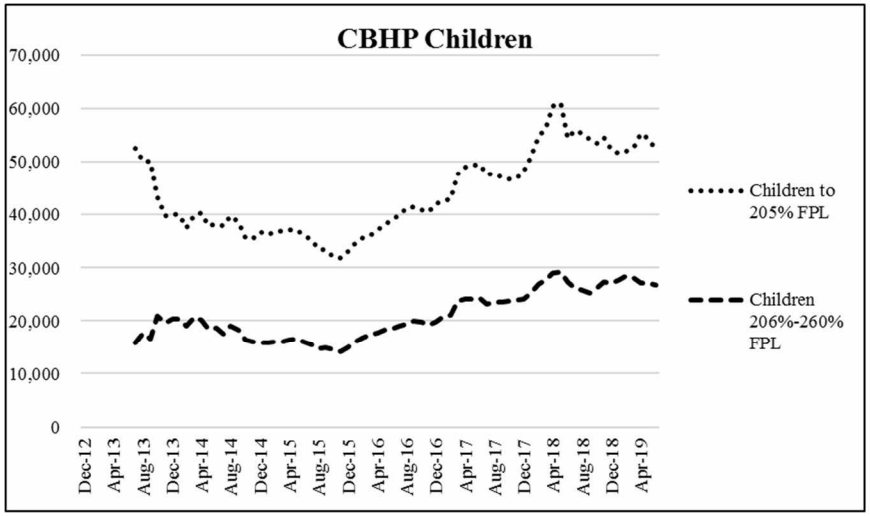
Children's Basic Health Plan Caseload by Fiscal Year

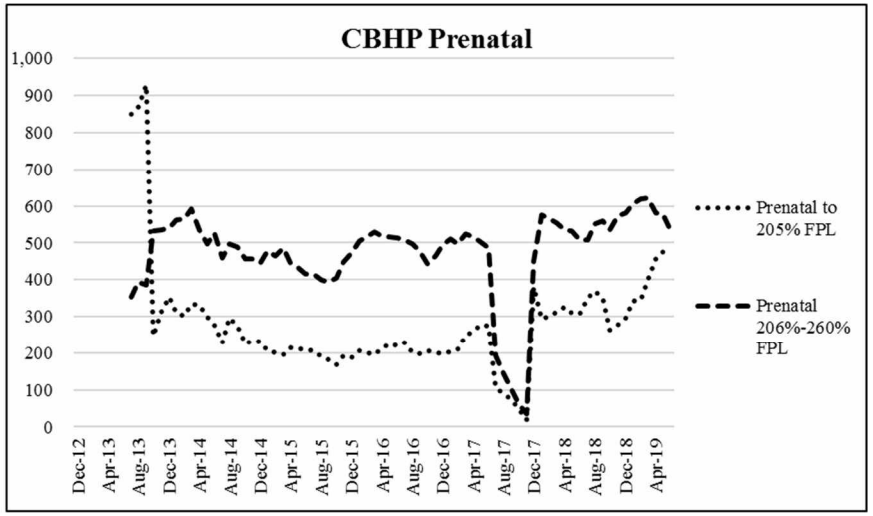
Caseload for the Children's Basic Health Plan is displayed in one table showing caseload by all CHP+ eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are 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 Caseload by Month

These tables show the actual caseload by month as reported in the JBC monthly report for the three most recent fiscal years. The Department uses data for members attributed to HMOs as the basis for thee forecast because it is a more accurate reflection of actual caps that will be paid in the fiscal year. All capitations paid for clients not initially tied to an HMO is captured in bottom line impacts.

As can be seen in the graphs shown below and on page C4-5, From January 2013 to January 2014 caseload decreased steadily for populations under 205% FPL, due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion, and increasing for populations above 205% FPL. The most recent months (January 2019 – June 2019) have experienced only slight amounts of growth, and caseload has been flat.





Children's Basic Health Plan Per Capita Historical Summary

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 capita. Figures for fiscal years up to the present fiscal year are actual per capita, while the current fiscal year and the request year per capita are estimates. Calculated per capita in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all expenditure adjustments for the given fiscal year. Forecasted per capita without bottom line adjustments can be found in exhibit C6. Calculations are described in exhibits C6 through C10.

Children's Basic Health Plan Historical Expenditures Summary

The history of expenditures shows total capitation expenditures for all CBHP eligibility categories. Medical and dental expenditures are listed separately. Actual expenditures through FY 2013-14 by eligibility category are available from the Colorado Financial Reporting System (COFRS) and actual expenditures for FY 2013-14 are also reported in exhibit C3-Expenditure Summary. Actual expenditure

from FY 2014-15 and forward are from the Colorado Operations Resource Engine (CORE). This exhibit also includes a similar summary of expenditure for all forecast years.

EXHIBIT C5 - CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES

Traditional Population Expenditures and Funding

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the 2019 Tobacco MSA Payment Forecast, allocation changes from HB 16-1408 "Cash Fund Allocations for Health-related Programs", and the actual expenditures from prior years. Calculations can be seen in exhibit C5.

As described above for exhibit C2, the CHP+ Federal Match increased by 23 percentage points in October 2015 and remains in effect until September 30, 2019. With this increased match, the Department forecasts that the CHP Trust Fund will have sufficient revenue to cover the expenditures of the CHP+ population under 205% FPL, through September 30, 2020. This results in $0 General Fund expenditure for capitation payments. Beginning October 1, 2020, when the enhanced federal match rate steps down to 67.88% the Department expects General Fund will be needed for this population as there will no longer be enough revenue in the CHP+ Trust Fund to support expenditures.

Expansion Population Expenditures and Funding

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%-260% FPL. These populations also receive the enhanced CHP+ Federal Match. Services for these clients are funded through the Healthcare Affordability and Sustainability Fee Cash Fund. This exhibit shows expenditures for the expansion population in isolation and provides additional detail to the calculation of fund splits.

Children's Health Plan Plus Enrollment Fees

Clients above 157% FPL owe an enrollment fee prior to accessing benefits. There is a fee for enrolling either one child, or more than one child. This exhibit shows the assumptions and calculations used to predict the collected enrollment fees. The amount accrued in

enrollment fees is exempt from the federal match, so this amount is subtracted from the estimated CHP+ expenditures that can receive a federal match for fund split calculations seen in exhibits C2 and C5.

EXHIBIT C6 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit C6 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 C8 through C10 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 in the exhibit C6.

After calculating total expenditure for capitations, the anticipated reconciliation payments for manual enrollments for each fiscal year are estimated and added to total expenditure. The sum of expenditure for capitation payments and reconciliation payments for manual enrollments is the total CBHP Capitation Payments summarized in exhibit C3. Following the addition of projected reconciliation payments for manual enrollments are any applicable bottom-line impacts to expenditure. Details are discussed below in exhibit C7.

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 C6. The methodology for determining the forecasted capitation rate is the subject of exhibits C8 through C10.

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. Page C6-4 presents the percentage of claims paid in a twelve-month period that come from that same period and those which come from previous periods.

EXHIBIT C7 - CHILDREN'S BASIC HEALTH PLAN BOTTOM LINE IMPACTS TO EXPENDITURE

Reconciliation payments for manual enrollments

As mentioned above, the Department makes reconciliation payments for clients that were manually enrolled. These are projected by applying growth rates from projected caseload (exhibit C4) and rate inflation (exhibit C9) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year. In FY 2018-19, the Department did not make any manual enrollment reconciliation payments for FY 2018-19; the payments made were only for prior fiscal years. Going forward the Department estimates that these reconciliations will no longer be necessary.

Delta Dental MLR Reconciliation

The Department requires its dental contractor to maintain a medical loss ratio of 80% or greater. In the past, the department has recouped funds from the contractor due to having a ratio of less than 80%. The Department expects to recoup funding again from the contractor in FY 2019-20 and beyond, but is unsure of the magnitude at this time. Therefore, the Department is estimating about $100,000 in recoupments.

Health Insurance Providers Fee (HIPF)

The Affordable Care Act imposed a requirement that for-profit health insurers are required to pay a fee. The amount of the fee is determined through a series of calculations that accounts for the total required collection and number of insurers. The fee was assessed in CY 2016 and will be assessed in CY 2018. There was a moratorium in place for CY 2017 and CY 2019, so the Department will not be responsible for paying the fee for those years.

HB 19-1038 Dental Services for Pregnant Women

In 2019, the state legislature passed HB 19-1038 which provides dental services to all prenatal CHP+ clients. Starting October 1, 2019 all pregnant women will benefit from the same dental services as CHP+ children except for orthodontics (braces). The benefits include diagnostic services (exams and x-rays), preventive (fluoride, sealants, and cleanings), basic restorative services (fillings), endodontics (roots canals), and emergency dental services. The annual maximum allowable benefit is $1,000 per calendar year (July 1st through June 30th) while the member is eligible and enrolled.

EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION 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 health maintenance organizations (HMOs) and State Managed Care Network (SMCN) 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 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 seven years of claims and caseload data. Exhibit C8 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The Department did experience a significant amount of duplicate claims through calendar year 2013, but these duplicate claims have been removed from this analysis. Historically, the Department's methodology for calculating the retroactivity factor was to use claims and caseload data for each cohort (i.e. Children to 205% FPL Medical, Children to 205% FPL Dental, Children 206%-260% FPL Medical, etc.), but due to trouble identifying a subset of the population, 201%-205% FPL, retroactivity is skewed. As a result, the new methodology used is to calculated an aggregate retroactivity factor based on all children for medical and dental, and all prenatal adults across all FPL groups and use that single factor for both FPL groups for children and prenatal women. Details on the selected retroactivity adjustment can be found on page C8-1.

Claims Distribution Adjustment Multiplier

To derive the claims distribution 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 seven years of data were examined.

As presented in Exhibit C8, for each eligibility category, the amount paid divided by claims was compared to the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual HMO or SMCN). 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. Details on the selected claims distribution adjustment for each eligibility in Exhibit C8.

EXHIBIT C9 - 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 C9 presents historical data as well as the forecasted weighted rates. Rates are first presented by poverty level and age group, and then aggregated by poverty level for all ages.

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 C10.

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 several factors. First, the rate is weighted within an eligibility category. Within an eligibility category, the rate is weighted by the health maintenance organizations' and state managed care network's proportion of claims processed within that eligibility category, the proportion attributable to each FPL category (0%-100%, 101%-156%, 157%-200%, and above 200%), and for children the proportion for each age range (ages 0-1, 2-5, and 6-18). Next, 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 C9 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. Below is a table showing the actual weighted rate for FY 2018-19, and the projected weighted rates through FY 2021-22.

Fiscal Year	Children Medical to 205% FPL	Children Medical 206%-259% FPL	Children Dental to 205% FPL	Children Dental 206%-259% FPL	Prenatal to 205% FPL	Prenatal 206%-259% FPL	Weighted CBHP Total
FY 2018-19 Actuals	**$157.86**	**$157.04**	**$19.68**	**$19.28**	**$980.79**	**$970.08**	**$187.71**
FY 2019-20 Estimated Rate	$169.59	$171.53	$20.73	$19.84	$980.61	$970.08	$210.26
% Change from FY 2018-19	*7.43%*	*9.23%*	*5.34%*	*2.90%*	*-0.02%*	*0.00%*	*12.01%*
FY 2020-21 Estimated Rate	$175.51	$177.79	$20.95	$19.91	$980.61	$970.08	$216.17
% Change from FY 2019-20	*3.49%*	*3.65%*	*1.06%*	*0.35%*	*0.00%*	*0.00%*	*3.07%*
FY 2021-22 Estimated Rate	$181.34	$183.75	$21.11	$20.05	$980.61	$970.08	$224.63
% Change from FY 2020-21	*3.32%*	*3.35%*	*0.76%*	*0.70%*	*0.00%*	*0.00%*	*3.65%*

EXHIBIT C10 - FORECAST MODEL COMPARISONS

Exhibit C10 produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in exhibit C6. Exhibit C10 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 C8.

Exhibit C10 also presents, a series of forecast models each eligibility category. From the models or from historical changes, a point estimate is selected as an input. Based on the point estimates, the adjustments presented in Exhibit C8 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit C6.

Final Forecasts

Exhibit C10 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 in Exhibit C10 (see below).

The forecasted rate is then adjusted by the claims distribution adjustment multiplier, calculated in Exhibit C8. The multiplier is applied to account for the distribution of clients amongst the different HMO's and the SMCN. The average amount paid may not perfectly reflect the estimated claims distribution. 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 C8, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit C8, 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 C6. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

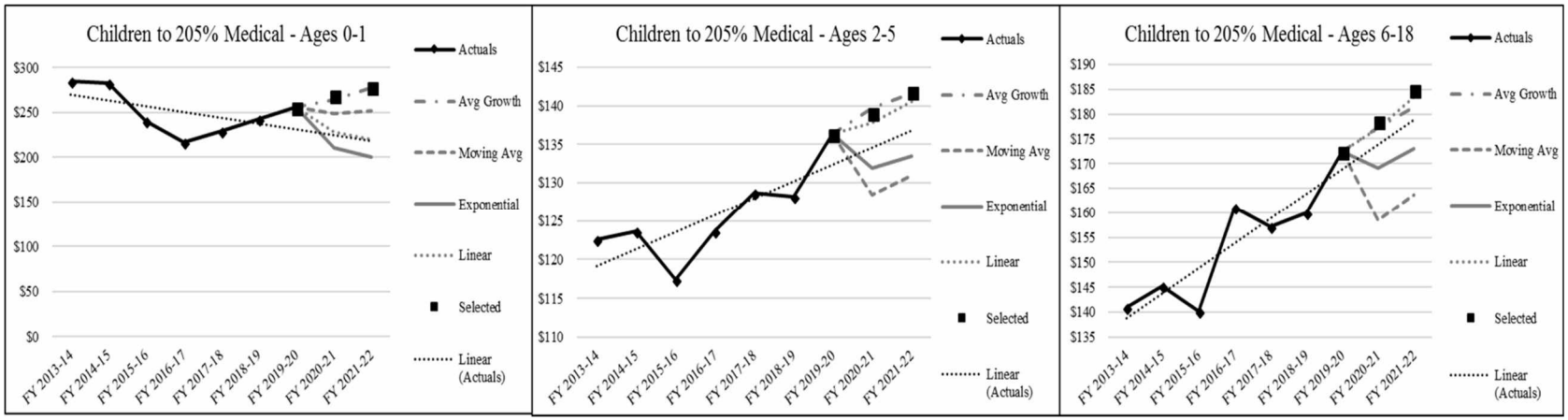
The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented in Exhibit C10.

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.

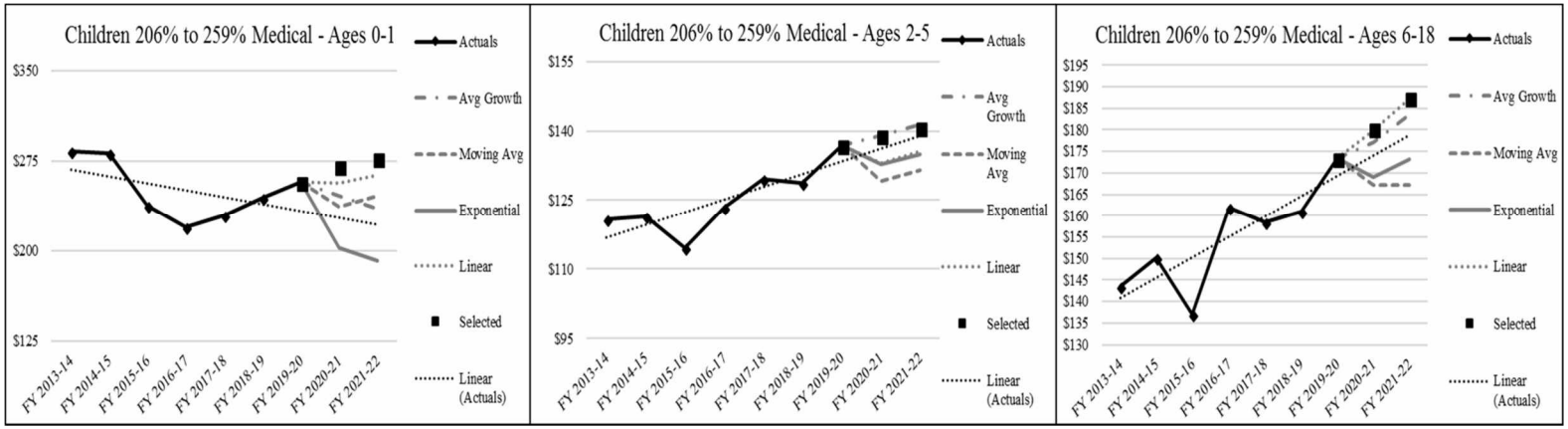
The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

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. 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. The tables beginning on the next page show the trends selected for the current and request years by eligibility category.

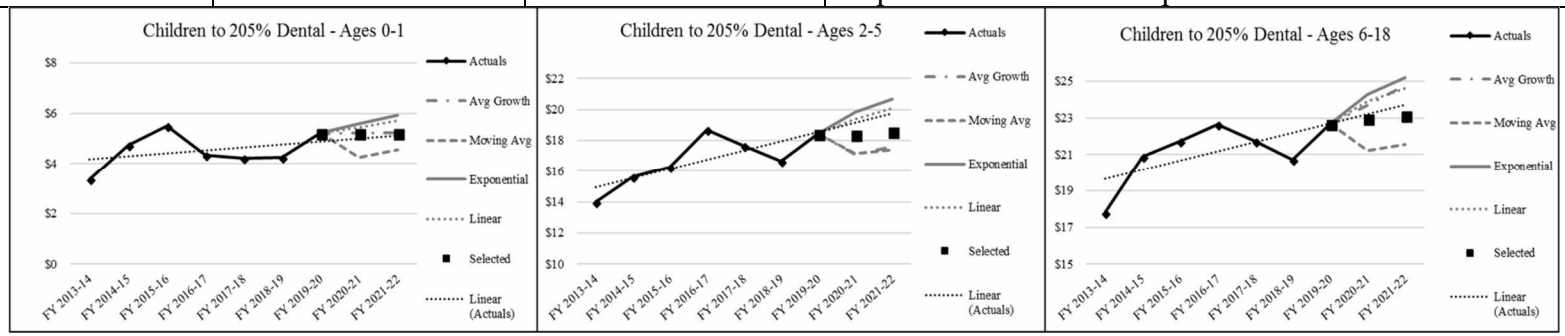
Rate Trends for Children Medical to 205% FPL			
Aid Category	**FY 2019-20 Trend Selection**	**FY 2020-21 Trend Selection**	**Justification**
Children to 205% FPL Medical Ages 0-1	**5.57%** Average Growth Model	**3.45%** Average Growth Model	Strong growth from previous 4 years. The Department expect this to continue.
Children to 205% FPL Medical Ages 2-5	**1.99%** Average Growth Model	**2.03%** Average Growth Model	Strong growth from previous 4 years. The Department expect this to continue.
Children to 205% FPL Medical Ages 6-18	**3.57%** Average Growth Model	**3.57%** Average Growth Model	Rates for Children 0 to 1 have been increasing rapidly over the past 4 years. The average rate growth over the past 4 years is around 6%; the Department expects this to slow slightly but strong growth to continue.



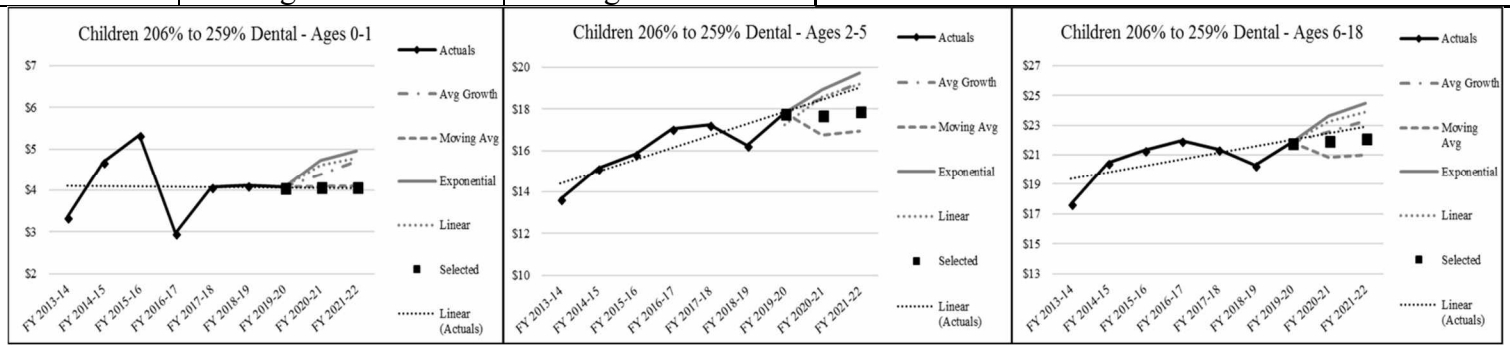
Rate Trends for Children Medical 206% to 260% FPL			
Aid Category	**FY 2019-20 Trend Selection**	**FY 2020-21 Trend Selection**	**Justification**
Children 206% to 260% FPL Medical Ages 0-1	**5.18%**	**2.45%**	Rate growth have been strong and the Department is anticipating increase in rates due to clients that use services at higher rates.
	Growth from FY 2016-17 to FY 2017-18	Two Period Moving Average	
Children 206% to 260% FPL Medical Ages 2-5	**1.64%**	**1.15%**	Rate growth have been strong and the Department is anticipating increase in rates due to clients that use services at higher rates
	Average Growth Model	Average Growth Model	
Children 206% to 260% FPL Medical Ages 6-18	**3.91%**	**4.00%**	Average rate increases for past 6 years are around 6%. The Department expects rate growth to be strong but the increase in the rates to get smaller.
	Average Growth Model	Average Growth Model	



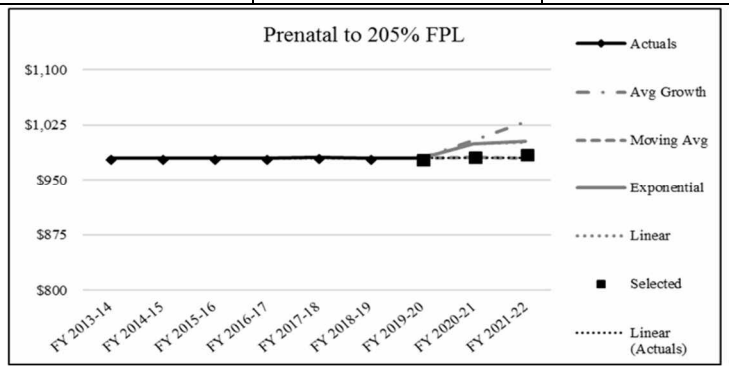
Rate Trends for Children Dental to 205% FPL			
Aid Category	**FY 2019-20 Trend Selection**	**FY 2020-21 Trend Selection**	**Justification**
Children to 205% FPL Dental Ages 0-1	**0.19%** Growth from FY 2017-18 to FY 2018-19 Rate	**0.19%** Growth from FY 2017-18 to FY 2018-19 Rate	Rates for this cohort remained flat for previous years but have bounced up following a slight decline in FY 2018-19. This is due to the unknowns when setting rates due to the expansion of the dental benefits and rates appear to be settling in. The Department uses a small positive trend.
Children to 205% FPL Dental Ages 2-5	**-0.38%** Average Growth Model	**1.14%** Average Growth Model	Rates for this cohort remained flat for previous years but have bounced up following a slight decline in FY 2018-19. This is due to the unknowns when setting rates due to the expansion of the dental benefits and rates appear to be settling in. The Department uses a small positive trend.
Children to 205% FPL Dental Ages 6-18	**1.46%** Two Period Moving Average Model	**0.74%** Two Period Moving Average Model	Rates for this cohort remained flat in FY 2018-19 following a slight decline in FY 2017-18. This is due to the unknowns when setting rates due to the expansion of the dental benefits and rates appear to be settling in. The Department uses a small positive trend.

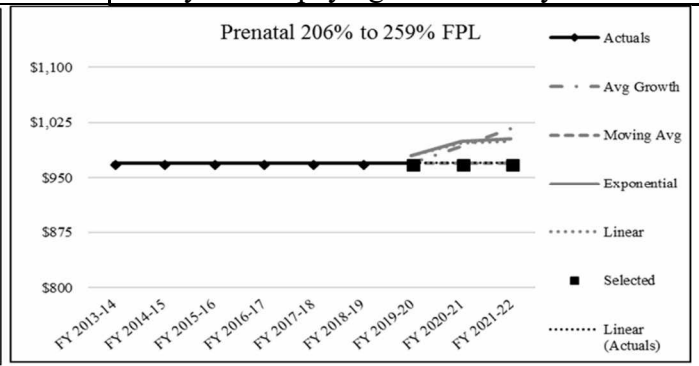


Rate Trends for Children Dental 206% to 260% FPL			
Aid Category	**FY 2019-20 Trend Selection**	**FY 2020-21 Trend Selection**	**Justification**
Children 206% to 260% FPL Dental Ages 0-1	**0.25%** Growth from FY 2017-18 to FY 2018-19 Rate	**0.24%** Growth from FY 2017-18 to FY 2018-19 Rate	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
Children 206% to 260% FPL Dental Ages 2-5	**-0.34%** Trend from 0-205% FPL Ages 2-5	**1.13%** Trend from 0-205% FPL Ages 2-5	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
Children 206% to 260% FPL Dental Ages 6-18	**0.73%** Trend from 0-205% FPL Ages 6-18	**0.73%** Trend from 0-205% FPL Ages 6-18	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.



Rate Trends for Prenatal			
Aid Category	**FY 2019-20 Trend Selection**	**FY 2020-21 Trend Selection**	**Justification**
Prenatal to 205% FPL	**0.00%**	**0.00%**	In the past the Department has recouped money from the SMCN due to systems issues. The Department has trued up its payments with the SMCN and is not expecting to recoup payments as the system is paying out correctly.
	Average Growth Model	Average Growth Model	
Prenatal 206%-260% FPL	**0.00%**	**0.00%**	In the past the Department has recouped money from the SMCN due to systems issues. The Department has trued up its payments with the SMCN and is not expecting to recoup payments as the system is paying out correctly.
	Average Growth Model	Exponential Growth Model	





CBHP CASELOAD

Length of Stay

CBHP caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The Department has started tracking the average length of stay for each eligibility category to further understand the behavior of the CHP+ clients. Results for FY 2015-16 (shaded) is subject to change as there may not be sufficient run out to capture the true length of stay for

all clients. The Department anticipates an increase in the average length of stay as continuous eligibility for Medicaid Eligible Children and CHP+ Children was implemented March 1st, 2014.

		CHP Children 0%-205%	CHP Children 206%-260%	CHP Prenatal 0%-205%	CHP Prenatal 206%-260%
FY 2012-13	Avg. LOS Mo's	8.53	11.37	5.19	6.35
	% > 12 Mo's	26.63%	42.59%	0.84%	0.62%
FY 2013-14	Avg. LOS Mo's	11.62	13.34	5.29	6.61
	% > 12 Mo's	37.13%	47.16%	1.33%	3.48%
FY 2014-15	Avg. LOS Mo's	16.56	15.12	7.81	7.27
	% > 12 Mo's	68.77%	58.39%	5.54%	3.69%
FY 2015-16	Avg. LOS Mo's	16.30	15.89	8.75	8.08
	% > 12 Mo's	81.51%	78.49%	12.72%	9.30%
FY 2016-17	Avg. LOS Mo's	15.55	16.07	7.23	7.06
	% > 12 Mo's	54.26%	59.42%	2.22%	1.54%

CBHP Caseload Models

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data is used from July 2007 to December 2018. CBHP caseload increased significantly in FY 2016-17 and coincides with the implementation of the interChange. A large percentage of the growth experienced are for members that are not tied to an HMO. For the purpose of forecasting caseload, the Department has chosen to forecast based on those clients that are actively tied to an HMO because that appears to be the best representation of actual enrollment and expenditure. As a result, caseload figures in the exhibits may not tie directly to those mentioned below for forecasting. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The Department is now using the software EViews 6 to estimate these models.

Trend and Seasonality Model

CBHP caseload is a non-stationary series with a positive trend and many of the categories experience some level of seasonality. One of the models used incorporates a time trend and monthly seasonal dummy variables.

ARIMA Model

ARIMA models, once referred to as Box-Jenkins models, rely on the past behavior of the series being forecasted. Relying on the past behavior of a series mandates that a series be stationary. Most of the eligibilities in Medicaid caseload have a positive growth trend (non-stationary) and require differencing to be made stationary.

Trend Stationary and Difference Stationary

Series that are stationary have a constant mean, caseload series frequently do not have this characteristic and often have a trending mean. Two popular models used for non-stationary series with a trending mean are trend stationary and difference stationary. The trend stationary serves as an effective model if the series has a deterministic trend. The difference stationary model proves effect should the trend be stochastic. Differencing the dependent variable gives a stationary series. The basic forms of the two models are listed below.

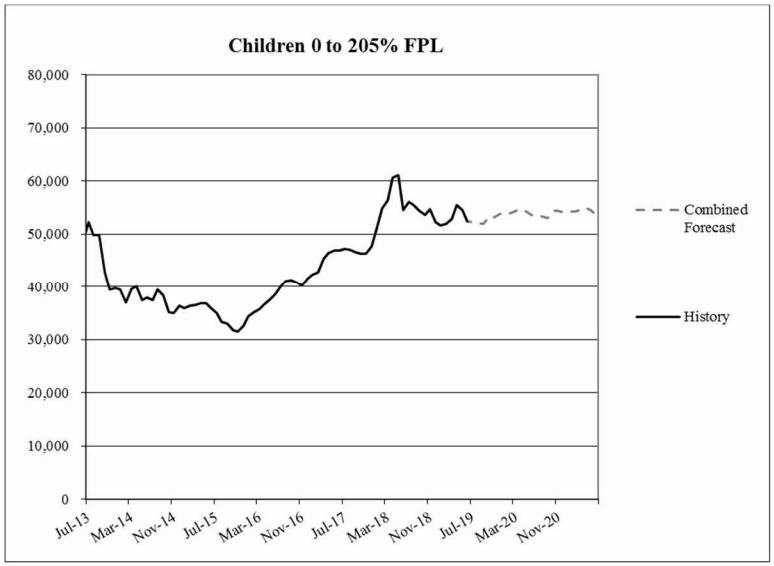
- Trend Stationary: $\log(y) = c + \text{trend} + \varepsilon$
- Difference Stationary: $\text{differenced}(\log(y)) = c + \varepsilon$

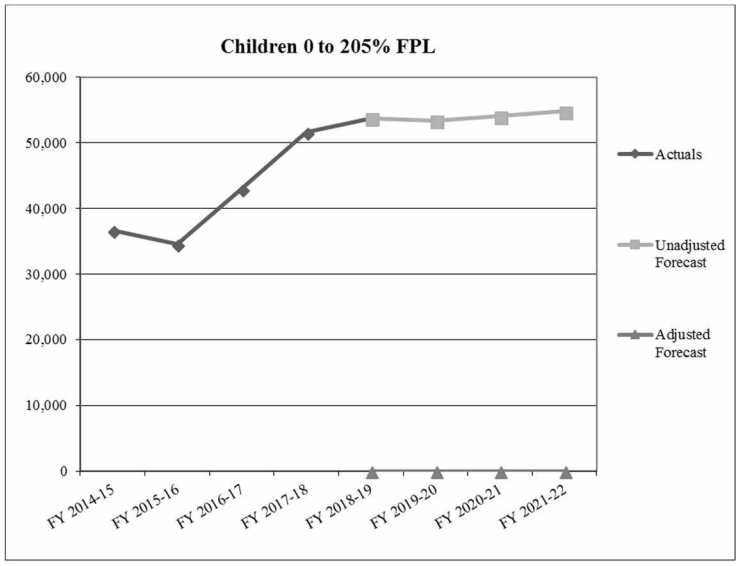
Model Selection

Models are created for each individual group that receives a separate rate. These groups are separated by FPL for both children and prenatal: under 100%, 101%-156%, 157%-200%, 201%-205%, and 206%-260%. Children's groups are also separated by age: age groups 0-1, 2-5, and 6-18. A model is selected to forecast each group After several different forecasts are produced, the Department normally chooses one for each category and then aggregated to the FPL categories for children and prenatal; under 205% and 206%-260%. When selecting a model, the Department closely analyzes the historical data as well as the goodness of fit of the model.

CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST

Children's Caseload Projections (Exhibit C4)





- Average monthly caseload in FY 2018-19 for CHP+ Children 0%-205% FPL was 53,426, which was higher than what was forecasted in the February forecast by 232 clients. If caseload for this group remained at this level for FY 2018-19 caseload would decrease by roughly 2.45% from year to year. The Department does expect some growth in FY 2019-20 beyond the baseline, projecting the final FY 2018-19 average monthly caseload of 53,426, but this would represent a decrease in caseload of 0.61%. The decrease in caseload has been driven by the June data point which was a decrease of 2,106 clients. The Department expects slow caseload growth in FY 2019-20 and FY 2020-21 as a result of the improving economy and slowing growth in Medicaid caseload for children.

- This population includes the subpopulation created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201% and 205% FPL.

Total Children 0 to 205%

	Actuals	Monthly Change	% Change
Jun-17	46,923		
Jul-17	47,138	215	0.46%
Aug-17	47,097	(41)	-0.09%
Sep-17	46,569	(528)	-1.12%
Oct-17	46,242	(327)	-0.70%
Nov-17	46,312	70	0.15%
Dec-17	47,629	1,317	2.84%
Jan-18	50,891	3,262	6.85%
Feb-18	54,854	3,963	7.79%
Mar-18	56,287	1,433	2.61%
Apr-18	60,590	4,303	7.64%
May-18	61,037	447	0.74%
Jun-18	54,475	(6,562)	-10.75%
Jul-18	56,021	1,546	2.84%
Aug-18	55,401	(620)	-1.11%
Sep-18	54,388	(1,013)	-1.83%
Oct-18	53,528	(860)	-1.58%
Nov-18	54,613	1,085	2.03%
Dec-18	52,204	(2,409)	-4.41%
Jan-19	51,644	(560)	-1.07%
Feb-19	51,991	347	0.67%
Mar-19	52,857	866	1.67%
Apr-19	55,395	2,538	4.80%
May-19	54,542	(853)	-1.54%
Jun-19	52,436	(2,106)	-3.86%

	Caseload	% Change	Level Change
FY 2010-11	-	-	-
FY 2011-12	-	-	-
FY 2012-13	61,897	-	-
FY 2013-14	42,060	-32.05%	(19,837)
FY 2014-15	36,660	-12.84%	(5,400)
FY 2015-16	34,586	-5.66%	(2,075)
FY 2016-17	42,952	24.19%	8,367
FY 2017-18	51,593	20.12%	8,641
FY 2018-19	53,752	4.18%	2,158
FY 2019-20	53,426	-0.61%	(326)
FY 2020-21	54,055	1.18%	629
FY 2021-22	54,833	1.44%	778

February 2018 Projection

FY 2017-18	51,478	-4.77%	(2,578)
FY 2018-19	53,927	4.76%	2,450
FY 2019-20	54,711	1.45%	784
FY 2020-21	56,091	2.52%	1,380

Monthly Average Growth Actuals

FY 2013-14 1st Half	(1,481)	-3.07%
FY 2013-14 2nd Half	(310)	-0.70%
FY 2013-14	(895)	-1.88%
FY 2014-15 1st Half	(235)	-0.53%
FY 2014-15 2nd Half	(80)	-0.21%
FY 2014-15	(158)	-0.37%
FY 2015-16 1st Half	(557)	-1.58%
FY 2015-16 2nd Half	989	2.83%
FY 2015-16	216	0.63%
FY 2016-17 1st Half	509	1.30%
FY 2016-17 2nd Half	890	2.05%
FY 2016-17	700	1.68%
FY 2017-18 1st Half	118	0.26%
FY 2017-18 2nd Half	1,141	2.48%
FY 2017-18	629	1.37%
FY 2018-19 1st Half	(379)	-0.68%
FY 2018-19 2nd Half	39	0.11%
FY 2018-19	(170)	-0.28%

Actuals

	Monthly Change	% Change
6-month average	39	0.11%
12-month average	(170)	-0.28%
18-month average	267	0.64%
24-month average	230	0.54%

Monthly Average Growth Comparisons

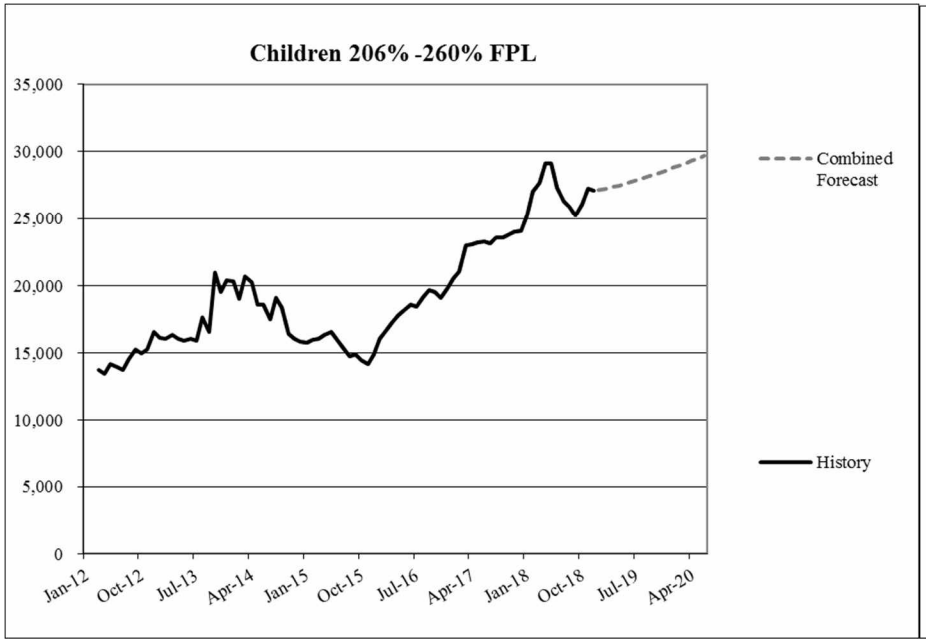
Request	Monthly Change	
	S-3	R-3
FY 2019-20 1st Half	0	215
FY 2019-20 2nd Half	112	(28)
FY 2019-20	56	93
FY 2020-21 1st Half	134	72
FY 2020-21 2nd Half	134	(28)
FY 2020-21	134	22
FY 2021-22 1st Half	#DIV/0!	218
FY 2021-22 2nd Half	#DIV/0!	(28)
FY 2021-22	#DIV/0!	95

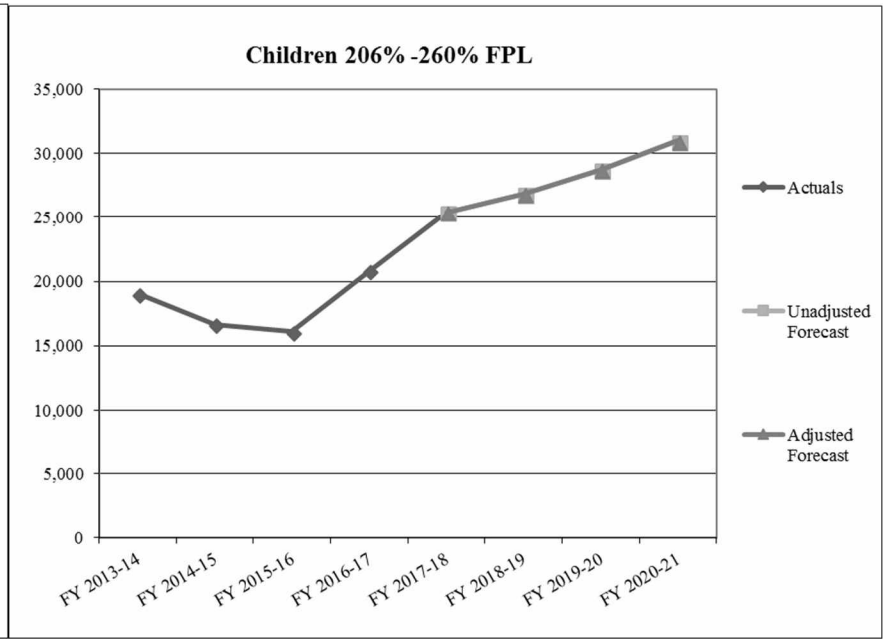
February 2019 Forecast

Forecasted June 2019 Level	54,542

Base trend from June 2019 level

FY 2019-20	52,436	-1.14%	(1,316)





- Average monthly caseload for FY 2018-19 for CHP+ Children 206%-260% FPL was 26,958, which was higher than what was forecasted in the February 2019 forecast by 82 clients. If caseload for this group remained at this level for FY 2019-20, then it would decrease by roughly 0.5%. from year to year. The Department does expect some growth in FY 2019-20 beyond the baseline, projecting the final FY 2019-20 average monthly caseload of 27,180, or an increase of 0.82% over FY 2018-19. The Department expects moderate caseload growth in FY 2019-20 and FY 2020-21 as a result of the improving economy and slowing growth in Medicaid caseload for children.

- 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 260% of the federal poverty level.

Total Children 206% to 260%

	Actuals	Monthly Change	% Change
Jun-17	23,302		
Jul-17	23,101	(201)	-0.86%
Aug-17	23,532	431	1.87%
Sep-17	23,551	19	0.08%
Oct-17	23,799	248	1.05%
Nov-17	24,001	202	0.85%
Dec-17	24,093	92	0.38%
Jan-18	25,260	1,167	4.84%
Feb-18	27,049	1,789	7.08%
Mar-18	27,694	645	2.38%
Apr-18	29,115	1,421	5.13%
May-18	29,160	45	0.15%
Jun-18	27,300	(1,860)	-6.38%
Jul-18	26,301	(999)	-3.66%
Aug-18	25,854	(447)	-1.70%
Sep-18	25,249	(605)	-2.34%
Oct-18	26,116	867	3.43%
Nov-18	27,269	1,153	4.41%
Dec-18	27,094	(175)	-0.64%
Jan-19	27,763	669	2.47%
Feb-19	28,465	702	2.53%
Mar-19	28,118	(347)	-1.22%
Apr-19	27,227	(891)	-3.17%
May-19	27,214	(13)	-0.05%
Jun-19	26,823	(391)	-1.44%

February 2019 Forecast	
Forecasted June 2019 Level	27,345

Base trend from June 2019 level			
FY 2019-20	26,823	-0.50%	(135)

	Caseload	% Change	Level Change
FY 2008-09	13	-	-
FY 2009-10	13	-	-
FY 2010-11	4,023	30455.70%	4,010
FY 2011-12	11,049	174.64%	7,026
FY 2012-13	15,576	40.97%	4,527
FY 2013-14	19,043	22.26%	3,468
FY 2014-15	16,668	-12.47%	(2,376)
FY 2015-16	16,100	-3.41%	(568)
FY 2016-17	20,808	29.24%	4,708
FY 2017-18	25,638	23.21%	4,830
FY 2018-19	26,958	5.15%	1,319
FY 2019-20	27,180	0.82%	222
FY 2020-21	27,741	2.06%	561
FY 2021-22	28,297	2.00%	556

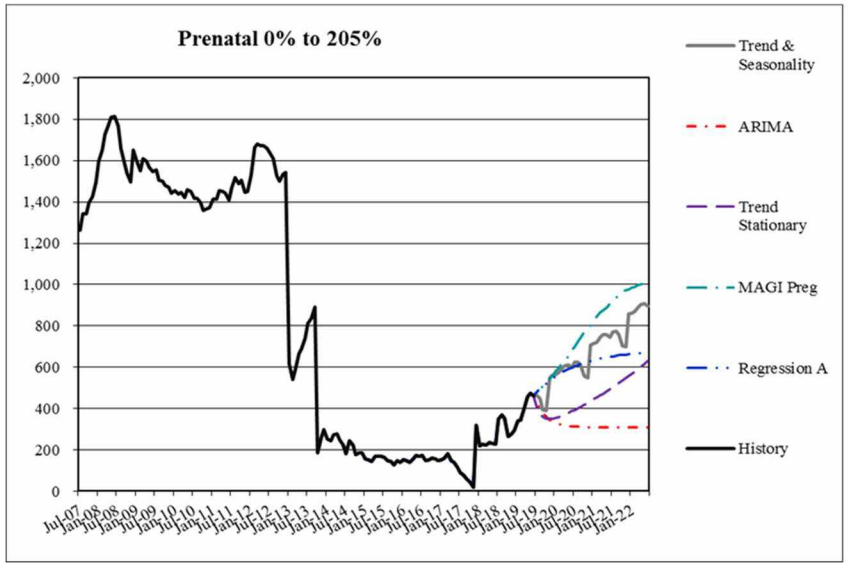
Actuals		
	Monthly Change	% Change
6-month average	(45)	-0.15%
12-month average	(40)	-0.11%
18-month average	152	0.66%
24-month average	147	0.63%

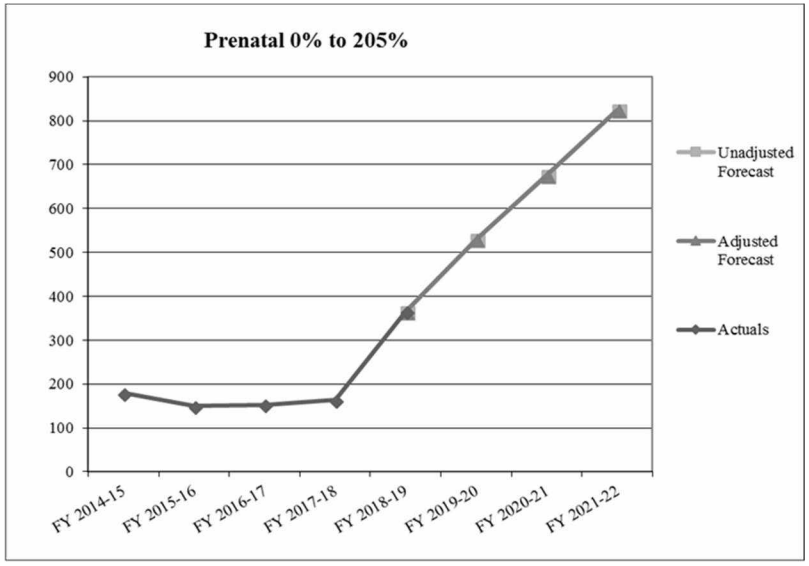
February 2018 Projection Before Adjustments			
FY 2018-19	25,465	-5.54%	(1,493)
FY 2019-20	27,002	6.04%	1,537
FY 2020-21	28,340	4.96%	1,338
FY 2021-22	30,526	7.71%	2,186

Monthly Average Growth Actuals		
FY 2013-14 1st Half	722	4.66%
FY 2013-14 2nd Half	(294)	-1.35%
FY 2013-14	214	1.66%
FY 2014-15 1st Half	(460)	-2.46%
FY 2014-15 2nd Half	26	0.18%
FY 2014-15	(217)	-1.14%
FY 2015-16 1st Half	(183)	-1.12%
FY 2015-16 2nd Half	610	3.74%
FY 2015-16	214	1.31%
FY 2016-17 1st Half	203	1.09%
FY 2016-17 2nd Half	587	2.81%
FY 2016-17	395	1.95%
FY 2017-18 1st Half	132	0.56%
FY 2017-18 2nd Half	535	2.20%
FY 2017-18	333	1.38%
FY 2018-19 1st Half	(34)	-0.08%
FY 2018-19 2nd Half	24	0.11%
FY 2018-19	(8)	0.01%

Monthly Average Growth Comparisons		
Request	Monthly Change	
	S-3	R-3
FY 2019-20 1st Half	148	60
FY 2019-20 2nd Half	172	44
FY 2019-20	160	52
FY 2020-21 1st Half	191	46
FY 2020-21 2nd Half	205	46
FY 2020-21	198	46
FY 2021-22 1st Half	#DIV/0!	47
FY 2021-22 2nd Half	#DIV/0!	47
FY 2021-22	#DIV/0!	47

Prenatal Caseload Projections (Exhibit C4)





- Average monthly caseload for FY 2018-19 for CHP+ Prenatal 0%-205% FPL was 365, with the June data point at 462 clients which was higher than what was forecasted in the February 2019 forecast by 148 clients. If caseload for this group remained at this level for FY 2019-20 caseload would grow by roughly 26% from year to year. The Department does expect additional growth in FY 2019-20 beyond the baseline, projecting the final FY 2019-20 average monthly caseload of 530, or an increase of 45% over FY 2018-19. The Department expects caseload in FY 2019-20 and FY 2020-21 to grow at a moderate rate.

- Along with the children's expansion to 205% FPL, this population includes the subpopulation that was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this subpopulation have family incomes between 201 and 205% of the federal poverty level.

CHP+ Prenatal 0% to 205%

	Actuals	Monthly Change	% Change
Jun-17	116	-	-
Jul-17	91	(25)	-21.55%
Aug-17	76	(15)	-16.48%
Sep-17	59	(17)	-22.37%
Oct-17	44	(15)	-25.42%
Nov-17	18	(26)	-59.09%
Dec-17	317	299	1661.11%
Jan-18	218	(99)	-31.23%
Feb-18	228	10	4.59%
Mar-18	222	(6)	-2.63%
Apr-18	235	13	5.86%
May-18	231	(4)	-1.70%
Jun-18	228	(3)	-1.30%
Jul-18	349	121	53.07%
Aug-18	369	20	5.73%
Sep-18	351	(18)	-4.88%
Oct-18	263	(88)	-25.07%
Nov-18	277	14	5.32%
Dec-18	295	18	6.50%
Jan-19	341	46	15.59%
Feb-19	344	3	0.88%
Mar-19	398	54	15.70%
Apr-19	455	57	14.32%
May-19	475	20	4.40%
Jun-19	462	(13)	-2.74%

February 2019 Forecast	
Forecasted June 2019 Level	481

Base trend from June 2019 level			
FY 2019-20	462	26.60%	97

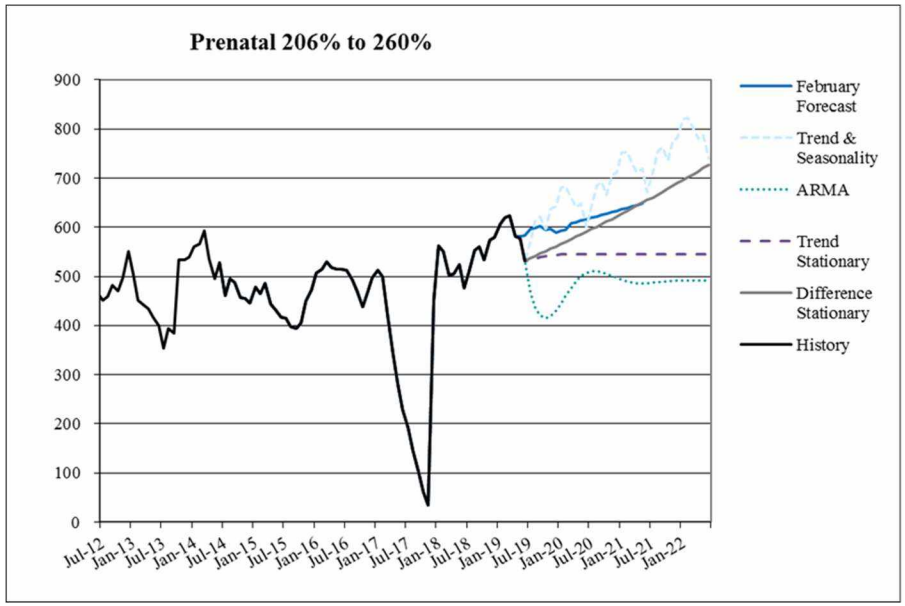
	Caseload	% Change	Level Change
FY 2008-09	1,598	-	-
FY 2009-10	1,469	-8.08%	(129)
FY 2010-11	1,409	-4.04%	(59)
FY 2011-12	1,563	10.92%	154
FY 2012-13	1,100	-29.64%	(463)
FY 2013-14	399	-63.71%	(701)
FY 2014-15	180	-55.02%	(220)
FY 2015-16	150	-16.34%	(29)
FY 2016-17	153	1.66%	3
FY 2017-18	164	7.37%	11
FY 2018-19	365	122.62%	201
FY 2019-20	530	45.24%	165
FY 2020-21	676	27.55%	146
FY 2021-22	825	22.04%	149

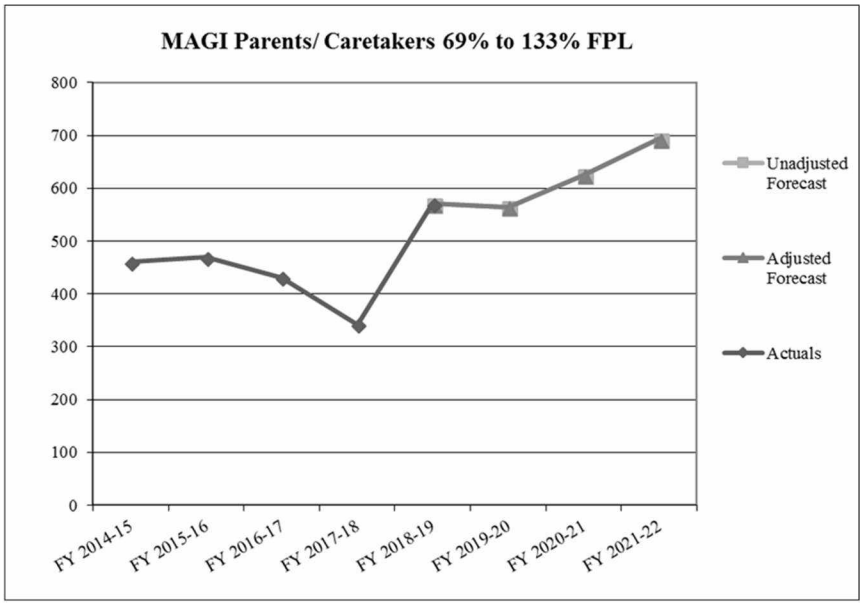
Actuals		
	Monthly Change	% Change
6-month average	28	8.03%
12-month average	20	7.40%
18-month average	8	3.47%
24-month average	14	65.77%

February 2019 Projection Before Adjustments			
FY 2017-18	305	56.41%	110
FY 2018-19	366	20.00%	61
FY 2019-20	521	42.35%	155
FY 2020-21	605	16.12%	84

Monthly Average Growth Actuals		
FY 2013-14 1st Half	(74)	-0.78%
FY 2013-14 2nd Half	(13)	-4.42%
FY 2013-14	(43)	-2.60%
FY 2014-15 1st Half	(6)	-1.32%
FY 2014-15 2nd Half	(3)	-1.34%
FY 2014-15	(5)	-1.33%
FY 2015-16 1st Half	(5)	-2.72%
FY 2015-16 2nd Half	5	3.48%
FY 2015-16	0	0.38%
FY 2016-17 1st Half	(3)	-1.64%
FY 2016-17 2nd Half	(6)	-3.41%
FY 2016-17	(4)	-2.53%
FY 2017-18 1st Half	34	252.70%
FY 2017-18 2nd Half	(15)	-4.40%
FY 2017-18	9	124.15%
FY 2018-19 1st Half	11	6.78%
FY 2018-19 2nd Half	28	8.03%
FY 2018-19	20	7.40%

Monthly Average Growth Comparisons				
Request	Monthly Change		Percent Change	
	S-3	R-3	S-3	R-3
FY 2019-20 1st Half	6	16	1.24%	4.45%
FY 2019-20 2nd Half	7	6	1.24%	1.09%
FY 2019-20	6	11	1.24%	2.77%
FY 2020-21 1st Half	7	19	1.24%	3.52%
FY 2020-21 2nd Half	8	6	1.24%	0.86%
FY 2020-21	7	12	1.24%	2.19%
FY 2021-22 1st Half	#DIV/0!	19	#DIV/0!	2.75%
FY 2021-22 2nd Half	#DIV/0!	6	#DIV/0!	0.71%
FY 2021-22	#DIV/0!	12	#DIV/0!	1.73%





- Average monthly caseload for FY 2018-19 for CHP+ Prenatal 206%-260% FPL was 571, which was higher than what was forecasted in the February forecast by 65 clients. If caseload for this group remained at this level for FY 2019-20 caseload would decrease by roughly 7.01%. from year to year. The Department does expect caseload to grow slightly in FY 2019-20, projecting the final FY 2018-19 average monthly caseload of 564. The Department expects caseload in FY 2019-20 and FY 2020-21 to increase slightly as well.

- 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 260% of the federal poverty level.

CHP+ Prenatal 206% to 260% FLP: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-17	230	-	-
Jul-17	192	(38)	-16.52%
Aug-17	145	(47)	-24.48%
Sep-17	101	(44)	-30.34%
Oct-17	62	(39)	-38.61%
Nov-17	34	(28)	-45.16%
Dec-17	452	418	1229.41%
Jan-18	562	110	24.34%
Feb-18	551	(11)	-1.96%
Mar-18	503	(48)	-8.71%
Apr-18	505	2	0.40%
May-18	524	19	3.76%
Jun-18	476	(48)	-9.16%
Jul-18	509	33	6.93%
Aug-18	552	43	8.45%
Sep-18	560	8	1.45%
Oct-18	534	(26)	-4.64%
Nov-18	574	40	7.49%
Dec-18	580	6	1.05%
Jan-19	606	26	4.48%
Feb-19	620	14	2.31%
Mar-19	623	3	0.48%
Apr-19	582	(41)	-6.58%
May-19	578	(4)	-0.69%
Jun-19	531	(47)	-8.13%

February 2019 Forecast	
Forecasted June 2019 Level	581

Base trend from June 2019 level			
FY 2019-20	531	-7.01%	(40)

	Caseload	% Change	Level Change
FY 2010-11	272	24	-
FY 2011-12	448	64.51%	176
FY 2012-13	463	3.46%	16
FY 2013-14	502	8.26%	38
FY 2014-15	460	-8.23%	(41)
FY 2015-16	469	1.96%	9
FY 2016-17	431	-8.17%	(38)
FY 2017-18	537	24.62%	106
FY 2018-19	571	6.28%	34
FY 2019-20	564	-1.18%	(7)
FY 2020-21	625	10.82%	61
FY 2021-22	693	10.88%	68

Actuals		
	Monthly Change	% Change
6-month average	(8)	-1.35%
12-month average	5	1.05%
18-month average	4	1.18%
24-month average	13	45.65%

February 2019 Projection Before Adjustments			
FY 2017-18	537	24.59%	106
FY 2018-19	575	7.08%	38
FY 2019-20	598	4.00%	23
FY 2020-21	632	5.69%	34

Monthly Average Growth Actuals		
FY 2013-14 1st Half	24	6.24%
FY 2013-14 2nd Half	(2)	-0.21%
FY 2013-14	11	3.02%
FY 2014-15 1st Half	(14)	-2.54%
FY 2014-15 2nd Half	(5)	-1.02%
FY 2014-15	(9)	-1.78%
FY 2015-16 1st Half	9	2.24%
FY 2015-16 2nd Half	7	1.47%
FY 2015-16	8	1.86%
FY 2016-17 1st Half	(3)	-0.42%
FY 2016-17 2nd Half	(45)	-11.64%
FY 2016-17	(24)	-6.03%
FY 2017-18 1st Half	37	179.05%
FY 2017-18 2nd Half	4	1.44%
FY 2017-18	21	90.25%
FY 2018-19 1st Half	17	3.45%
FY 2018-19 2nd Half	(8)	-1.35%
FY 2018-19	5	1.05%

Monthly Average Growth Comparisons

Request	Monthly Change		Percent Change	
	S-3	R-3	S-3	R-3
FY 2019-20 1st Half	3	5	1.24%	0.92%
FY 2019-20 2nd Half	3	5	1.24%	0.86%
FY 2019-20	3	5	1.24%	0.89%
FY 2020-21 1st Half	3	5	1.24%	0.86%
FY 2020-21 2nd Half	3	5	1.24%	0.86%
FY 2020-21	3	5	1.24%	0.86%
FY 2021-22 1st Half	#DIV/0!	6	#DIV/0!	0.86%
FY 2021-22 1st Half	#DIV/0!	6	#DIV/0!	0.86%
FY 2021-22 1st Half	#DIV/0!	6	#DIV/0!	0.86%

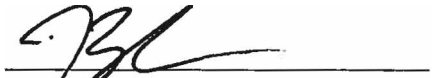
Schedule 13

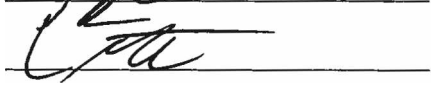
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-04 Medicare Modernization Act State Contribution

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$151,073,595**	**$0**	**$151,073,595**	**$17,929,806**	**$26,393,297**
	FTE	0.0	0.0	0.0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	$151,073,595	$0	$151,073,595	$17,929,806	$26,393,297
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$151,073,595**	**$0**	**$151,073,595**	**$17,929,806**	**$26,393,297**
06. Other Medical Services, (A) Other Medical Services, (1) Other Medical Services - Medicare Modernization Act State Contribution Payment	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$151,073,595	$0	$151,073,595	$17,929,806	$26,393,297
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-4
Request Detail: Medicare Modernization Act

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$9,321,829**	**$17,929,806**	**$26,393,297**
FTE	0.0	0.0	0.0
General Fund	$9,321,829	$17,929,806	$26,393,297
Cash Funds	$0	$0	$0
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request:

The Department requests $9,321,829 General Fund in FY 2019-20 and $17,929,806 General Fund in FY 2020-21, and $26,393,297 in FY 2021-22 to true up funding related to the State's share of the costs of the Medicare Part D outpatient prescription drug benefit for dual-eligible clients. This request does not require any additional FTE and represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

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, who are individuals eligible for both Medicare and Medicaid. States are required to make mandatory state payments to the federal government, known as the "clawback" payment, to help finance the Medicaid Part D benefit for the dual-eligible population for the states' share of the costs of outpatient prescription drugs. The amount of each state's clawback payment roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligible clients. These clawback payments, if left unpaid, are subject to automatic deduction – plus interest – from the federal funds the State receives for the Medicaid program.

Problem or Opportunity:

Current projections indicate that the Department's appropriation for Medicare Modernization Act in FY 2019-20 and its base spending authority in FY 2020-21 are not sufficient to make payments for the required clawback payments in those years.

Proposed Solution:

The Department requests an increase of $9,321,829 General Fund in FY 2019-20 and an increase of $17,929,806 General Fund in FY 2020-21 for funding adjustment to the Medicare Modernization Act State Contribution Payment line item to cover the State's share of the costs of the Medicare Part D outpatient prescription drug benefit for dual-eligible clients. The Medicare Modernization Act State Contribution Payment line item is entirely General Fund, as it is a reimbursement to the federal government and is not eligible to receive a federal match.

Anticipated Outcomes:

One of the Department's top priorities in its Performance Plan is cost control within the Medicaid program. The approval of this request would be a direct implementation of this goal by allowing the Department to meet its obligation to the federal government, and ensuring that no amount of federal funds owed to the State for Medicaid would be subject to deduction plus interest.

Assumptions and Calculations:

Detailed calculations for the request are included in the attached appendix.

A summary of the funding request for the Medicare Modernization Act State Contribution Payment line item by fund type is provided for FY 2019-20, FY 2020-21, and FY 2021-22 in tables 1.1, 1.2, and 1.3, respectively.

The State´s clawback payment is calculated according to three factors:

1. The projected number of Medicare and Medicaid dual-eligible clients enrolled in a Part D plan;

2. A per member per month (PMPM) estimate of the amount the State otherwise would have spent on Medicaid prescription drugs for dual-eligible clients; and
3. A "phasedown" percentage of the State's obligation for the PMPM rate was set forth by the MMA starting at 90% in 2006 and declined by 1.67% each year thereafter until 2015 when it reached 75%, where it will remain ongoing.

The Department's current estimates of the clawback payment are $160,395,424 for FY 2019-20; $169,003,401 for FY 2020-21; and $177,466,892 for FY 2021-22, based on the Department's most recent caseload projections and actual and projected per member per month (PMPM) rates paid by the State as required by federal regulations.

The total caseload and expenditure estimates for FY 2019-20, FY 2020-21, and FY 2021-22 are calculated in tables 2.1a and 2.1b, 2.2a, and 2.3a, respectively. The Department assumes the dual-eligible caseload will follow a 1.72% annual growth trend, consistent with growth over three years from August 2016 through July 2019. This method estimates caseload by increasing the total caseload incurred each month by 0.13% to forecast the total caseload for the following month. Rows A through L on tables 2.1a, 2.2a and 2.3a of the appendix show the actual and projected caseload for a given month by the calendar year for which the caseload is attributed. 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 state fiscal year includes invoices received between May and April. Retroactivity is also considered in this forecast because clients are able to be retroactively enrolled and disenrolled for up to 36 months. Tables 2.1b provides calculations of caseload and expenditures for dual-eligible clients by the various PMPM rates for the calendar year resulting from changes in the Federal Medical Assistance Percentage (FMAP). The PMPM rates are also adjusted based on changes in the FMAP rate which occur on a federal fiscal year (October 1 through September 30 timespan) as follows:

- FFY 2016: 50.72%
- FFY 2017: 50.02%
- FFY 2018: 50.00%
- FFY 2019: 50.00%
- FFY 2020: 50.00% is estimated

The changes in the PMPM rate are based on a prescribed methodology established by CMS. Table 3.1 shows the actual CY 2019 PMPM for January through December 2019 at a 50.00% FMAP rate. The estimated PMPM rates for CY 2020, CY 2021, and CY 2022 are calculated by in tables 3.2, 3.3, and 3.4, respectively. The CY 2020 change in percentage of growth in table 3.2 row G is calculated by dividing the projected 2020 National Health Expenditure (NHE) percentage growth rate of per capita prescription drug expenditure between years 2003 and 2006 in row F by the 2018 NHE percentage of growth in row C, minus 1. For CY 2021 and CY 2022, the Department uses the median of the last seven years of the annual percentage increase (API) in average per capita Part D expenditures from CY 2012 to CY 2019 to project the percentage change

in the rate (found in row J of tables 3.2 and 3.3). The final percentage change in the PMPM rate is calculated in row K of tables 3.3 and 3.4.

Table 4.1 provides actual caseload history from FY 2006-07 through FY 2018-19 and caseload projections based on current trends for FY 2019-20 through FY 2021-22. Table 4.2 provides actual and projected aggregate monthly caseload history by number of member months and average monthly caseload. Table 4.3 shows the PMPM rate history from CY 2014 to CY 2019 and projected PMPM rates for CY 2020 to CY 2022. Table 4.4 shows the actual PMPM rate history by each quarter of the calendar year from CY 2006 to CY 2019 and projected PMPM rates for CY 2020 to CY 2022.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

The supplemental request is necessary as a result of changes in dual-eligible caseload, which impacts the amount paid in the clawback payment.

Table 1.1
FY 2019-20 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2019-20 Spending Authority	$151,073,595	$151,073,595	Long Bill Appropriation (SB 19-207)
B	Projected FY 2019-20 Expenditures	$160,395,424	$160,395,424	Table 2.1a Row O
C	**FY 2019-20 Estimated Change from Appropriation**	**$9,321,829**	**$9,321,829**	**Row B - Row A**

Table 1.2
FY 2020-21 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2020-21 Spending Authority	$151,073,595	$151,073,595	Long Bill Appropriation (SB 19-207)
B	Projected FY 2020-21 Expenditures	$169,003,401	$169,003,401	Table 2.2a Row O
C	**FY 2020-21 Estimated Change from Appropriation**	**$17,929,806**	**$17,929,806**	**Row B - Row A**

Table 1.3
FY 2021-22 Summary of Incremental Funding Request
LBG (6) Other Medical Services, Medicare Modernization Act State Contribution Payment Line Item

Row	Item	Total Funds	General Fund	Source
A	FY 2021-22 Spending Authority	$151,073,595	$151,073,595	Long Bill Appropriation (SB 19-207)
B	Projected FY 2021-22 Expenditures	$177,466,892	$177,466,892	Table 2.3a Row O
C	**FY 2021-22 Estimated Change from Appropriation**	**$26,393,297**	**$26,393,297**	**Row B - Row A**

Table 2.1a
FY 2019-20 Projected Caseload and Expenditures

Row	Month	CY 2017	CY 2018	CY 2019	CY 2020	FY 2019-20 TOTAL
A	May 2019	109	961	76,537	0	77,607
B	June 2019	393	3,879	83,857	0	88,129
C	July 2019	60	523	78,624	0	79,207
D	August 2019	32	360	78,851	0	79,243
E	September 2019	24	298	79,016	0	79,338
F	October 2019	16	248	79,179	0	79,443
G	November 2019	8	208	79,335	0	79,551
H	December 2019	0	175	79,471	0	79,646
I	January 2020	0	146	4,220	75,388	79,754
J	February 2020	0	122	2,449	77,282	79,853
K	March 2020	0	99	1,567	78,288	79,954
L	April 2020	0	84	1,014	78,961	80,059
M	CY Client Total	642	7,103	644,120	309,919	961,784
N	CY PMPM Rate [1]	Varies [2]	$160.92	$164.04	$172.59	
O	**Expenditures [3]**	**$102,044**	**$1,143,015**	**$105,661,445**	**$53,488,920**	**$160,395,424**

(1) PMPM Rates in Row N are shown in table 2.1b
(2) Rate changes occured for calendar year 2017 due to FMAP changes shown in Table 4.3
(3) Expenditures are calculated by multiplying client total by the respective PMPM rates

Table 2.1b
Caseload Breakdown for FY 2019-20 with CY 2017 Rates

Row	Rate Period	Caseload Forecast	Rates	Total	Source
D	Jan - Sept 2017	260	$158.91	$41,317	Caseload Forecast * Actual Rate
E	Oct - Dec 2017	382	$158.97	$60,727	Caseload Forecast * Actual Rate
F	**CY 2017 Total**	**642**		**$102,044**	Row D + Row E

Table 2.2a
FY 2020-21 Projected Caseload and Expenditures

Row	Month	CY 2018	CY 2019	CY 2020	CY 2021	FY 2020-21 TOTAL
A	May 2020	68	709	79,381	0	80,158
B	June 2020	56	562	79,645	0	80,263
C	July 2020	43	450	79,868	0	80,361
D	August 2020	32	370	80,064	0	80,466
E	September 2020	24	308	80,237	0	80,569
F	October 2020	17	254	80,400	0	80,671
G	November 2020	8	210	80,549	0	80,767
H	December 2020	0	184	80,693	0	80,877
I	January 2021	0	151	4,286	76,540	80,977
J	February 2021	0	123	2,492	78,463	81,078
K	March 2021	0	103	1,594	79,487	81,184
L	April 2021	0	85	1,030	80,167	81,282
M	CY Client Total	248	3,509	650,239	314,657	968,653
N	CY PMPM Rate	$160.92	$164.04	$172.59	$178.49	
O	**Expenditures**	**$39,908**	**$575,616**	**$112,224,749**	**$56,163,128**	**$169,003,401**

Table 2.3a
FY 2021-22 Projected Caseload and Expenditures

Row	Month	CY 2019	CY 2020	CY 2021	CY 2022	FY 2021-22 TOTAL
A	May 2021	69	725	80,594	0	81,388
B	June 2021	58	571	80,863	0	81,492
C	July 2021	43	461	81,089	0	81,593
D	August 2021	35	375	81,285	0	81,695
E	September 2021	24	313	81,462	0	81,799
F	October 2021	18	260	81,630	0	81,908
G	November 2021	8	214	81,784	0	82,006
H	December 2021	0	186	81,924	0	82,110
I	January 2022	0	151	4,353	77,710	82,214
J	February 2022	0	128	2,531	79,662	82,321
K	March 2022	0	105	1,617	80,700	82,422
L	April 2022	0	85	1,046	81,392	82,523
M	CY Client Total	255	3,574	660,178	319,464	983,471
N	CY PMPM Rate [1]	$164.04	$172.59	$178.49	$184.60	
O	**Expenditures [3]**	**$41,830**	**$616,837**	**$117,835,171**	**$58,973,054**	**$177,466,892**

Table 3.1
CY 2019 PMPM Rate Calculation

Row	Item		Source
A	CY 2019 PMPM Rate (January through December 2019 with 50.00% FMAP)	$164.04	Centers for Medicare and Medicaid Services (CMS) [1]
B	FFY 19 FMAP State Share Percentage	50.00%	FFY 19 FMAP is 50.00%
C	FFY 20 FMAP State Share Percentage	50.00%	The projected FFY 20 FMAP is 50%
D	**CY 2019 PMPM Rate (October through December 2019 with 50.00% FMAP)**	**$164.04**	Row A / Row B * Row C

(1) Centers for Medicare and Medicaid Services (CMS) State Medicaid Director Letter Calendar Year (CY) 2019 Jan - Sep Phased- down State Contribution Final Per-Capita Rates , Issued October 16, 2018

Table 3.2
Estimated CY 2020 PMPM Rate Calculation

Row	Item		Source
	2018 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.48%	(Row B ÷ Row A) - 1
	Projected 2019 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.48%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
	Projected Figures from Announcements of CY 2012 through CY 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
H	Projected Annual percentage trend for July 2019	5.25%	Median Change from CY 2012 to CY 2019
I	Projected Prior Year Revisions of the Annual percentage trend	-0.04%	Average Change from CY 2012 to CY 2019
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2019	5.21%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2019**	**5.21%**	Row G + Row H
L	CY 2019 PMPM Rate Prior to FMAP and Phasedown	$437.45	Table 3.2 Row M
M	Projected CY 2020 PMPM Rate Prior to FMAP and Phasedown	$460.24	Row L × (1 + Row K)
N	Projected FFY 20 FMAP State Share	50.00%	Estimated FFY 19 FMAP is 50%
O	Projected CY 2020 PMPM Rate Prior to Phasedown	$230.12	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Statutory rate : Sec. 1935. (C) (5) [42 U.S.C. 1396u-5]
Q	**Estimated CY 2020 PMPM Rate (January through December 2020 with 50.00% FMAP)**	**$172.59**	Row O × Row P

Source: Centers for Medicare and Medicaid Services (CMS), 2011 thru 2015 NHE estimates; and Announcements of CY 2012 through CY 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 3.3
Estimated CY 2021 PMPM Rate Calculation

Row	Item		Source
	Projected 2019 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.48%	(Row B ÷ Row A) - 1
	Projected 2020 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.48%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
	Projected Figures from Announcements of CY 2012 through CY 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
H	Projected Annual percentage trend for July 2019	3.89%	Median Change from CY 2012 to CY 2019
I	Projected Prior Year Revisions of the Annual percentage trend	-0.45%	Average Change from CY 2012 to CY 2019
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	3.42%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2019**	**3.42%**	Row G + Row H
L	CY 2020 PMPM Rate Prior to FMAP and Phasedown	$460.24	Table 3.2 Row M
M	Projected CY 2021 PMPM Rate Prior to FMAP and Phasedown	$475.98	Row L × (1 + Row K)
N	Projected FFY 21 FMAP State Share	50.00%	Estimated FFY 19 FMAP is 50%
O	Projected CY 2021 PMPM Rate Prior to Phasedown	$237.99	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Statutory rate : Sec. 1935. (C) (5) [42 U.S.C. 1396u-5]
Q	**Estimated CY 2021 PMPM Rate (January through December 2021 with 50.00% FMAP)**	**$178.49**	Row O × Row P

Source: Centers for Medicare and Medicaid Services (CMS), 2011 thru 2015 NHE estimates; and Announcements of CY 2012 through CY 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 3.4
Estimated CY 2022 PMPM Rate Calculation

Row	Item		Source
	Projected 2019 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
C	Percentage Growth	23.48%	(Row B ÷ Row A) - 1
	Projected 2020 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$609	Department estimate
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	Department estimate
F	Percentage Growth	23.48%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
	Projected Figures from Announcements of CY 2012 through CY 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
H	Projected Annual percentage trend for July 2019	3.89%	Median Change from CY 2012 to CY 2019
I	Projected Prior Year Revisions of the Annual percentage trend	-0.45%	Average Change from CY 2012 to CY 2019
J	Projected Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2018	3.42%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2019**	**3.42%**	Row G + Row H
L	CY 2021 PMPM Rate Prior to FMAP and Phasedown	$475.98	Table 3.2 Row M
M	Projected CY 2022 PMPM Rate Prior to FMAP and Phasedown	$492.26	Row L × (1 + Row K)
N	Projected FFY 22 FMAP State Share	50.00%	Estimated FFY 19 FMAP is 50%
O	Projected CY 2022 PMPM Rate Prior to Phasedown	$246.13	Row M × Row N
P	Ongoing Phasedown Percentage Rate	75.00%	Statutory rate : Sec. 1935. (C) (5) [42 U.S.C. 1396u-5]
Q	**Estimated CY 2022 PMPM Rate (January through December 2022 with 50.00% FMAP)**	**$184.60**	Row O × Row P

Source: Centers for Medicare and Medicaid Services (CMS), 2011 thru 2015 NHE estimates; and Announcements of CY 2012 through CY 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 4.1
Invoice Caseload History

Item	Total Member Months Caseload	Average Monthly Caseload
FY 2006-07	611,212	50,934
FY 2007-08	642,840	53,570
% Change from FY 2006-07	5.17%	5.18%
FY 2008-09	651,968	54,331
% Change from FY 2007-08	1.42%	1.42%
FY 2009-10	664,292	55,358
% Change from FY 2008-09	1.89%	1.89%
FY 2010-11	697,817	58,151
% Change from FY 2009-10	5.05%	5.05%
FY 2011-12	725,075	60,423
% Change from FY 2010-11	3.91%	3.91%
FY 2012-13	750,509	62,542
% Change from FY 2011-12	3.51%	3.51%
FY 2013-14	812,812	67,734
% Change from FY 2012-13	8.30%	8.30%
FY 2014-15	865,253	72,104
% Change from FY 2013-14	6.45%	6.45%
FY 2015-16	877,707	73,142
% Change from FY 2014-15	1.44%	1.44%
FY 2016-17	882,749	73,562
% Change from FY 2015-16	0.57%	0.57%
FY 2017-18	897,632	74,803
% Change from FY 2016-17	1.69%	1.69%
FY 2018-19	919,107	76,592
% Change from FY 2017-18	2.39%	1.69%
FY 2019-20 Projection	962,349	80,196
% Change from FY 2018-19 Projection	4.70%	2.39%
FY 2020-21 Projection	968,653	80,721
% Change from FY 2019-20 Projection	0.66%	0.65%
FY 2021-22 Projection	983,471	81,956
% Change from FY 2020-21 Projection	1.53%	1.53%

Table 4.2 Aggregate Monthly Caseload History		
Item	**Total Member Months Caseload**	**Average Monthly Caseload**
FY 2006-07	618,862	51,572
FY 2007-08	630,715	52,560
% Change from FY 2006-07	1.92%	1.92%
FY 2008-09	649,533	54,128
% Change from FY 2007-08	2.98%	2.98%
FY 2009-10	665,732	55,478
% Change from FY 2008-09	2.49%	2.49%
FY 2010-11	693,267	57,772
% Change from FY 2009-10	4.14%	4.13%
FY 2011-12	728,875	60,740
% Change from FY 2010-11	5.14%	5.14%
FY 2012-13	757,424	63,119
% Change from FY 2011-12	3.92%	3.92%
FY 2013-14	803,259	66,938
% Change from FY 2012-13	6.05%	6.05%
FY 2014-15	860,591	71,716
% Change from FY 2013-14	7.14%	7.14%
FY 2015-16	864,799	72,067
% Change from FY 2014-15	0.49%	0.49%
FY 2016-17	890,432	74,203
% Change from FY 2015-16	2.96%	2.96%
FY 2017-18	914,779	76,232
% Change from FY 2016-17	2.73%	2.73%
FY 2018-19	927,279	77,273
% Change from FY 2017-18	1.37%	1.37%
FY 2019-20 Projection	952,873	79,406
% Change from FY 2018-19 Projection	2.76%	2.76%
FY 2020-21 Projection	968,880	80,740
% Change from FY 2019-20 Projection	1.68%	1.68%
FY 2021-22 Projection	983,686	81,974
% Change from FY 2020-21 Projection	1.53%	1.53%

Table 4.3
Summary of PMPM Rates by Calendar Year (CY) with FMAP Adjustments

Row	Year	Rate	FMAP	Source
	CY 2014			
A	Jan-Sept 2014	$125.50	50.00%	Actual CMS
B	Oct-Dec 2014	$122.97	51.01%	Actual CMS
	CY 2015			
C	Jan-Sept 2015	$124.68	51.01%	Actual CMS
D	Oct-Dec 2015	$125.42	50.72%	Actual CMS
	CY 2016			
E	Jan-Sept 2016	$139.98	50.72%	Actual CMS
F	Oct-Dec 2016	$141.97	50.02%	Actual CMS
	CY 2017			
G	Jan-Sept 2017	$158.91	50.02%	Actual CMS
H	Oct-Dec 2017	$158.97	50.00%	Actual CMS
	CY 2018			
I	Jan-Dec 2018	$160.92	50.00%	Actual CMS
J	Oct-Dec 2018	$160.92	50.00%	Actual CMS
	CY 2019			
K	Jan-Dec 2019	$164.04	50.00%	Actual CMS
	CY 2020			
L	Estimated Jan-Dec 2020	$172.59	50.00%	Table 3.2 Row Q
	CY 2021			
M	Estimated Jan-Dec 2021	$178.49	50.00%	Table 3.3 Row Q
	CY 2022			
N	Estimated Jan-Dec 2022	$184.60	50.00%	Table 3.4 Row Q

Table 4.4
Quarterly PMPM Rate History

Item	Q1	Q2	Q3	Q4	Average PMPM Rate
CY 2006	$114.71	$114.71	$114.71	$114.71	**$114.71**
CY 2007	$120.30	$120.30	$120.30	$120.30	**$120.30**
% Change from CY 2006					4.87%
CY 2008	$120.03	$120.03	$120.03	$98.95	**$114.76**
% Change from CY 2007					-4.61%
CY 2009	$106.03	$98.81	$98.81	$98.81	**$100.62**
% Change from CY 2008					-12.33%
CY 2010	$101.49	$101.49	$101.49	$101.49	**$101.49**
% Change from CY 2009					0.87%
CY 2011	$107.07	$111.97	$129.84	$129.84	**$119.68**
% Change from CY 2010					17.92%
CY 2012	$132.41	$132.41	$132.41	$132.41	**$132.41**
% Change from CY 2011					10.64%
CY 2013	$133.62	$133.62	$133.62	$133.62	**$133.62**
% Change from CY 2012					0.91%
CY 2014	$125.50	$125.50	$125.50	$122.97	**$124.87**
% Change from CY 2013					-6.55%
CY 2015	$124.68	$124.68	$124.68	$125.42	**$124.87**
% Change from CY 2014					0.00%
CY 2016	$139.98	$139.98	$139.98	$141.97	**$140.48**
% Change from CY 2015					12.50%
CY 2017	$158.91	$158.91	$158.91	$158.97	**$158.93**
% Change from CY 2016					13.13%
CY 2018	$160.92	$160.92	$160.92	$160.92	**$160.92**
% Change from CY 2017					1.26%
CY 2019	$164.04	$164.04	$164.04	$164.04	**$164.04**
% Change from CY 2018					1.94%
CY 2020 Projection	$172.59	$172.59	$172.59	$172.59	**$172.59**
% Change from CY 2019					5.21%
CY 2021 Projection	$178.49	$178.49	$178.49	$178.49	**$178.49**
% change from CY 2020					3.42%
CY 2022 Projection	$184.60	$184.60	$184.60	$184.60	**$184.60**
% change from CY 2021					3.42%

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-05 Office of Community Living

Dept. Approval By: _____ ____ **Supplemental FY 2019-20**

OSPB Approval By: _____ ____ **Budget Amendment FY 2020-21**

X **Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$675,219,967**	**$0**	**$675,062,285**	**$35,370,073**	**$74,811,432**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$340,952,451	$0	$343,590,629	$17,697,932	$37,507,956
	CF	$6,951,769	$0	$4,242,116	($489,128)	($470,441)
	RF	$0	$0	$0	$0	$0
	FF	$327,315,747	$0	$327,229,540	$18,161,269	$37,773,917

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Adult Comprehensive Services	**Total**	**$503,255,278**	**$0**	**$502,793,147**	**$32,532,746**	**$63,787,208**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$248,117,256	$0	$250,596,573	$16,266,372	$31,893,603
	CF	$3,510,383	$0	$800,001	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$251,627,639	$0	$251,396,573	$16,266,374	$31,893,605
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Adult Supported Living Services	**Total**	**$86,732,157**	**$0**	**$86,971,925**	**$2,518,170**	**$6,888,104**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$45,959,837	$0	$46,082,518	$1,390,900	$3,661,091
	CF	$2,676,085	$0	$2,676,689	($450,800)	($422,324)
	RF	$0	$0	$0	$0	$0
	FF	$38,096,235	$0	$38,212,718	$1,578,070	$3,649,337

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Children's Extensive Support Services	**Total**	**$27,062,419**	**$0**	**$27,080,575**	**$2,947,458**	**$4,877,476**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$13,531,210	$0	$13,540,287	$1,473,730	$2,438,739
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$13,531,209	$0	$13,540,288	$1,473,728	$2,438,737
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Case Management	**Total**	**$45,206,293**	**$0**	**$45,243,320**	**($2,105,990)**	**($207,710)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$23,571,393	$0	$23,590,677	($1,288,143)	($340,550)
	CF	$150,346	$0	$150,471	$194,130	$195,676
	RF	$0	$0	$0	$0	$0
	FF	$21,484,554	$0	$21,502,172	($1,011,977)	($62,836)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Family Support Services	**Total**	**$7,811,600**	**$0**	**$7,817,740**	**($232,458)**	**($243,793)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,196,645	$0	$7,202,785	$0	$0
	CF	$614,955	$0	$614,955	($232,458)	($243,793)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Children's Habilitation Residential Program	**Total**	**$5,152,220**	**$0**	**$5,155,578**	**($289,853)**	**($289,853)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,576,110	$0	$2,577,789	($144,927)	($144,927)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,576,110	$0	$2,577,789	($144,926)	($144,926)

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-5
Request Detail: Office of Community Living Cost and Caseload

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**($2,658,717)**	**$35,370,073**	**$74,811,432**
FTE	0.0	0.0	0.0
General Fund	($1,133,637)	$17,697,932	$37,507,956
Cash Funds	($579,579)	($489,128)	($470,441)
Reappropriated Funds	$0	$0	$0
Federal Funds	($945,501)	$18,161,269	$37,773,917

Summary of Request:

In FY 2019-20, the Department requests a decrease of $2,658,717 total funds, including a decrease of $1,133,637 General Fund, and a decrease of $237,241 Individuals with Intellectual and Development Disabilities (IDD) Cash Fund and a decrease of $342,338 Healthcare Affordability & Sustainability Fee Cash Fund. For FY 2020-21, the Department requests an increase of $35,370,073 total funds, including an increase of $17,697,932 General Fund, and a decrease of $312,966 Healthcare Affordability & Sustainability Fee Cash Fund and a decrease of $176,162 Family Support Services Program Cash Fund. These funds would be used to fund Home and Community Based Services (HCBS) waiver program costs. The request includes funding for Adult Comprehensive (HCBS-DD) reserved capacity and emergency enrollments totaling 556 enrollments in FY 2019-20, 398 enrollments in FY 2020-21, and 396 enrollments in FY 2021-22.

Current Program:

Effective July 2018, the Department manages four Medicaid HCBS waiver programs for people with developmental disabilities: Adult Comprehensive Services (HCBS-DD), Supported Living Services (HCBS-SLS), Children's Extensive Services (HCBS-CES), and Children's Habilitation Residential Program (HCBS-CHRP). These programs provide services such as residential care, day habilitation services and behavioral services, as well as case management, and are delivered through a variety of approved providers.

Problem or Opportunity:

Each year, the Department's appropriations for programs serving individuals with intellectual and developmental disabilities are set in advance of the fiscal year, based on prior year utilization and expenditure. As more recent data becomes available, the appropriation needs to be adjusted to account for the most recent projections of expenditure and caseload, in order to minimize any potential over or under-expenditures. The Department requests to adjust existing appropriations and designated full program equivalents (FPE) within four Medicaid waiver programs for people with developmental disabilities: Home and Community Based Services Adult Comprehensive Services (HCBS-DD), Supported Living Services (HCBS-SLS), Children's Extensive Services (HCBS-CES), and Children's Habilitation Residential Program (HCBS-CHRP); further, the Department's request accounts for associated changes to the Targeted Case Management (TCM) service. Adjustments to targeted appropriations accurately reflect the current cost per FPE, based upon current spending trends, and maximize the number of individuals that can be served in the programs.

The Home and Community Based Services, Adult Comprehensive services program (HCBS-DD) provides services to 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. The Home and Community Based Services - Supported Living Services program (HCBS-SLS) is 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 Home and Community Based Services - Children's Extensive Services program (HCBS-CES) provides benefits to children who have a developmental disability or delay, and who need near constant line of sight supervision due to behavioral or medical needs. The Home and Community Based Services – Children's Habilitation Residential Program (HCBS-CHRP) provides treatment and out of home services for children with intellectual and developmental disabilities and very high needs. The CHRP waiver was transferred from the Colorado Department of Human Services (DHS) to the Department effective July 1, 2018. HB 18-1328 "Redesign Residential Child Health Care Waiver" gave the Department authority to operate the waiver and directed the Department to redesign the waiver and receive federal approval from the Centers for Medicare and Medicaid Services (CMS) on the newly redesign waiver. The Department received approval from CMS on the redesigned waiver in June 2019 and the redesigned waiver went into effect July 1, 2019.

In FY 2012-13, the Department of Human Services requested and received funding to eliminate the waiting list for the HCBS-CES program. In FY 2013-14, the Department of Health Care Policy and Financing

requested and received funding to eliminate the waiting list for the HCBS-SLS program. In order to prevent new waiting lists, the General Assembly must provide new funding each year to allow for growth in both programs. In contrast, the HCBS-DD program continues to have a waiting list for services; as of the November 1, 2019 Update to the Strategic Plan for Assuring Timely Access to Services for Individuals with Intellectual and Developmental Disabilities (House Bill 14-1051), there are 2,895 people waiting to receive HCBS-DD waiver services. The waiting lists may include those requiring emergency enrollments as well as those transitioning out of institutional settings. Additionally, the list may include current Medicaid recipients being served in an alternative waiver that does not fully meet their needs and may also include individuals being served in nursing facilities or hospitals that are not as cost-effective as the HCBS waivers.

Each year, additional enrollments in the HCBS-DD waiver are needed to provide resources for emergency placements, individuals transitioning out of foster care, from HCBS-CES, or Colorado Choice Transition (CCT) clients transitioning from an institutional setting. Without additional enrollments each year, people with intellectual and developmental disabilities would transition to other less appropriate, costlier settings or become vulnerable to abuse, neglect or homelessness as an increasing number of people continue to wait on the list to receive the services they need.

Proposed Solution:

In order to adjust the current appropriations for the programs administered by the Office of Community Living in FY 2019-20, the Department requests a decrease of $2,658,717 total funds, including a decrease of $1,133,637 General Fund, and a decrease of $237,241 Individuals with Intellectual and Development Disabilities (IDD) Cash Fund and a decrease of $342,338 Healthcare Affordability & Sustainability Fee Cash Fund. For FY 2020-21, the Department requests an increase of $35,370,073 total funds, including an increase of $17,697,932 General Fund, and a decrease of $312,966 Healthcare Affordability & Sustainability Fee Cash Fund and a decrease of $176,162 Family Support Services Program Cash Fund.

Based on the assumptions used in this request, the Department calculated maximum enrollment figures for each waiver program and TCM services and the number of full-program equivalents (FPE) for each fiscal year. If this request is approved, the Department calculates that by the end of FY 2019-20 it would serve: 6,329 FPE on the HCBS-DD waiver 4,512 FPE on the HCBS-SLS waiver; 1,784 FPE on the HCBS-CES waiver; and 40 FPE on the HCBS-CHRP waiver. For the years covered in the request, the Department would limit HCBS-DD enrollments to the maximum enrollment figure. However, for the HCBS-SLS, HCBS-CES, and HCBS-CHRP programs, the Department would adhere to the policy of maintaining no waiting lists; therefore, the enrollment numbers are for information only, and the Department would exceed those figures if necessary and use the regular budget process to account for any change in the estimates. The number of associated FPE for each fiscal year is shown in exhibit D.3 of the appendix.

Anticipated Outcomes:

The Office of Community Living finances long term services and supports in the community to adults and children with developmental disabilities who would otherwise receive services in more restrictive and

expensive institutional settings or who would be without services altogether. The Department strives to provide the right services to the right people at the right time and place.

The Department's request includes funding to provide needed services for the highest number as well as most at-risk eligible people as possible. If the Department's request is approved, the Department would have resources to cover 13,411 people on average per month in FY 2019-20, and 14,124 people on average per month in FY 2020-21, thereby improving their physical, mental, and social well-being and quality of life.

Assumptions and Calculations:

The Department's calculations are contained in the appendix. The appendix is organized into a series of exhibits, providing both calculation information and historical cost and caseload detail. The section below describes each exhibit individually. In many cases, the specific assumptions and calculations are contained in the exhibits directly; the narrative information below provides additional information and clarification where necessary.

Exhibit A.1.1 – A.1.3: Calculation of Request

This exhibit provides the final calculation of the incremental request, by line item. Values in the total request column are taken from calculations in exhibits A.2 through A.4, as well as exhibit C which relates to projected expenditure. The adjusted spending authority amounts reflect the estimated appropriation for each line and can be found in Tables G.1 through G.3. The incremental request is the sum of the differences between total request and spending authority for each line item.

Exhibit A.2 through A.4: Current, Request, and Out Year Fund Splits

These exhibits provide a breakdown for each line item's expenditure estimate including fund splits for each program. This exhibit also allows for adjustments in the federal financial participation rate (FFP) based on the type of services delivered within each program. The Federal Medical Assistance Percentage (FMAP) Colorado decreased in October 2016 to 50.02%. The FMAP for FFY 2017-18 decreased to 50.00% and the Department assumes it will remain the same in FFY 2019-20 at 50.00%. For state fiscal years this translates to an FMAP of 50.00% in FY 2019-20 through FY 2021-22. FMAP forecasts can be found in exhibit R of the Department's FY 2019-20 R-1 "Medical Services Premiums Request".

HB 16-1321 "Medicaid Buy-In Certain Waivers" created a buy-in option for working adults who would otherwise not qualify due to income or asset limits for the HCBS-SLS waiver. The program was implemented on December 1, 2017. The state portion of Buy-In expenditure will be paid for with Healthcare Affordability & Sustainability Fee Cash Fund dollars, while standard HCBS-SLS and TCM are paid for with General Fund dollars. Costs associated with Buy-In HCBS-SLS and TCM services are separated in these exhibits to reflect the difference in funding source.

Exhibit A.5: Cash Funds Report

Recent iterations of the Department's forecast include the addition of several cash fund sources. In light of this, the Department has added Exhibit A.5 to clarify the amount of and source of cash funds allocated and

requested in each year. The Department is requesting to use the existing balance in the Family Support Loan Program Fund to partially fund Family Support Services in FY 2019-20 and FY 2020-21. The Family Support Services program provides financial support for families who have children, including adult children, with developmental disabilities or delays with costs that are beyond those normally experienced by other families. The Department was appropriated $6,386,407 from the IDD Cash Fund, including $3,386,407 from its FY 2019-20 R-16 "Employment First Initiatives and State Programs for People with IDD" budget request, and $3,000,000 from a JBC action to appropriate 150 new enrollments in the HCBS-DD waiver.

Exhibit A.6: Buy-In Adjustments
This tab separates expected expenditure on HCBS-SLS clients using the disabled buy-in eligibility criteria to access the waiver. Expected expenditure for this population is included in the total expenditure values calculated in Exhibit B and C but is funded with Healthcare Affordability & Sustainability Fee Cash Fund (CHASE) dollars instead of General Fund dollars. Exhibit A.6 services to isolate the amount expected to be spent on this population and to calculate the amount of funding required from CHASE. This exhibit can also be used to track cost and caseload trends in the HCBS-SLS Buy-In program.

Exhibit B: Summary of Program Costs
This exhibit provides a summary of historical program expenditure, as paid for through the Department's Medicaid Management Information System (MMIS), and projected totals as calculated in exhibit C.

Exhibit C: Calculation of Projected Expenditure
This exhibit provides the calculation of projected expenditure using revised assumptions about caseload and per FPE cost (calculated in exhibits D.3 and E, respectively). The exhibit then calculates the difference between the appropriated or base request amounts which results in the estimated over/under-expenditure for each waiver, by fiscal year. In fiscal years where systemic under-expenditure exists, this exhibit would also calculate an additional number of people that could be enrolled within existing resources and converts the total enrollment figures into new paid enrollments and calculated the new cost for additional enrollments for each fiscal year. This exhibit calculates costs for Medicaid matched services only and does not include State-Only programs. Therefore, the appropriation reflected in this exhibit does not match the adjusted appropriation in Exhibit A.1.

Exhibit D.1: Calculation of Maximum Enrollment
To forecast the number of enrollments, the Department took the appropriated enrollments from the Long Bill and estimated a base trend. Selection of trends for each waiver are discussed below. Once the base enrollments are determined, the Department adds in additional enrollments authorized through special bills or other initiatives, as Bottom Line Adjustments, to reach the final estimated maximum enrollment. This process is repeated for the request year and the out year. Information on trend selection and Bottom Line Adjustments for each program are provided below.

As of FY 2014-15 there is no longer a waiver cap in the HCBS-SLS or HCBS-CES waivers, so the maximum enrollment forecast for these waivers has been removed from the exhibits. Because TCM enrollment is

derivative of HCBS-SLS and HCBS-CES enrollment, the maximum TCM enrollment forecast has also been removed from the exhibits.

Adult Comprehensive Waiver (DD)
For FY 2019-20 the Department was appropriated funding for 6,884 enrollments through SB 19-207 "FY 2019-20 Long Appropriations Bill" which included a request to increase the HCBS-DD enrollment cap by 549 clients as bottom line adjustments. These bottom line adjustments were composed of 228 emergency enrollments, 36 foster care transitions, 3 clients expected to move from an institutional setting into the HCBS-DD waiver in FY 2019-20, 75 youth transitions expected to move to the HCBS-DD waiver as they age out of the HCBS-CES waiver as requested in the Department's FY 2014-15 R-8 "Developmental Disabilities New Full Program Equivalents", 57 enrollments due to new aging caregiver criteria established in HB 18-1407 "Access to Disability Services and Stable Workforce", and 150 enrollments appropriated through JBC action. The Department has adjusted the number of transitions from institutions from 3 to 10 given changes to the Colorado Choice Transitions (CCT) program. Therefore, the Department is requesting 6,891 enrollments for FY 2019-20 for the HCBS-DD waiver, an increase of 7 over the current FY 2019-20 appropriation.

In FY 2020-21 the Department requests an additional 398 HCBS-DD enrollments, which includes no change to estimated emergency enrollments, no change to estimated foster care transitions, a reduction of 8 clients expected to move from an institutional setting into the DD waiver, no change to estimated foster care transitions, no change to youth transitions, and 59 enrollments due to aging caregiver criteria established in HB 18-1407 "Access to Disability Services and Stable Workforce". With the requested additions, the maximum enrollment number for FY 2020-21 would be 7,289. In FY 2021-22 the Department requests an additional 396 enrollments to reach a maximum enrollment figure of 7,685.

The Department bases its emergency enrollment forecast on the number of emergency enrollments that enrolled in the HCBS-DD waiver through the three most recent fiscal years. Between FY 2013-14 and FY 2016-17 the number of emergency enrollments authorized each month steadily increased. The Department believes that this was the result of several compounding factors. In FY 2014-15 and FY 2015-16 the Department provided increased training to Community Centered Boards (CCBs) on the emergency enrollment criteria and process, while at the same time updating the forms necessary to initiate an emergency enrollment. The Department believes that part of the increase in emergency enrollments is a result of CCBs becoming more adept at identifying potential emergency enrollments, and more aware of the steps necessary enroll a client as an emergency enrollment.

The Department also believes that trends in the Colorado housing market have impacted the number of emergency enrollments into the HCBS-DD waiver. A common cause of an emergency enrollment is impending homelessness. Many individuals have lost housing due to rent increases, homes being sold after elderly caregivers and parents pass away, and limited access to Section 8 housing. The Department has received feedback from stakeholders that there has been an increase in the age of caregivers. As caregivers

age, some become less willing or able to provide the level of care needed by the client, leaving them neglected and more likely to qualify as an emergency enrollment.

Clients authorized as emergency enrollments, who may or may not be on the HCBS-DD waitlist, are allowed to enroll in the HCBS-DD waiver prior to clients on the waitlist. Without additional enrollments allocated for these clients, they will continue to take priority over clients on the HCBS-DD waitlist thereby increasing the size of the waitlist and waiting period for clients on the waitlist. If there are no allocated enrollments available, clients meeting the emergency criteria may find themselves in settings that do not meet their needs, leave them open to abuse or neglect, or leave them vulnerable to homelessness. Emergency enrollment, however, has been more constant throughout the three most recent fiscal years. The Department believes this is due to the focus on authorizing enrollments through churn and increased resources for managing the waiting list. Therefore, this forecast does not include any substantial changes to the way emergency enrollments are forecast.

Using updated data through June 2019, the Department estimates that 36 clients are likely to transition to HCBS-DD as foster care transitions in FY 2019-20, which is the same number estimated in the Department's FY 2019-20 S-5. Also, using updated data through June 2019, the Department anticipates that 75 youth will transition to the HCBS-DD waiver from the HCBS-CES waiver. This estimate is based on the previous forecast and FY 2018-19 actuals. All categories of anticipated emergency enrollments were very close to FY 2018-19 actuals therefore the Department has decided to maintain forecasted values from the previous request.

Additionally, the Department is now predicting that 10 CCT clients will transition from institutions to the HCBS-DD waiver in FY 2019-20. CCT enrollments are forecasted in exhibit R of the Department's R-1 "Medical Services Premiums Request", see this exhibit for more information on the Department's revised CCT forecast. The Department has changed the name of this category from "Colorado Choice Transitions (CCT)" to "Transitions from Institutions" because the CCT is a grant-funded program that will end December 31, 2020 and is currently being transitioned into the existing waiver programs through HB 18-1326 "Support for Transition from Institutional Settings".

Exhibit D.2: Conversion of Enrollment to Full Program Equivalent (FPE)

In order to properly calculate expenditure, the Department must use a consistent caseload metric that directly ties to expenditure. In this exhibit, and throughout the request, the Department uses average monthly paid enrollment to determine the number of clients for which it anticipates paying claims for in each fiscal year. This caseload metric is referred to as "full-program equivalents," or FPE. The Department notes, however, that the number of FPE is not always equal to the enrollment for each waiver. The relationship of FPE to maximum enrollment can vary based on a large number of factors including lag between enrollment and delivery of services and the lag between delivery of services and billing of claims; however, in order to accurately set the appropriation and manage the program, it is critical to explicitly identify both the number of FPE, enrollment, and the interaction between the two.

The Department's methodology to account for the above-mentioned variation includes the selection of an FPE conversion factor which is based on the ratio of average monthly enrollments (as calculated in Exhibit D.3) to FPE in historical data. Enrollments are derived from the number of unique waiver clients in a given month with an active prior authorization request (PAR) which means that these clients have been authorized by the CCBs to receive services. The Department then uses this metric to convert the average monthly enrollment forecast to projected FPE in Exhibit D.3.

For each waiver and TCM, the selected FPE current year conversion factor is calculating using an average of historical data. For HCBS-SLS and HCBS-CES the Department used an average of the previous two years since those waivers have been relatively steady. For HCBS-DD, HCBS-CHRP, and TCM, the Department utilized the average monthly conversion factor from FY 2018-19 to predict future years since there have been several recent policy changes that affect those programs. The selected factors for FY 2019-20 are also the conversion factors for the request year and out year.

The Department assumes that the conversion factor for HCBS-SLS and TCM Buy-In services will match those of non-Buy-In HCBS-SLS and TCM services because Buy-In clients will exist in the same provider environment, with the same barriers to access, as non-Buy-In clients. Furthermore, the Department expects Buy-In clients to exhibit fluctuations in service demand similar to those of non-Buy-In clients based on their similar medical conditions that qualify them for the service, though varying due to their unique physical, psychological, and social states. The Department will reassess this assumption after the program exists for long enough to collect adequate data.

Exhibit D.3: Calculation of Average Monthly Enrollment and FPE

This exhibit provides a summary of historical average monthly enrollment and estimates average monthly enrollment and FPE for the years covered in this request. The Department's methodology involves three steps and begins with the enrollment level at the end of the prior fiscal year. First, the final estimated average monthly enrollment under current policy is calculated by waiver specific methods, discussed below; these enrollments are then adjusted based on a linear enrollment ramp-up over the fiscal year. The Department assumes that by the end of each fiscal year, enrollment will be at the maximum appropriated or maximum assumed level and that the increase in enrollments from the beginning of the fiscal year to the end will happen evenly across 12 months.

Finally, the FPE adjustment factor, described in the conversion of enrollment to FPE, Exhibit D.2, is applied to the final estimated average monthly enrollment to arrive at the estimated FPE for the fiscal year. The steps described above are repeated for each waiver and fiscal year with the request and out years beginning with the FY 2019-20 and through FY 2021-22 estimated maximum enrollment levels.

Maximum Assumed Enrollment for the HCBS-DD Waiver

For the HCBS-DD waiver, maximum enrollment comes from total appropriated enrollments. This is due to the existence of the enrollment cap in this waiver. In most fiscal years, the Department assumes that a number of members equal to the appropriated enrollment amount will be authorized for services for each year in this

request, which is the case in this request. To calculate average monthly enrollment in the HCBS-DD waiver, the maximum authorized enrollment is adjusted downwards based on the ratio of authorized to enrolled clients using the monthly linear enrollment calculation. The calculation of Maximum Assumed Enrollment is shown in table 1.1.

Row	Item	FY 2019-20	FY 2020-21	Notes
A	Requested Maximum HCBS-DD Enrollment	6,891	7,289	Appendix A - Exhibit D.1
B	Ratio of Enrollments Authorized HCBS-DD Enrollments to Enrolled with a Prior Authorization (PAR)	96.05%	96.28%	Actuals
C	**Maximum Assumed HCBS-DD Enrollment**	**6,619**	**7,018**	**Row A * Row B**

Exhibit D.5: Regional Center Information

This exhibit details the historical average enrollment and costs for clients receiving HCBS-DD services in Regional Centers. Regional Center claims are paid for from an appropriation within the Department via a transfer to the Department of Human Services (CDHS) who manages Regional Center programs. The cost of these clients is not forecasted in this request. Clients in Regional Centers do however receive TCM services as well as Quality Assurance and Utilization Reviews (QA/UR) which are managed and paid for by HCPF, so Regional Center enrollment information is included in this request to fully account for these costs. To determine utilization of these services the Department predicts that enrollment will remain constant over the request period.

Exhibit E: Calculation of Per-FPE Expenditure

This exhibit provides a summary of historical per FPE expenditure and calculates estimated per FPE expenditure for the years covered in this request.

The Department did not include a base trend on cost per utilizer projections for the waivers or TCM since there has been no indication of an increase or decrease in utilization of services. Instead, all adjustments to the cost per utilizer trend stem from rate increases or legislative impacts in FY 2019-20 and FY 2020-21. There were several different rate increases for FY 2019-20 and the request year that included an across the board increase as well as targeted rate increases for specific services.

In addition to the rate increase adjustments, bottom line adjustments account for the expected effect of approved policy in the Long Bill and any special bills.

A bottom line adjustment was added to account for increased costs in the HCBS-SLS waiver due to the expansion of access to Consumer Directed Attendant Support Services (CDASS) as requested in the

Departments FY 2015-16 R-7: "Participant Directed Programs Expansion". This policy was implemented August 15, 2018. Using the assumption that CDASS will continue to ramp up over time to reach full utilization, the increase in costs for the HCBS-SLS waiver were annualized in each year with full utilization expected to be reached in FY 2021-22.

Now that CDASS is available on the HCBS-SLS waiver, the waiver has all services offered by the 1915(i) waiver along with additional services and supports. All 1915(i) clients have transitioned to the HCBS-SLS waiver since the policy change. Due to higher than average utilization of consumer directed services amongst this population, these clients are expected to increase the aggregate cost per-client on the HCBS-SLS waiver as they transition.

A bottom line impact exists in FY 2019-20 in response to the Department's FY 2018-19 R-10 "Regional Center Task Force Recommendation Implementation" request. The Department proposes expanding Intensive Case Management (ICM) eligibility to clients living in Intermediate Care Facilities (ICF) or clients on the HCBS-DD waiver receiving services from a Regional Center for up to one year after their transition begins. The impact is to cost per FPE for TCM in FY 2019-20.

There are 53 pay periods in FY 2019-20 compared to the normal number of 52. Therefore, a bottom line impact was added in FY 2019-20 to account for the additional week of billing. In FY 2020-21 there is a corresponding negative adjustment to avoid double-counting the impact of the extra pay period.

A bottom line impact was added for new policy HB 18-1326 "Community Transition Services". The Department's 2018-19 R-7 "HCBS Transition Services Continuation and Expansion" Request, and the accompanying bill, moved services previously available under the CCT program to the HCBS waivers and to the Medicaid State Plan. The CCT grant program had been in operation since April 2013 but will expire on December 31, 2020. HB 18-1326 appropriated the continuation of 5.0 FTE to administer the new program once the CCT grant ends which will provide community transition services and supports to persons who are in an institutional setting, who are eligible for Medicaid, and who desire to transition to an HCBS setting.

Several rate increases were passed in the 2019 legislative session including a 1% across the board rate increase and several targeted rate increases. There were targeted rate increases to every support level of Group Residential Services and Supports (GRSS) of the HCBS-DD waiver. There was also a targeted rate increase in FY 2019-20 for homemaker and personal care services for the SLS and CES waivers. All targeted rate increases are expected to be implemented January 1, 2020.

Exhibit F: Quality Assurance, Utilization Review and Support Intensity Scale Services Forecast
This exhibit forecasts Quality Assurance (QA), Utilization Review (UR), and Support Intensity Scale (SIS) service costs. These services are provided on a monthly, yearly or periodic basis for clients. As a result, utilization and expenditure for these services are directly tied to the number of clients enrolled in the IDD programs.

The Department pays QA costs monthly for each client related to performance of activities related to the waiver Quality Improvement Strategy (QIS) as well as the mechanisms for overall quality assurance and system improvement. Such activities include application of policies and procedures for the resolution of complaints and grievances, critical incident reporting and response, and the assessment and reporting of process and outcome performance measures. To calculate QA costs, the exhibit takes the estimated monthly enrollment from Table D.3 and multiplies that by the rate and then by 12 months for the year.

The Department pays UR costs on a monthly basis for each client. UR activities include the implementation of processes to ensure that waiver services have been authorized in conformance to waiver requirements and monitoring service utilization to ensure that the amount of services is within the levels authorized in the service plan. This also includes identifying instances when individuals are not receiving services authorized in the service plan or the amount of services utilized is substantially less than the amount authorized to identify potential problems in service access. For UR the exhibit multiples monthly enrollment and the current rate.

The Department performs SIS assessments for IDD clients. SIS includes an assessment of the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing). Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale. For SIS, the exhibit calculates expenditure by assuming that all new enrollments would receive an assessment and an additional ten percent of the current population would receive assessments. This would be a result of clients requesting a new assessment and churn within the programs. Children receiving services through the HCBS-CES waiver do not receive SIS assessments.

The Department uses a separate tool for CHRP clients that is similar to SIS assessment but specifically designed for CHRP children. The Inventory for Client and Agency Planning (ICAP) tool is used to determine the support level for respite and habilitation. The support level produced by the ICAP is used to determine the reimbursement rate for respite and habilitation services. The ICAP measures support needs by examining "adaptive behaviors" (motor skills, social and communication skills, personal living skills, and community living skills) and "problem behaviors" (hurtful to self or others, destructive to property, disruptive or offensive behavior, unusual or repetitive habits, etc). The tool ranks the client's primary problem and indicates frequency and severity and then assigns a final score using the *adaptive behavior* and *general maladaptive* scores. Final scores then translate to a support level used for habilitation purposes. Similar to the SIS assessment, the exhibit calculates expenditure by assuming that all new enrollments would receive an assessment and an additional ten percent of the current population would receive assessments. This would be a result of clients requesting a new assessment and churn within the programs.

SB 16-192 “Assessment Tool Intellectual & Developmental Disabilities” requires the Department to design and implement a new assessment tool for individuals receiving long-term services and supports, including services for persons with intellectual and developmental disabilities. This entails the re-assessment of everyone receiving these services in FY 2020-21 and FY 2021-22. A row has been added to the QA/UR/SIS forecast tables in these fiscal years to account for increased assessments.

Exhibit G.1 through G.3: Appropriation Build

Exhibit G.1 through G.3 build the appropriation for the current, request and out years based on Long Bill and special bill appropriations and changes made to spending authority through budget requests. The appropriation builds for each year then separates out the programs within each appropriation with assumed amounts attributed to each of them.

To build the request and out year appropriations the Department begins each exhibit with the prior year’s final estimated appropriation for each program and adjusts the appropriation based on incremental amounts for each approved request or bill.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

The supplemental request is necessary because of changes in enrollment, per utilizer trends, and legislative policy implementations.

Table A1.1 - Calculation of Request					
FY 2019-20					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$507,543,510	$250,560,836	$3,210,919	$0	$253,771,755
Adjusted Spending Authority	$503,255,278	$248,117,256	$3,510,383	$0	$251,627,639
Incremental Request	$4,288,232	$2,443,580	($299,464)	$0	$2,144,116
Adult Supported Living Services (HCBS-SLS)					
Total Request	$85,182,273	$45,348,832	$2,196,564	$0	$37,636,877
Adjusted Spending Authority	$86,732,157	$45,959,837	$2,676,085	$0	$38,096,235
Incremental Request	($1,549,884)	($611,005)	($479,521)	$0	($459,358)
Children's Extensive Support Services (HCBS-CES)					
Total Request	$28,260,121	$14,130,060	$0	$0	$14,130,061
Adjusted Spending Authority	$27,062,419	$13,531,210	$0	$0	$13,531,209
Incremental Request	$1,197,702	$598,850	$0	$0	$598,852
Children's Habilitation Residential Program (HCBS-CHRP)					
Total Request	$3,409,614	$1,704,807	$0	$0	$1,704,807
Adjusted Spending Authority	$5,152,220	$2,576,110	$0	$0	$2,576,110
Incremental Request	($1,742,606)	($871,303)	$0	$0	($871,303)
Case Management					
Total Request	$40,410,428	$20,877,634	$406,048	$0	$19,126,746
Adjusted Spending Authority	$45,206,293	$23,571,393	$150,346	$0	$21,484,554
Incremental Request	($4,795,865)	($2,693,759)	$255,702	$0	($2,357,808)
Family Support Services					
Total Request	$7,755,304	$7,196,645	$558,659	$0	$0
Adjusted Spending Authority	$7,811,600	$7,196,645	$614,955	$0	$0
Incremental Request	($56,296)	$0	($56,296)	$0	$0
Preventive Dental Hygiene					
Total Request	$65,445	$65,445	$0	$0	$0
Adjusted Spending Authority	$65,445	$65,445	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,197,573	$3,197,573	$0	$0	$0
Adjusted Spending Authority	$3,197,573	$3,197,573	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Supported Employment Provider & Certification Reimbursement					
Total Request	$303,158	$303,158	$0	$0	$0
Adjusted Spending Authority	$303,158	$303,158	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Supported Employment Pilot					
Total Request	$500,000	$0	$500,000	$0	$0
Adjusted Spending Authority	$500,000	$0	$500,000	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$676,627,426	$343,384,990	$6,872,190	$0	$326,370,246
Adjusted Spending Authority	$679,286,143	$344,518,627	$7,451,769	$0	$327,315,747
Incremental Request	**($2,658,717)**	**($1,133,637)**	**($579,579)**	**$0**	**($945,501)**

Table A1.2 - Calculation of Request FY 2020-21					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$535,325,893	$266,862,945	$800,001	$0	$267,662,947
Adjusted Spending Authority	$502,793,147	$250,596,573	$800,001	$0	$251,396,573
Incremental Request	$32,532,746	$16,266,372	$0	$0	$16,266,374
Adult Supported Living Services (HCBS-SLS)					
Total Request	$89,490,095	$47,473,418	$2,225,889	$0	$39,790,788
Adjusted Spending Authority	$86,971,925	$46,082,518	$2,676,689	$0	$38,212,718
Incremental Request	$2,518,170	$1,390,900	($450,800)	$0	$1,578,070
Children's Extensive Support Services (HCBS-CES)					
Total Request	$30,028,033	$15,014,017	$0	$0	$15,014,016
Adjusted Spending Authority	$27,080,575	$13,540,287	$0	$0	$13,540,288
Incremental Request	$2,947,458	$1,473,730	$0	$0	$1,473,728
Children's Habilitation Residential Program (HCBS-CHRP)					
Total Request	$4,865,725	$2,432,862	$0	$0	$2,432,863
Adjusted Spending Authority	$5,155,578	$2,577,789	$0	$0	$2,577,789
Incremental Request	($289,853)	($144,927)	$0	$0	($144,926)
Case Management					
Total Request	$43,137,330	$22,302,534	$344,601	$0	$20,490,195
Adjusted Spending Authority	$45,243,320	$23,590,677	$150,471	$0	$21,502,172
Incremental Request	($2,105,990)	($1,288,143)	$194,130	$0	($1,011,977)
Family Support Services					
Total Request	$7,585,282	$7,202,785	$382,497	$0	$0
Adjusted Spending Authority	$7,817,740	$7,202,785	$614,955	$0	$0
Incremental Request	($232,458)	$0	($232,458)	$0	$0
Preventive Dental Hygiene					
Total Request	$65,499	$65,499	$0	$0	$0
Adjusted Spending Authority	$65,499	$65,499	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,200,203	$3,200,203	$0	$0	$0
Adjusted Spending Authority	$3,200,203	$3,200,203	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Supported Employment Provider & Certification Reimbursement					
Total Request	$303,158	$303,158	$0	$0	$0
Adjusted Spending Authority	$303,158	$303,158	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Supported Employment Pilot					
Total Request	$500,000	$0	$500,000	$0	$0
Adjusted Spending Authority	$500,000	$0	$500,000	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$714,501,218	$364,857,421	$4,252,988	$0	$345,390,809
Adjusted Spending Authority	$679,131,145	$347,159,489	$4,742,116	$0	$327,229,540
Incremental Request	**$35,370,073**	**$17,697,932**	**($489,128)**	**$0**	**$18,161,269**

Table A1.3 - Calculation of Request FY 2021-22					
Item	**Total Request**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Adult Comprehensive Services (HCBS-DD)					
Total Request	$567,176,618	$282,788,308	$800,001	$0	$283,588,309
Adjusted Spending Authority	$503,389,410	$250,894,705	$800,001	$0	$251,694,704
Incremental Request	$63,787,208	$31,893,603	$0	$0	$31,893,605
Adult Supported Living Services (HCBS-SLS)					
Total Request	$93,860,029	$49,743,609	$2,254,365	$0	$41,862,055
Adjusted Spending Authority	$86,971,925	$46,082,518	$2,676,689	$0	$38,212,718
Incremental Request	$6,888,104	$3,661,091	($422,324)	$0	$3,649,337
Children's Extensive Support Services (HCBS-CES)					
Total Request	$31,958,051	$15,979,026	$0	$0	$15,979,025
Adjusted Spending Authority	$27,080,575	$13,540,287	$0	$0	$13,540,288
Incremental Request	$4,877,476	$2,438,739	$0	$0	$2,438,737
Children's Habilitation Residential Program (HCBS-CHRP)					
Total Request	$4,865,725	$2,432,862	$0	$0	$2,432,863
Adjusted Spending Authority	$5,155,578	$2,577,789	$0	$0	$2,577,789
Incremental Request	($289,853)	($144,927)	$0	$0	($144,926)
Case Management					
Total Request	$45,035,610	$23,250,127	$346,147	$0	$21,439,336
Adjusted Spending Authority	$45,243,320	$23,590,677	$150,471	$0	$21,502,172
Incremental Request	($207,710)	($340,550)	$195,676	$0	($62,836)
Family Support Services					
Total Request	$7,573,947	$7,202,785	$371,162	$0	$0
Adjusted Spending Authority	$7,817,740	$7,202,785	$614,955	$0	$0
Incremental Request	($243,793)	$0	($243,793)	$0	$0
Preventive Dental Hygiene					
Total Request	$65,499	$65,499	$0	$0	$0
Adjusted Spending Authority	$65,499	$65,499	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Eligibility Determination and Waiting List Management					
Total Request	$3,200,203	$3,200,203	$0	$0	$0
Adjusted Spending Authority	$3,200,203	$3,200,203	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Supported Employment Provider & Certification Reimbursement					
Total Request	$303,158	$303,158	$0	$0	$0
Adjusted Spending Authority	$303,158	$303,158	$0	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Supported Employment Pilot					
Total Request	$575,000	$0	$575,000	$0	$0
Adjusted Spending Authority	$575,000	$0	$575,000	$0	$0
Incremental Request	$0	$0	$0	$0	$0
Office of Community Living Total					
Total Request	$754,613,840	$384,965,577	$4,346,675	$0	$365,301,588
Adjusted Spending Authority	$679,802,408	$347,457,621	$4,817,116	$0	$327,527,671
Incremental Request	**$74,811,432**	**$37,507,956**	**($470,441)**	**$0**	**$37,773,917**

Table A.2 - Calculation of Fund Splits						
FY 2019-20						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services[1][2]	$507,543,510	$250,560,836	$3,210,919	$253,771,755	50.00%	Table B.1 Row M
Subtotal	$507,543,510	$250,560,836	$3,210,919	$253,771,755	50.00%	
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services	$74,322,960	$37,161,480	$0	$37,161,480	50.00%	Table A.6.5 Row C
Medicaid Services (Buy-In)[3]	$950,795	$0	$475,398	$475,397	50.00%	Table A.6.5 Row B
State Only Services[2]	$9,908,518	$8,187,352	$1,721,166	$0	0.00%	Table G.1 Row W
Subtotal	$85,182,273	$45,348,832	$2,196,564	$37,636,877		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$28,260,121	$14,130,060	$0	$14,130,061	50.00%	Table B.1 Row M
Children's Habilitation Residential Program (HCBS-CHRP)						
Subtotal	$3,409,614	$1,704,807	$0	$1,704,807	50.00%	Table B.1 Row M
Case Management						
Medicaid Services[2]	$32,651,588	$16,263,571	$62,223	$16,325,794	50.00%	Table A.6.5 Row C
Medicaid Services (Buy-In)[3]	$114,906	$0	$57,453	$57,453	50.00%	Table A.6.5 Row B
State Only Services[2]	$2,156,935	$1,873,238	$283,697	$0	0.00%	Table G.1 Row AR
Quality Assurance, Utilization Review, Support Intensity Scale	$5,481,649	$2,740,825	$0	$2,740,824	50.00%	Table A.6.5 Row C
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[3]	$5,350	$0	$2,675	$2,675	50.00%	Table A.6.5 Row B
Subtotal	$40,410,428	$20,877,634	$406,048	$19,126,746		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,197,573	$3,197,573	$0	$0	0.00%	Table G.1 Row BI
PASRR	$0	$0	$0	$0	75.00%	Table G.1 Row BH
Subtotal	$3,197,573	$3,197,573	$0	$0		
Other Programs						
Family Support Services[2][4]	$7,755,304	$7,196,645	$558,659	$0	0.00%	Table G.1 Row AX
Preventive Dental Hygiene	$65,445	$65,445	$0	$0	0.00%	Table G.1 Row BB
Supported Employment Provider & Certification Reimbursement	$303,158	$303,158	$0	$0	0.00%	Table G.1 Row BQ
Supported Employment Pilot[2]	$500,000	$0	$500,000	$0	0.00%	Table G.1 Row BT
Subtotal	$8,623,907	$7,565,248	$1,058,659	$0		
Grand Total	**$676,627,426**	**$343,384,990**	**$6,872,190**	**$326,370,246**		

(1) Cash funds sourced from the Health Care Expansion Fund.

(2) Cash funds sourced from the Intellectual and Developmental Disabilities Cash Fund.

(3) Cash funds sourced from the Healthcare Affordability & Sustainability Fee Cash Fund. Premiums from clients in Buy-In programs are credited to the Medical Services Premiums line item, and as such are excluded from this request.

(4) Cash funds from the Family Support Loan Program Fund

Table A.3 - Calculation of Fund Splits						
FY 2020-21						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services[(1)(2)]	$535,325,893	$266,862,945	$800,001	$267,662,947	50.00%	Table B.1 Row N
Subtotal	$535,325,893	$266,862,945	$800,001	$267,662,947	50.00%	Table B.1 Row N
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services (Standard)	$78,572,132	$39,286,066	$0	$39,286,066	50.00%	Table A.6.6 Row C
Medicaid Services (Buy-In)[(3)]	$1,009,445	$0	$504,723	$504,722	50.00%	Table A.6.6 Row B
State Only Services[(2)]	$9,908,518	$8,187,352	$1,721,166	$0	0.00%	Table G.2 Row N
Subtotal	$89,490,095	$47,473,418	$2,225,889	$39,790,788		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$30,028,033	$15,014,017	$0	$15,014,016	50.00%	Table B.1 Row N
Children's Habilitation Residential Program (HCBS-CHRP)						
Subtotal	$4,865,725	$2,432,862	$0	$2,432,863	50.00%	Table B.1 Row N
Case Management						
Medicaid Services (Standard)	$33,929,183	$16,964,592	$0	$16,964,591	50.00%	Table A.6.6 Row C
Medicaid Services (Buy-In)[(3)]	$116,347	$0	$58,174	$58,173	50.00%	Table A.6.6 Row B
State Only Services[(2)]	$2,156,935	$1,873,238	$283,697	$0	0.00%	Table G.2 Row Z
Quality Assurance, Utilization Review, Support Intensity Scale (Standard)	$6,884,973	$3,442,487	$0	$3,442,486	50.00%	Table A.6.6 Row C
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[(3)]	$5,459	$0	$2,730	$2,729	50.00%	Table A.6.6 Row B
Quality Assurance, Utilization Review, CHRP Assessment	$44,433	$22,217	$0	$22,216	50.00%	Table F.1 Rows C, I, L
Subtotal	$43,137,330	$22,302,534	$344,601	$20,490,195		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,200,203	$3,200,203	$0	$0	0.00%	Table G.2 Row AL
PASRR	$0	$0	$0	$0	75.00%	Table G.2 Row AK
Subtotal	$3,200,203	$3,200,203	$0	$0		
Other Programs						
Family Support Services[(2)(4)]	$7,585,282	$7,202,785	$382,497	$0	0.00%	Table G.2 Row AD
Preventive Dental Hygiene	$65,499	$65,499	$0	$0	0.00%	Table G.2 Row AG
Supported Employment Provider & Certification Reimbursement	$303,158	$303,158	$0	$0	0.00%	Table G.2 Row AQ
Supported Employment Pilot[(2)]	$500,000	$0	$500,000	$0	0.00%	Table G.2 Row AS
Subtotal	$8,453,939	$7,571,442	$882,497	$0		
Grand Total	**$714,501,218**	**$364,857,421**	**$4,252,988**	**$345,390,809**		

Definitions: FFP: Federal financial participation rate

(1) Cash funds sourced from the Health Care Expansion Fund.

(2) Cash funds sourced from the Intellectual and Developmental Disabilities Cash Fund.

(3) Cash funds sourced from the Healthcare Affordability & Sustainability Fee Cash Fund. Premiums from clients in Buy-In programs are credited to the Medical Services Premiums line item, and as such are

(4) Cash funds from the Family Support Loan Program Fund

Table A.4 - Calculation of Fund Splits						
FY 2021-22						
Item	**Total Request**	**General Fund**	**Cash Funds**	**Federal Funds**	FFP	**Source**
Adult Comprehensive Services (HCBS-DD)						
Medicaid Services[(1)(2)]	$567,176,618	$280,377,390	$3,210,919	$283,588,309	50.00%	Table B.1 Row O
Subtotal	$567,176,618	$282,788,308	$800,001	$283,588,309	50.00%	Table B.1 Row O
Adult Supported Livings Services (HCBS-SLS)						
Medicaid Services (Standard)	$82,657,712	$41,328,856	$0	$41,328,856	50.00%	Table A.6.7 Row C
Medicaid Services (Buy-In)[(3)]	$1,066,398	$0	$533,199	$533,199	50.00%	Table A.6.7 Row B
State Only Services[(2)]	$10,135,919	$8,414,753	$1,721,166	$0	0.00%	Table G.2 Row H
Subtotal	$93,860,029	$49,743,609	$2,254,365	$41,862,055		
Children's Extensive Support Services (HCBS-CES)						
Subtotal	$31,958,051	$15,979,026	$0	$15,979,025	50.00%	Table B.1 Row O
Children's Habilitation Residential Program (HCBS-CHRP)						
Subtotal	$4,865,725	$2,432,862	$0	$2,432,863	50.00%	Table B.1 Row O
Case Management						
Medicaid Services (Standard)	$35,579,791	$17,789,896	$0	$17,789,895	50.00%	Table A.6.7 Row C
Medicaid Services (Buy-In)[(3)]	$119,330	$0	$59,665	$59,665	50.00%	Table A.6.7 Row B
State Only Services[(2)]	$2,156,935	$1,873,238	$283,697	$0	0.00%	Table G.3 Row O
Quality Assurance, Utilization Review, Support Intensity Scale (Standard)	$7,140,646	$3,570,323	$0	$3,570,323	50.00%	Table A.6.7 Row C
Quality Assurance, Utilization Review, Support Intensity Scale (Buy-In)[(3)]	$5,569	$0	$2,785	$2,784	50.00%	Table A.6.7 Row B
Quality Assurance, Utilization Review, CHRP Assessment	$33,339	$16,670	$0	$16,669	50.00%	Table F.3
Subtotal	$45,035,610	$23,250,127	$346,147	$21,439,336		
Eligibility Determination and Waiting List Management						
Medical Eligibility Determination	$3,200,203	$3,200,203	$0	$0	0.00%	Table G.3 Row W
PASRR	$0	$0	$0	$0	75.00%	Table G.3 Row V
Subtotal	$3,200,203	$3,200,203	$0	$0		
Other Programs						
Family Support Services[(2)]	$7,573,947	$7,202,785	$371,162	$0	0.00%	Table G.3 Row Q
Preventive Dental Hygiene	$65,499	$65,499	$0	$0	0.00%	Table G.3 Row S
Supported Employment Provider & Certification Reimbursement	$303,158	$303,158	$0	$0	0.00%	Table G.3 Row AC
Supported Employment Pilot[(2)]	$575,000	$0	$575,000	$0	0.00%	Table G.3 Row AE
Subtotal	$8,517,604	$7,571,442	$946,162	$0		
Grand Total	**$754,613,840**	**$384,965,577**	**$4,346,675**	**$365,301,588**		

Definitions: FFP: Federal financial participation rate

(1) Cash funds sourced from the Health Care Expansion Fund.

(2) Cash funds sourced from the Intellectual and Developmental Disabilities Cash Fund.

(3) Cash funds sourced from the Healthcare Affordability & Sustainability Fee Cash Fund. Premiums from clients in Buy-In programs are credited to the Medical Services Premiums line item, and as such are

Table A.5 - Office of Community Living Cash Funds Report									
Cash Fund	**FY 2019-20**			**FY 2020-21**			**FY 2021-22**		
	Base Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Intellectual and Developmental Disabilities Cash Fund	$6,386,407	$6,149,166	($237,241)	$3,676,025	$3,676,025	$0	$3,751,025	$3,751,025	$0
Family Support Loan Program Fund	$187,497	$187,497	$0	$187,497	$11,335	($176,162)	$187,497	$0	($187,497)
Healthcare Affordability & Sustainability Fee Cash Fund	$877,864	$535,526	($342,338)	$878,593	$565,627	($312,966)	$878,593	$595,649	($282,944)
Total Cash Funds	**$7,451,769**	**$6,872,190**	**($579,579)**	**$4,742,116**	**$4,252,988**	**($489,128)**	**$4,817,116**	**$4,346,675**	**($470,441)**

Table A.6.1 - Historic Expenditure on Buy-In HCBS-SLS Programs						
Row	**Fiscal Year**	**HCBS-SLS**	**TCM**	**QA/UR**	**SIS**	**Total**
A	FY 2007-08	$0	$0	$0	$0	$0
B	FY 2008-09	$0	$0	$0	$0	$0
C	FY 2009-10	$0	$0	$0	$0	$0
D	FY 2010-11	$0	$0	$0	$0	$0
E	FY 2011-12	$0	$0	$0	$0	$0
F	FY 2012-13	$0	$0	$0	$0	$0
G	FY 2013-14	$0	$0	$0	$0	$0
H	FY 2014-15	$0	$0	$0	$0	$0
I	FY 2015-16	$0	$0	$0	$0	$0
J	FY 2016-17	$0	$0	$0	$0	$0
K	FY 2017-18	$197,857	$248,662	$1,371	$0	$447,890
L	FY 2018-19	$412,388	$105,517	$17,141	$0	$535,046
M	Estimated FY 2019-20	$950,795	$114,906	$4,156	$1,194	$1,071,051
N	Estimated FY 2020-21	$1,009,445	$116,347	$4,265	$1,194	$1,131,251
O	Estimated FY 2021-22	$1,066,398	$119,330	$4,375	$1,194	$1,191,297

Table A.6.2 - FY 2019-20 HB 16-1321 Buy-In Expansion Cost and Caseload Estimate						
Row	**Item**	**HCBS-SLS**	**TCM**	**QA/UR**	**SIS[(1)]**	**Notes**
A	Previous Year Average Monthly Enrollment	56	37	37	0	July 2018 Data + SLS Enrollment Trend
B	Selected Trend	2.59%	2.59%	2.59%	N/A	SLS Trend - Table D.3.3 Row B
C	Estimated Average Monthly Enrollment	57	38	38	5	Row A + (1 + Row B)
D	Anticipated Buy-In Cost/Client	$16,680.61	$3,023.83	$109.37	$238.71	Table E.1 Row M, Table F.1 for QA/UR/SIS
E	Anticipated Buy-in Cost	$950,795	$114,906	$4,156	$1,194	Row C * Row D

Table A.6.3 - FY 2020-21 HB 16-1321 Buy-In Expansion Cost and Caseload Estimate						
Row	**Item**	**HCBS-SLS**	**TCM**	**QA/UR**	**SIS[(1)]**	**Notes**
A	Previous Year Average Monthly Enrollment	57	38	38	5	Table A.6.2 Row C
B	Selected Trend	3.07%	3.07%	3.07%	0.00%	SLS Trend - Table D.3.4 Row B
C	Estimated Average Monthly Enrollment	59	39	39	5	Row A + (1 + Row B) SIS Cost includes all buy-in clients due to SB 192 reassessments
D	Anticipated Buy-In Cost/Client	$17,109.24	$2,983.26	$109.37	$238.71	Table E.2 Row N, Table F.2 for QA/UR/SIS
E	Anticipated Buy-in Cost	$1,009,445	$116,347	$4,265	$1,194	Row C * Row D

Table A.6.4 - FY 2021-22 HB 16-1321 Buy-In Expansion Cost and Caseload Estimate						
Row	**Item**	**HCBS-SLS**	**TCM**	**QA/UR**	**SIS[(1)]**	**Notes**
A	Previous Year Average Monthly Enrollment	59	39	39	5	Table A.6.3 Row C
B	Selected Trend	2.96%	2.96%	2.96%	0.00%	SLS Trend - Table D.3.5 Row B
C	Estimated Average Monthly Enrollment	61	40	40	5	Row A + (1 + Row B)
D	Anticipated Buy-In Cost/Client	$17,481.93	$2,983.26	$109.37	$238.71	Table E.2 Row O, Table F.3 for QA/UR/SIS
E	Anticipated Buy-in Cost	$1,066,398	$119,330	$4,375	$1,194	Row C * Row D

(1) The Department assumes that all new clients on the HCBS-SLS Waiver will receive a SIS assessment, and 10% of existing clients will receive a SIS assessment.

Table A.6.5 - FY 2019-20 Buy-In Breakout					
Row	**Item**	**Total Request**	**TCM**	**QA/UR/SIS**	**Source**
A	HCBS-SLS Total Request	$75,273,755	$32,766,494	$5,486,999	Table B.1 Row M, Table F.1 Row M
B	HCBS-SLS Buy-In	$950,795	$114,906	$5,350	Table A.6.2 Row E
C	HCBS-SLS Standard	$74,322,960	$32,651,588	$5,481,649	Row A - Row B

Table A.6.6 - FY 2020-21 Buy-In Breakout					
Row	**Item**	**Total Request**	**TCM**	**QA/UR/SIS**	**Source**
A	HCBS-SLS Total Request	$79,581,577	$34,045,530	$6,890,432	Table B.1 Row N, Table F.2 Row M
B	HCBS-SLS Buy-In	$1,009,445	$116,347	$5,459	Table A.6.3 Row E
C	HCBS-SLS Standard	$78,572,132	$33,929,183	$6,884,973	Row A - Row B

Table A.6.7 - FY 2021-22 Buy-In Breakout					
Row	**Item**	**Total Request**	**TCM**	**QA/UR/SIS**	**Source**
A	HCBS-SLS Total Request	$83,724,110	$35,699,121	$7,146,215	Table B.1 Row O, Table F.3 Row M
B	HCBS-SLS Buy-In	$1,066,398	$119,330	$5,569	Table A.6.4 Row E
C	HCBS-SLS Standard	$82,657,712	$35,579,791	$7,140,646	Row A - Row B

Table B.1 - Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure and Forecast							
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) [1]**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM) [1]**	**Total**
A	FY 2007-08	$202,943,588	$39,607,629	$5,894,263	N/A	$13,661,560	$262,107,040
B	FY 2008-09	$223,362,025	$46,391,718	$6,913,410	N/A	$13,848,967	$290,516,120
C	FY 2009-10	$253,798,612	$37,399,799	$7,158,025	N/A	$16,484,735	$314,841,171
D	FY 2010-11	$273,096,876	$37,579,497	$7,956,073	N/A	$19,114,672	$337,747,118
E	FY 2011-12	$264,899,518	$37,030,578	$7,361,601	$4,167,690	$16,875,522	$330,334,909
F	FY 2012-13	$261,817,957	$37,273,663	$7,015,707	$3,410,635	$16,117,073	$325,635,035
G	FY 2013-14	$282,475,249	$39,288,448	$9,125,302	$3,089,752	$17,441,960	$351,420,711
H	FY 2014-15	$314,878,204	$44,654,327	$14,967,843	$2,793,542	$20,230,023	$397,523,939
I	FY 2015-16	$330,217,987	$53,275,897	$21,074,423	$2,084,490	$22,103,255	$428,756,052
J	FY 2016-17	$347,057,913	$58,395,990	$25,113,943	$1,889,200	$22,242,358	$454,699,404
K	FY 2017-18	$372,706,454	$64,188,404	$25,698,431	$1,556,384	$30,164,217	$494,313,890
L	FY 2018-19	$422,166,719	$64,028,039	$23,559,173	$1,747,427	$29,560,074	$541,061,431
M	Estimated FY 2019-20	$507,543,510	$75,273,755	$28,260,121	$3,409,614	$32,766,494	$647,253,494
N	Estimated FY 2020-21	$535,325,893	$79,581,577	$30,028,033	$4,865,725	$34,045,530	$683,846,758
O	Estimated FY 2021-22	$567,176,618	$83,724,110	$31,958,051	$4,865,725	$35,699,121	$723,423,625

Table B.1.2- Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure							
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS) [1]**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM) [1]**	**Total**
A	FY 2007-08						
B	FY 2008-09	10.06%	17.13%	17.29%		1.37%	10.84%
C	FY 2009-10	13.63%	-19.38%	3.54%		19.03%	8.37%
D	FY 2010-11	7.60%	0.48%	11.15%		15.95%	7.28%
E	FY 2011-12	-3.00%	-1.46%	-7.47%		-11.71%	-2.19%
F	FY 2012-13	-1.16%	0.66%	-4.70%	-18.16%	-4.49%	-1.42%
G	FY 2013-14	7.89%	5.41%	30.07%	-9.41%	8.22%	7.92%
H	FY 2014-15	11.47%	13.66%	64.03%	-9.59%	15.98%	13.12%
I	FY 2015-16	4.87%	19.31%	40.80%	-25.38%	9.26%	7.86%
J	FY 2016-17	5.10%	9.61%	19.17%	-9.37%	0.63%	6.05%
K	FY 2017-18	7.39%	9.92%	2.33%	-17.62%	35.62%	8.71%
L	FY 2018-19	13.27%	-0.25%	-8.32%	12.27%	-2.00%	9.46%
M	Estimated FY 2019-20	20.22%	17.56%	19.95%	95.12%	10.85%	19.63%
N	Estimated FY 2020-21	5.47%	5.72%	6.26%	42.71%	3.90%	5.65%
O	Estimated FY 2021-22	5.95%	5.21%	6.43%	0.00%	4.86%	5.79%

(1) Program expenditure amounts do not include State Only Programs - total program expenditure shown on Tables A.2 - A.4

(2) Program expenditure amounts reflect what was reported in CORE as of 7/23/2019 and may differ from actuals reported elsewhere due to post-close entries

Table C.1 - FY 2019-20 Projected Expenditure								
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Total**	**Source/Calculation**
A	Adjusted Appropriation	$503,255,278	$76,596,238	$27,062,419	$5,152,220	$33,362,828	$645,428,983	Table G.1, See Footnote (1)
B	Projected FPE	6,329.43	4,512.65	1,784.84	39.92	10,836.09	N/A	Table D.3 Row G
C	Projected Per FPE Expenditure	$80,187.87	$16,680.61	$15,833.42	$85,411.18	$3,023.83	N/A	Table E.1, Row M
D	Total Projected Expenditure	$507,543,510	$75,273,755	$28,260,121	$3,409,614	$32,766,494	$647,253,494	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$4,288,232**	**($1,322,483)**	**$1,197,702**	**($1,742,606)**	**($596,334)**	**$1,824,511**	**Row D - Row A**

Table C.2 - FY 2020-21 Projected Expenditure								
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Total**	**Source/Calculation**
A	Adjusted Appropriation	$502,793,147	$76,836,006	$27,080,575	$5,155,578	$33,399,855	$645,265,161	Table G.2, See Footnote (1)
B	Projected FPE	6,739.69	4,651.38	1,892.37	57.74	11,412.19	N/A	Table D.3 Row G
C	Projected Per FPE Expenditure	$79,428.86	$17,109.24	$15,867.95	$84,269.57	$2,983.26	N/A	Table E.1 Row N
D	Total Projected Expenditure	$535,325,893	$79,581,577	$30,028,033	$4,865,725	$34,045,530	$683,846,758	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$32,532,746**	**$2,745,571**	**$2,947,458**	**($289,853)**	**$645,675**	**$38,581,597**	**Row D - Row A**

Table C.3 - FY 2021-22 Projected Expenditure								
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Total**	**Source/Calculation**
A	Adjusted Appropriation	$503,389,410	$76,836,006	$27,080,575	$5,155,578	$33,399,855	$645,861,424	Table G.3, See Footnote (1)
B	Projected FPE	7,133.18	4,789.18	2,014.00	57.74	11,966.48	N/A	Table D.3 Row G
C	Projected Per FPE Expenditure	$79,512.45	$17,481.93	$15,867.95	$84,269.57	$2,983.26	N/A	Table E.1 Row O
D	Total Projected Expenditure	$567,176,618	$83,724,110	$31,958,051	$4,865,725	$35,699,121	$723,423,625	Row B * Row C
E	**Estimated Over/(Under-expenditure)**	**$63,787,208**	**$6,888,104**	**$4,877,476**	**($289,853)**	**$2,299,266**	**$77,562,201**	**Row D - Row A**

(1) All appropriation amounts above are for Medicaid funded individuals only and do not include state-only funded individuals, clients served at regional centers, payments made through client cash sources, or administrative costs.

Table D.1.1 -FY 2019-20 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast		
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**
A	Prior Year Maximum Enrollment	6,335
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2019-20 Enrollment	6,335
	Bottom Line Adjustments	
D	FY 2019-20 JBC Action	150
E	Transitions from Institutions	10
F	Aging Caregiver Enrollments	57
G	Emergency Enrollments	228
H	Foster Care Transitions	36
I	Youth Transitions	75
J	Total Bottom Line Adjustments	556
K	**Estimated FY 2019-20 Maximum Enrollment**	**6,891**
L	Churn and Enrollment Lag Adjustment(1)	96.05%
M	**Estimated Year End-Enrollment**	**6,619**

(1) Accounts for clients entering and leaving waiver, and the time necessary to enroll an individual with an HCBS-DD PAR once authorized by the Department.

Table D.1.2 -FY 2020-21 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast		
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**
A	Estimated FY 2019-20 Maximum Enrollment	6,891
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2020-21 Enrollment	6,891
	Bottom Line Adjustments	
D	Transitions from Institutions	2
E	Emergency Enrollments	228
F	Aging Caregiver Enrollments	57
G	Foster Care Transitions	36
H	Youth Transitions	75
I	Total Bottom Line Adjustments	398
J	**Estimated FY 2020-21 Maximum Enrollment**	**7,289**
K	Churn and Enrollment Lag Adjustment	96.28%
L	**Estimated Year End-Enrollment**	**7,018**

(1) Accounts for clients entering and leaving waiver, and the time necessary to enroll an individual with an HCBS-DD PAR once authorized by the Department.

Table D.1.3 - FY 2021-22 HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) Maximum Enrollment Forecast		
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**
A	Estimated FY 2020-21 Maximum Enrollment	7,289
B	Base Trend Increase	0.00%
C	Initial Estimated FY 2021-22 Enrollment	7,289
	Bottom Line Adjustments	
D	Transitions from Institutions	0
E	Emergency Enrollments	228
F	Aging Caregiver Enrollments	57
G	Foster Care Transitions	36
H	Youth Transitions	75
I	Total Bottom Line Adjustments	396
J	**Estimated FY 2021-22 Maximum Enrollment**	**7,685**
K	Churn and Enrollment Lag Adjustment	96.47%
L	**Estimated Year End-Enrollment**	**7,414**

(1) Accounts for clients entering and leaving waiver, and the time necessary to enroll an individual with an HCBS-DD PAR once authorized by the Department.

Table D.2 - DIDD Average Monthly Enrollment vs. Full Program Equivalent (FPE)							
Row	**Fiscal Year**		**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	Average Monthly Enrollment	4,399	2,871	383	-	7,773
B		FPE	3,654	2,287	291	-	6,165
C		FPE as a Percentage of Average Monthly Enrollment	83.06%	79.66%	75.98%	-	79.31%
D	FY 2008-09	Average Monthly Enrollment	4,390	2,992	400	-	7,911
E		FPE	3,854	2,369	328	-	6,420
F		FPE as a Percentage of Average Monthly Enrollment	87.79%	79.18%	82.00%	-	81.15%
G	FY 2009-10	Average Monthly Enrollment	4,401	3,104	404	-	8,027
H		FPE	4,063	2,625	325	-	6,049
I		FPE as a Percentage of Average Monthly Enrollment	92.32%	84.57%	80.45%	-	75.36%
J	FY 2010-11	Average Monthly Enrollment	4,397	3,116	385	-	8,020
K		FPE	4,123	2,848	358	-	7,045
L		FPE as a Percentage of Average Monthly Enrollment	93.77%	91.40%	92.99%	-	87.84%
M	FY 2011-12	Average Monthly Enrollment	4,397	3,140	373	-	8,032
N		FPE	4,113	2,860	338	-	6,578
O		FPE as a Percentage of Average Monthly Enrollment	93.54%	91.08%	90.62%	-	81.90%
P	FY 2012-13	Average Monthly Enrollment	4,384	3,178	377	72	8,074
Q		FPE	4,156	3,021	347	67	6,760
R		FPE as a Percentage of Average Monthly Enrollment	94.80%	95.06%	92.04%	93.06%	83.73%
S	FY 2013-14	Average Monthly Enrollment	4,392	3,183	607	64	8,309
T		FPE	4,339	3,015	498	64	6,795
U		FPE as a Percentage of Average Monthly Enrollment	98.79%	94.72%	82.04%	100.00%	81.78%
V	FY 2014-15	Average Monthly Enrollment	4,685	3,678	971	51	9,458
W		FPE	4,617	3,381	836	53	7,812
X		FPE as a Percentage of Average Monthly Enrollment	98.55%	91.92%	86.10%	103.92%	82.60%
Y	FY 2015-16	Average Monthly Enrollment	4,903	4,311	1,373	36	10,704
Z		FPE	4,832	3,896	1,200	36	8,994
AA		FPE as a Percentage of Average Monthly Enrollment	98.55%	90.37%	87.40%	100.00%	84.02%
AB	FY 2016-17	Average Monthly Enrollment	5,077	4,637	1,602	34	11,428
AC		FPE	4,933	4,136	1,395	30	8,947
AD		FPE as a Percentage of Average Monthly Enrollment	97.16%	89.20%	87.08%	88.24%	78.29%
AE	FY 2017-18	Average Monthly Enrollment	5,162	4,778	1,696	31	11,667
AF		FPE	5,119	4,475	1,547	24	10,133
AG		FPE as a Percentage of Average Monthly Enrollment	99.17%	93.66%	91.21%	77.42%	86.85%
AH	FY 2018-19	Average Monthly Enrollment	5,741	4,788	1,861	30	12,523
AI		FPE	5,664	4,313	1,583	21	10,120
AJ		FPE as a Percentage of Average Monthly Enrollment	98.66%	90.08%	85.06%	70.00%	80.81%
AK	**FY 2019-20 Selected FPE Conversion Factor**		**98.62%**	**91.87%**	**88.14%**	**71.29%**	**80.80%**
AL	**FY 2020-21 and FY 2021-22 Selected FPE Conversion Factor**		**98.62%**	**91.87%**	**88.14%**	**71.29%**	**80.80%**

Table D.3.1 - Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment Forecast						
Row	**Fiscal Year**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	4,399	2,871	383	-	7,773
B	FY 2008-09	4,390	2,992	400	-	7,911
C	FY 2009-10	4,401	3,104	404	-	8,027
D	FY 2010-11	4,397	3,116	385	-	8,020
E	FY 2011-12	4,397	3,140	373	-	8,032
F	FY 2012-13	4,384	3,178	377	72	8,074
G	FY 2013-14	4,392	3,183	607	64	8,309
H	FY 2014-15	4,685	3,678	971	51	9,458
I	FY 2015-16	4,903	4,311	1,373	36	10,703
J	FY 2016-17	5,077	4,637	1,602	34	11,428
K	FY 2017-18	5,162	4,778	1,696	31	11,740
L	FY 2018-19	5,741	4,788	1,861	30	12,523
M	Estimated FY 2019-20	6,418	4,912	2,025	56	13,411
N	Estimated FY 2020-21	6,834	5,063	2,147	81	14,124
O	Estimated FY 2021-22	7,233	5,213	2,285	81	14,810

Table D.3.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment						
Row	**Fiscal Year**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2008-09	-0.20%	4.21%	4.44%	-	1.78%
B	FY 2009-10	0.25%	3.74%	1.00%	-	1.47%
C	FY 2010-11	-0.09%	0.39%	-4.70%	-	-0.09%
D	FY 2011-12	0.00%	0.77%	-3.12%	-	0.15%
E	FY 2012-13	-0.30%	1.21%	1.07%	-	0.52%
F	FY 2013-14	0.18%	0.16%	61.01%	-11.11%	2.91%
G	FY 2014-15	6.67%	15.55%	59.97%	-20.31%	13.83%
H	FY 2015-16	4.65%	17.21%	41.40%	-29.41%	13.17%
I	FY 2016-17	3.55%	7.56%	16.68%	-5.56%	6.77%
J	FY 2017-18	1.67%	3.04%	5.87%	-8.82%	2.73%
K	FY 2018-19	11.22%	0.21%	9.73%	-3.23%	6.67%
L	Estimated FY 2019-20	11.79%	2.59%	8.81%	86.67%	7.09%
M	Estimated FY 2020-21	6.48%	3.07%	6.02%	44.64%	5.32%
N	Estimated FY 2021-22	5.84%	2.96%	6.43%	0.00%	4.86%

Table D.3.3 - Calculation of FY 2019-20 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2019-20**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Prior Year Average Monthly Enrollment	5,741	4,788	1,861	30	12,523	Actuals
B	Base Trend Increase	11.79%	2.59%	8.81%	86.67%	7.09%	Trend based on previous enrollment growth (HCBS-DD growth due to additional appropriated enrollments Table D.1.1)
C	Preliminary Average Monthly Enrollment	6,418	4,912	2,025	56	13,411	Row A * (1 + Row B)
	Bottom Line Adjustments						See narrative
D	Total Bottom Line Adjustments	0	0	0	0	0	
E	**Average Monthly Enrollment**	**6,418**	**4,912**	**2,025**	**56**	**13,411**	**Row C + Row D**
F	FPE Adjustment Factor	98.62%	91.87%	88.14%	71.29%	80.80%	Table D.2, Row AK
G	**Estimated FPE**	**6,329.43**	**4,512.65**	**1,784.84**	**39.92**	**10,836.09**	**Row E * Row F**

Table D.3.4 - Calculation of FY 2020-21 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2020-21**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Prior Year Average Monthly Enrollment	6,418	4,912	2,025	56	13,411	Actuals
B	Base Trend Increase	6.48%	3.07%	6.02%	44.64%	5.32%	Trend based on previous enrollment growth (HCBS-DD growth due to additional appropriated enrollments Table D.1.2.)
C	Preliminary Average Monthly Enrollment	6,834	5,063	2,147	81	14,124	Row A * (1 + Row B)
	Bottom Line Adjustments						See narrative
D	Total Bottom Line Adjustments	0	0	0	0	0	
E	**Average Monthly Enrollment**	**6,834**	**5,063**	**2,147**	**81**	**14,124**	**Row C + Row D**
F	FPE Adjustment Factor	98.62%	91.87%	88.14%	71.29%	80.80%	Table D.2, Row AL
G	**Estimated FPE**	**6,739.69**	**4,651.38**	**1,892.37**	**57.74**	**11,412.19**	**Row E * Row F**

Table D.3.5 - Calculation of FY 2021-22 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2021-22**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Prior Year Average Monthly Enrollment	6,834	5,063	2,147	81	14,124	Actuals
B	Base Trend Increase	5.84%	2.96%	6.43%	0.00%	4.86%	Trend based on previous enrollment growth (HCBS-DD growth due to additional appropriated enrollments Table D.1.3)
C	Preliminary Average Monthly Enrollment	7,233	5,213	2,285	81	14,810	Row A * (1 + Row B)
	Bottom Line Adjustments						See narrative
D	Total Bottom Line Adjustments	0	0	0	0	0	
E	**Average Monthly Enrollment**	**7,233**	**5,213**	**2,285**	**81**	**14,810**	**Row C + Row D**
F	FPE Adjustment Factor	98.62%	91.87%	88.14%	71.29%	80.80%	Table D.2, Row AL
G	**Estimated FPE**	**7,133.18**	**4,789.18**	**2,014.00**	**57.74**	**11,966.48**	**Row G * Row H**

Table D.5 - HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers							
Row	**Fiscal Year**	**Average Monthly Enrollment**	**Total Cost**	**Per Utilizer Cost**	**Percent Change in Enrollment**	**Percent Change in Total Cost**	**Percent Change in Per-Utilizer Cost**
A	FY 2007-08	120	$19,814,222	$165,119	-	-	-
B	FY 2008-09	129	$26,028,730	$201,773	7.50%	31.36%	22.20%
C	FY 2009-10	118	$28,360,034	$240,339	-8.53%	8.96%	19.11%
D	FY 2010-11	122	$24,142,015	$197,885	3.39%	-14.87%	-17.66%
E	FY 2011-12	122	$25,276,720	$207,186	0.00%	4.70%	4.70%
F	FY 2012-13	135	$24,167,096	$179,016	10.66%	-4.39%	-13.60%
G	FY 2013-14	127	$22,225,364	$175,003	-5.93%	-8.03%	-2.24%
H	FY 2014-15	124	$21,454,023	$173,016	-2.36%	-3.47%	-1.14%
I	FY 2015-16	116	$19,900,398	$171,186	-6.25%	-7.24%	-1.06%
J	FY 2016-17[(1)]	112	$19,175,157	$171,207	-3.66%	-3.64%	0.01%
K	FY 2017-18	104	$31,987,342	$307,571	-7.14%	66.82%	79.65%
L	FY 2018-19	102	$25,474,050	$248,730	-1.52%	-20.36%	-19.13%

(1) Through February 2017. Regional Center payments were manually processed after the implementation of interChange and caseload data is not available for these months.

Table E.1 - Division for Intellectual and Developmental Disabilities (DIDD) Per Full Program Equivalent (FPE) Expenditure and Forecast						
Row	**Fiscal Year**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	$55,540.12	$17,318.60	$20,255.20	-	$2,215.99
B	FY 2008-09	$57,955.90	$19,582.83	$21,077.47	-	$2,157.16
C	FY 2009-10	$62,465.82	$14,247.54	$22,024.69	-	$2,725.20
D	FY 2010-11	$66,237.42	$13,195.05	$22,223.67	-	$2,713.23
E	FY 2011-12	$64,405.43	$12,947.75	$21,779.88	-	$2,565.45
F	FY 2012-13	$62,997.58	$12,338.19	$20,218.18	$50,905.00	$2,384.18
G	FY 2013-14	$65,101.46	$13,030.99	$18,323.90	$48,277.38	$2,566.88
H	FY 2014-15	$68,199.74	$13,207.43	$17,904.12	$52,708.34	$2,589.61
I	FY 2015-16	$68,339.82	$13,674.51	$17,562.02	$57,902.50	$2,457.56
J	FY 2016-17	$70,354.33	$14,118.95	$18,002.83	$62,973.33	$2,486.01
K	FY 2017-18	$72,808.45	$14,343.78	$16,611.78	$64,849.33	$2,976.83
L	FY 2018-19	$74,535.08	$14,845.36	$14,882.61	$83,210.82	$2,920.96
M	Estimated FY 2019-20	$80,187.87	$16,680.61	$15,833.42	$85,411.18	$3,023.83
N	Estimated FY 2020-21	$79,428.86	$17,109.24	$15,867.95	$84,269.57	$2,983.26
O	Estimated FY 2021-22	$79,512.45	$17,481.93	$15,867.95	$84,269.57	$2,983.26

Table E.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure and Forecast						
Row	**Fiscal Year**	**HCBS - Adult Comprehensive Waiver (HCBS-DD)**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2008-09	4.35%	13.07%	4.06%	-	-2.65%
B	FY 2009-10	7.78%	-27.24%	4.49%	-	26.33%
C	FY 2010-11	6.04%	-7.39%	0.90%	-	-0.44%
D	FY 2011-12	-2.77%	-1.87%	-2.00%	-	-5.45%
E	FY 2012-13	-2.19%	-4.71%	-7.17%	-	-7.07%
F	FY 2013-14	3.34%	5.62%	-9.37%	-5.16%	7.66%
G	FY 2014-15	4.76%	1.35%	-2.29%	9.18%	0.89%
H	FY 2015-16	0.21%	3.54%	-1.91%	9.85%	-5.10%
I	FY 2016-17	2.95%	3.25%	2.51%	8.76%	1.16%
J	FY 2017-18	3.49%	1.59%	-7.73%	2.98%	19.74%
K	FY 2018-19	2.37%	3.50%	-10.41%	28.31%	-1.88%
L	Estimated FY 2019-20	7.58%	12.36%	6.39%	2.64%	3.52%
M	Estimated FY 2020-21	-0.95%	2.57%	0.22%	-1.34%	-1.34%
N	Estimated FY 2021-22	0.11%	2.18%	0.00%	0.00%	0.00%

Table E.3 - Calculation of FY 2019-20 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure							
Row	**FY 2019-20**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Previous Year Expenditure Per-Capita Actuals	$74,535.08	$14,845.36	$14,882.61	$83,210.82	$2,920.96	Table E.1 Row L
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%	Assuming stable utilization
C	Estimated Base Per FPE Expenditure	$74,535.08	$14,845.36	$14,882.61	$83,210.82	$2,920.96	Row A * (1 + Row B)
D	*Rate Adjustments*	4.72%	4.48%	2.80%	0.09%	0.09%	FY 2018-19 across the board and targeted rate increases
E	Estimated Base Per FPE Expenditure after Rate Adjustments	$78,053.14	$15,510.43	$15,299.32	$83,285.71	$2,923.59	Row C * (1 + Row D)
	Bottom Line Adjustments						
F	Annualization of FY 2015-16 R-7 Participant Directed Programs Expansion	$0.00	$457.46	$0.00	$0.00	$0.00	Addition of CDASS + Impact of 1915i clients
G	Annualization of FY 2018-19 R-10 Regional Center Task Force Recommendation Implementation	$0.00	$0.00	$0.00	$0.00	$18.84	Addition of Intensive Case Management for clients transitioning out of institutional settings.
H	FY 2019-20 53 Pay Periods	$1,111.07	$225.88	$205.15	$1,199.77	$43.81	Additional pay period in FY 2019-20
I	HB 18-1326 Support for Transition From Institutional Settings	$115.93	$0.00	$0.00	$0.00	$0.00	5 CCT demonstration services added to DD waiver
J	FY 2019-20 1% Across the Board Rate Increase	$701.45	$179.65	$89.82	$925.70	$37.59	1% Across the board effective 7/1/2019
K	FY 2019-20 R-13 Provider Rate Adjustments	$206.28	$137.81	$194.89	$0.00	$0.00	Targeted rate increases effective 1/1/2020
L	FY 2019-20 Long Bill Action on IHSS and CDASS	$0.00	$37.89	$0.00	$0.00	$0.00	CDASS Rate Increase effective 1/1/2020
M	SB 19-238 Improve Wages And Accountability Home Care Workers	$0.00	$131.49	$44.24	$0.00	$0.00	Personal care and homemaker rate increase effective 1/1/2020
N	**Estimated FY 2019-20 Per FPE Expenditure**	**$80,187.87**	**$16,680.61**	**$15,833.42**	**$85,411.18**	**$3,023.83**	**Sum of Row F Through M**

Table E.4 - Calculation of FY 2020-21 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure							
Row	**FY 2020-21**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Estimated FY 2019-20 Per FPE Expenditure	$80,187.87	$16,680.61	$15,833.42	$85,411.18	$3,023.83	Table E.3 Row N
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%	Assuming stable utilization
C	Estimated Base Per FPE Expenditure	$80,187.87	$16,680.61	$15,833.42	$85,411.18	$3,023.83	Row A * (1 + Row B)
D	*Rate Adjustments*	0.00%	0.00%	0.00%	0.00%	0.00%	Assuming stable utilization
E	Estimated Base Per FPE Expenditure after Rate Adjustments	$80,187.87	$16,680.61	$15,833.42	$85,411.18	$3,023.83	Row C * (1 + Row D).
	Bottom Line Adjustments						
F	Annualization of FY 2015-16 R-7 Participant Directed Programs Expansion	$0.00	$181.87	$0.00	$0.00	$0.00	Addition of CDASS + Impact of 1915i clients
G	Annualization of FY 2018-19 R-10 Regional Center Task Force Recommendation Implementation	$0.00	$0.00	$0.00	$0.00	$0.00	Addition of Intensive Case Management for clients transitioning out of institutional settings.
H	FY 2019-20 53 Pay Periods	($1,111.07)	($225.88)	($205.15)	($1,199.77)	($43.81)	Additional pay period in FY 2019-20
I	HB 18-1326 Support for Transition From Institutional Settings	$91.67	$0.00	$0.00	$0.00	$0.00	5 CCT demonstration services added to DD waiver
J	FY 2019-20 1% Across the Board Rate Increase	$59.89	$15.84	$7.70	$58.16	$3.24	1% Across the board effective 7/1/2019
K	FY 2019-20 R-13 Provider Rate Adjustments	$200.50	$138.38	$190.25	$0.00	$0.00	Targeted rate increases effective 1/1/2020
L	FY 2019-20 Long Bill Action on IHSS and CDASS	$0.00	$71.23	$0.00	$0.00	$0.00	CDASS Rate Increase effective 1/1/2020
M	SB 19-238 Improve Wages And Accountability Home Care Workers	$0.00	$247.19	$41.73	$0.00	$0.00	Personal care and homemaker rate increase effective 1/1/2020
N	**Estimated FY 2020-21 Per FPE Expenditure**	**$79,428.86**	**$17,109.24**	**$15,867.95**	**$84,269.57**	**$2,983.26**	**Sum of Row F Through M**

Table E.5 - Calculation of FY 2021-22 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure							
Row	**FY 2021-22**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program (HCBS-CHRP)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Estimated FY 2020-21 Per FPE Expenditure	$79,428.86	$17,109.24	$15,867.95	$84,269.57	$2,983.26	Table E.4 Row N
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%	
C	Estimated Base Per FPE Expenditure	$79,428.86	$17,109.24	$15,867.95	$84,269.57	$2,983.26	Row A * (1 + Row B)
D	*Rate Adjustments*	0.00%	0.00%	0.00%	0.00%	0.00%	Assuming stable utilization
E	Estimated Base Per FPE Expenditure after Rate Adjustments	$79,428.86	$17,109.24	$15,867.95	$84,269.57	$2,983.26	Row C * (1 + Row D).
	Bottom Line Adjustments						
F	Annualization of FY 2015-16 R-7 Participant Directed Programs Expansion	$0.00	$372.69	$0.00	$0.00	$0.00	Addition of CDASS + Impact of 1915i clients
G	Annualization of FY 2018-19 R-10 Regional Center Task Force Recommendation Implementation	$0.00	$0.00	$0.00	$0.00	$0.00	Addition of Intensive Case Management for clients transitioning out of institutional settings.
H	FY 2019-20 53 Pay Periods	$0.00	$0.00	$0.00	$0.00	$0.00	Additional pay period in FY 2019-20
I	HB 18-1326 Support for Transition From Institutional Settings	$83.59	$0.00	$0.00	$0.00	$0.00	5 CCT demonstration services added to DD waiver
J	FY 2019-20 1% Across the Board Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	1% Across the board effective 7/1/2019
K	FY 2019-20 R-13 Provider Rate Adjustments	$0.00	$0.00	$0.00	$0.00	$0.00	Targeted rate increases effective 1/1/2020
L	FY 2019-20 Long Bill Action on IHSS and CDASS	$0.00	$0.00	$0.00	$0.00	$0.00	CDASS Rate Increase effective 1/1/2020
M	SB 19-238 Improve Wages And Accountability Home Care Workers	$0.00	$0.00	$0.00	$0.00	$0.00	Personal care and homemaker rate increase effective 1/1/2020
N	**Estimated FY 2021-22 Per FPE Expenditure**	**$79,512.45**	**$17,481.93**	**$15,867.95**	**$84,269.57**	**$2,983.26**	**Sum of Row F Through M**

Table F.1 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2019-20 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast								
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Children's Habilitation Residential Program**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	5,741	4,788	1,861	56	12,446	Table D.3.1 Row M
B		Rate	$26.11	$26.11	$26.11	$26.11		FY 2019-20 Rate
C		Estimated Total Expenditure	$1,798,770	$1,500,176	$583,089	$17,546	$3,899,581	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	5,741	4,788	1,861	56	12,446	Table D.3.1 Row M
E		Rate	$83.26	$83.26	$83.26	$83.26		FY 2019-20 Rate
F		Estimated Total Expenditure	$477,996	$398,649	$154,947	$4,663	$1,036,255	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	1,164	764	344	N/A	2,237	Estimated June 2020 Enrollment - Estimated June 2019 Enrollment + 10% of Estimated June 2019 Enrollment
H		Rate	$238.71	$238.71	$238.71	N/A		FY 2019-20 Rate
I		Estimated Total Expenditure	$277,858	$182,374	$82,116	$0	$542,348	Row G * Row H
J	**CHRP Support Need Level Assessment**	Estimated New and Renewal Average Monthly Enrollment	N/A	N/A	N/A	58	58	Estimated June 2020 Enrollment - Estimated June 2019 Enrollment + 10% of Estimated June 2019 Enrollment
K		Rate	N/A	N/A	N/A	$151.98	$151.98	FY 2019-20 Rate
L		Estimated Total Expenditure	$0	$0	$0	$8,815	$8,815	Row J * Row K
M	**Estimated Total Expenditure**		**$2,554,624**	**$2,081,199**	**$820,152**	**$31,024**	**$5,486,999**	**Row C + Row F + Row I + Row L**

Table F.2 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2020-21 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast									
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Family Support Services and State Only Supported Living Services**	**HCBS - Children's Habilitation Residential Program**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	6,418	4,912	2,025	0	81	13,355	Table D.3.1 Row N
B		Rate	$26.11	$26.11	$26.11	$0.00	$26.11		FY 2019-20 Rate
C		Estimated Total Expenditure	$2,010,888	$1,539,028	$634,473	$0	$25,379	$4,209,768	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	6,418	4,912	2,025	0	81	13,355	Table D.3.1 Row N
E		Rate	$83.26	$83.26	$83.26	$0.00	$83.26		FY 2019-20 Rate
F		Estimated Total Expenditure	$534,363	$408,973	$168,602	$0	$6,744	$1,118,682	Row D* Row E
G	**Support Intensity Scale**	Estimated SB 16-192 Enrollment	3,209	2,456	1,013	0	0	6,678	Additional Enrollments From implementation of SB 16-192. See Narrative for further detail.
H		Estimated New and Renewal Average Monthly Enrollment	3,209	2,456	1,013	0	0	6,678	Row G
I		Rate	$238.71	$238.71	$238.71	$238.71	$238.71	$238.71	FY 2019-20 Rate
J		Estimated Total Expenditure	$766,020	$586,272	$241,813	$0	$0	$1,594,105	Row H * Row I
K	**CHRP Support Need Level Assessment**	Estimated New and Renewal Average Monthly Enrollment	N/A	N/A	N/A	N/A	81	81	Additional Enrollments From implementation of SB 16-192. See Narrative for further detail.
L		Rate	N/A	N/A	N/A	N/A	$151.98	$151.98	FY 2019-20 Rate
M		Estimated Total Expenditure	$0	$0	$0	$0	$12,310	$12,310	Row K * Row L
N	**Estimated Total Expenditure**		**$3,311,271**	**$2,534,273**	**$1,044,888**	**$0**	**$44,433**	**$6,934,865**	**Row C + Row F + Row J + Row M**

Table F.3 - Division for Intellectual and Developmental Disabilities (DIDD) FY 2021-22 Quality Assurance, Utilization Review and Support Intensity Scale Service Forecast									
Row	**Service**	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**Family Support Services and State Only Supported Living Services**	**HCBS - Children's Habilitation Residential Program**	**Total**	**Source/Calculation**
A	**Quality Assurance**	Estimated Total Average Monthly Enrollment	6,834	5,063	1,861	0	81	13,758	Table D.3.1 Row O
B		Rate	$26.11	$26.11	$26.11	$0.00	$26.11		FY 2019-20 Rate
C		Estimated Total Expenditure	$2,141,229	$1,586,339	$583,089	$0	$25,379	$4,336,036	Row A * Row B * 12
D	**Utilization Review**	Estimated Total Average Monthly Enrollment	6,834	5,063	1,861	0	81	13,758	Table D.3.1 Row O
E		Rate	$83.26	$83.26	$83.26	$0.00	$83.26		FY 2019-20 Rate
F		Estimated Total Expenditure	$568,999	$421,545	$154,947	$0	$6,744	$1,152,235	Row D* Row E
G	**Support Intensity Scale**	Estimated New and Renewal Average Monthly Enrollment	3,625	2,607	848	0	0	7,080	Additional Enrollments From implementation of SB 16-192. See Narrative for further detail.
H		Rate	$238.71	$238.71	$238.71	$238.71	N/A	$238.71	FY 2019-20 Rate
I		Estimated Total Expenditure	$865,324	$622,317	$202,426	$0	$0	$1,690,067	Row G * Row H
J	**CHRP Support Need Level Assessment**	Estimated New and Renewal Average Monthly Enrollment	N/A	N/A	N/A	N/A	8	8	Additional Enrollments From implementation of SB 16-192. See Narrative for further detail.
K		Rate	N/A	N/A	N/A	N/A	$151.98	$151.98	FY 2019-20 Rate
L		Estimated Total Expenditure	$0	$0	$0	$0	$1,216	$1,216	Row J * Row K
M	**Estimated Total Expenditure**		**$3,575,552**	**$2,630,201**	**$940,462**	**$0**	**$33,339**	**$7,179,554**	**Row C + Row F + Row I + Row L**

Table G.1 FY 2019-20 Office of Community Living Appropriation Build

Row	Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
	Adult Comprehensive Services							
A	FY 2018-19 Final Spending Authority	$414,664,927	0.0	$207,332,462	$0	$1	$0	$207,332,464
B	Annualization of FY 2018-19 R-09 Provider Rate Adjustments	$316,097	0.0	$158,049	$0	$0	$0	$158,048
C	Annualization of FY 2018-19 JBC NMT Rate Increase	$86,607	0.0	$43,303	$0	$0	$0	$43,304
D	Annualization of HB 18-1326 Support for Transition from Institutional Settings	$733,772	0.0	$366,886	$0	$0	$0	$366,886
E	Annualization of HB 18-1407 Access to Disability Services and Stable Workforce	$33,139,843	0.0	$16,569,921	$0	$0	$0	$16,569,922
F	FY 2019-20 S-5 Office of Community Living Cost and Caseload	$36,361,312	0.0	$18,180,657	$0	$0	$0	$18,180,655
G	FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$0	0.0	($510,382)	$0	$510,382	$0	$0
H	FY 2019-20 R-13 Provider Rate Adjustments	$6,398,220	0.0	$3,199,110	$0	$0	$0	$3,199,110
I	FY 2019-20 JBC Action on IDD Enrollments	$11,554,500	0.0	$2,777,250	$0	$3,000,000	$0	$5,777,250
J	Total FY 2019-20 Spending Authority	$503,255,278	0.0	$248,117,256	$0	$3,510,383	$0	$251,627,639
	Adult Supported Living Services							
K	FY 2018-19 Final Spending Authority	$73,725,126	0.0	$40,312,397	$0	$603,310	$0	$32,809,419
L	Annualization of FY 2018-19 R-09 Provider Rate Adjustments	$63,738	0.0	$34,736	$0	$222	$0	$28,780
M	Annualization of FY 2018-19 JBC NMT Rate Increase	$48,322	0.0	$23,974	$0	$187	$0	$24,161
N	Annualization of HB 18-1407 Access to Disability Services and Stable Workforce	$7,382,898	0.0	$3,691,448	$0	$0	$0	$3,691,450
O	FY 2019-20 S-5 Office of Community Living Cost and Caseload	$673,421	0.0	$257,029	$0	$76,594	$0	$339,798
P	FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$1,948,567	0.0	$0	$0	$1,948,567	$0	$0
Q	FY 2019-20 R-13 Provider Rate Adjustments	$1,743,531	0.0	$902,525	$0	$6,655	$0	$834,351
R	FY 2018-19 JBC Actions	$0	0.0	$164,451	$0	$40,550	$0	($205,001)
S	FY 2019-20 Long Bill Personal Care and Homemaker Rate Increases	$256,484	0.0	$128,242	$0	$0	$0	$128,242
T	SB 19-238 Home Care Wages	$890,070	0.0	$445,035	$0	$0	$0	$445,035
U	Total FY 2019-20 Spending Authority	$86,732,157	0.0	$45,959,837	$0	$2,676,085	$0	$38,096,235
V	**SLS Services**	$76,596,238	0.0	$37,772,485	$0	$727,518	$0	$38,096,235
W	**SLS State-Only**	$10,135,919	0.0	$8,187,352	$0	$1,948,567	$0	$0
	Children's Extensive Support Services							
X	FY 2018-19 Final Spending Authority	$23,111,955	0.0	$11,555,977	$0	$0	$0	$11,555,978
Y	Annualization of FY 2018-19 R-09 Provider Rate Adjustments	$11,581	0.0	$5,791	$0	$0	$0	$5,790
Z	Annualization of HB 18-1407 Access to Disability Services and Stable Workforce	$1,774,826	0.0	$887,412	$0	$0	$0	$887,414
AA	FY 2019-20 S-5 Office of Community Living Cost and Caseload	$619,759	0.0	$309,879	$0	$0	$0	$309,880
AB	FY 2019-20 R-13 Provider Rate Adjustments	$1,425,843	0.0	$712,922	$0	$0	$0	$712,921
AC	SB 19-238 Home Care Wages	$118,455	0.0	$59,228	$0	$0	$0	$59,227
AD	Total FY 2019-20 Spending Authority	$27,062,419	0.0	$13,531,210	$0	$0	$0	$13,531,209
	Case Management							
AE	FY 2018-19 Final Spending Authority	$37,740,183	0.0	$19,799,260	$0	$138,620	$0	$17,802,303
AF	SB 16-192 Needs Assessment for Persons Eligible for LTSS Annualization - FY 2019-20	$3,398,536	0.0	$1,699,268	$0	$0	$0	$1,699,268
AG	HB 18-1328 CHRP Transfer Annualization	$253,530	0.0	$126,765	$0	$0	$0	$126,765
AH	Annualization of HB 18-1407 Access to Disability Services and Stable Workforce	$903,590	0.0	$451,795	$0	$0	$0	$451,795
AI	FY 2017-18 R-10 RCTF Recommendation Implementation Annualization Documentation	$13,217	0.0	$6,609	$0	$0	$0	$6,608
AJ	Annualization of FY 2018-19 R-09 Provider Rate Adjustments	$30,754	0.0	$16,143	$0	$48	$0	$14,563
AK	Annualization of FY 2018-19 R-17 Single Assessment Tool Financing	($1,501,927)	0.0	($750,963)	$0	$0	$0	($750,964)
AL	FY 2019-20 S-05 Office of Community Living Cost and Caseload	$3,961,104	0.0	$1,967,446	$0	$12,294	$0	$1,981,364
AM	FY 2019-20 R-13 Provider Rate Adjustments	$407,306	0.0	$212,131	$0	$1,379	$0	$193,796
AN	FY 2018-19 JBC Adjustments	$0	0.0	$42,939	$0	($1,995)	$0	($40,944)
AO	Total FY 2019-20 Spending Authority	$45,206,293	0.0	$23,571,393	$0	$150,346	$0	$21,484,554
AP	**Targeted Case Management**	$33,362,828	0.0	$16,586,661	$0	$134,877	$0	$16,641,290
AQ	**QA, UR and SIS**	$9,686,530	0.0	$4,827,797	$0	$15,469	$0	$4,843,264
AR	**Case Management - State Only**	$2,156,935	0.0	$2,156,935	$0	$0	$0	$0
	Family Support Services							
AS	FY 2018-19 Final Spending Authority	$7,123,184	0.0	$7,123,184	$0	$0	$0	$0
AT	Annualization FY 2018-19 R-09: Provider Rate Adjustments	$5,923	0.0	$5,923	$0	$0	$0	$0
AU	FY 2019-20 S-05 Office of Community Living Cost and Caseload	$187,497	0.0	$0	$0	$187,497	$0	$0
AV	FY 2019-20 R-13 Provider Rate Adjustments	$67,538	0.0	$67,538	$0	$0	$0	$0
AW	FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$427,458	0.0	$0	$0	$427,458	$0	$0
AX	Total FY 2019-20 Spending Authority	$7,811,600	0.0	$7,196,645	$0	$614,955	$0	$0
	Preventive Dental Hygiene							
AY	FY 2018-19 Final Spending Authority	$64,792	0.0	$64,792	$0	$0	$0	$0
AZ	FY 2018-19 R-09 Provider Rate Adjustments	$54	0.0	$54	$0	$0	$0	$0
BA	FY 2019-20 R-13 Provider Rate Adjustments	$599	0.0	$599	$0	$0	$0	$0
BB	Total FY 2019-20 Spending Authority	$65,445	0.0	$65,445	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
BC	FY 2018-19 Final Spending Authority	$3,194,162	0.0	$3,173,042	$0	$0	$0	$21,120
BD	Annualization of FY 2018-19 R-09 Provider Rate Adjustments	$2,656	0.0	$2,638	$0	$0	$0	$18
BE	FY 2019-20 R-13 Provider Rate Increases	$28,933	0.0	$28,933	$0	$0	$0	$0
BF	FY 2019-20 R-14 OCL Governance	($28,178)	0.0	($7,040)	$0	$0	$0	($21,138)
BG	Total FY 2019-20 Spending Authority	$3,197,573	0.0	$3,197,573	$0	$0	$0	$0
BH	**PASRR**	$0	0.0	$0	$0	$0	$0	$0
BI	**Medicaid Eligibility Determination**	$3,197,573	0.0	$3,197,573	$0	$0	$0	$0
	Children's Habilitation Residential Program Waiver							
BJ	FY 2018-19 Final Spending Authority	$1,907,449	0.0	$953,725	$0	$0	$0	$953,724
BK	HB 18-1328 CHRP Transfer Annualization	$67,940	0.0	$33,970	$0	$0	$0	$33,970
BL	FY 2019-20 S-05 Office of Community Living Cost and Caseload	$3,139,877	0.0	$1,569,938	$0	$0	$0	$1,569,939
BM	FY 2019-20 R-13 Provider Rate Adjustments	$36,954	0.0	$18,477	$0	$0	$0	$18,477
BN	Total FY 2019-20 Spending Authority	$5,152,220	0.0	$2,576,110	$0	$0	$0	$2,576,110
	Supported Employment Provider & Certification Reimbursement							
BO	FY 2018-19 Final Appropriation	$0	0.0	$0	$0	$0	$0	$0
BP	FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$303,158	0.0	$303,158	$0	$0	$0	$0
BQ	Total FY 2019-20 Spending Authority	$303,158	0.0	$303,158	$0	$0	$0	$0
	Supported Employment Pilot Program							
BR	FY 2018-19 Final Appropriation	$0	0.0	$0	$0	$0	$0	$0
BS	FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$500,000	0.0	$0	$0	$500,000	$0	$0
BT	Total FY 2019-20 Spending Authority	$500,000	0.0	$0	$0	$500,000	$0	$0
BU	**Grand Total FY 2019-20 Spending Authority**	**$679,286,143**	**0.0**	**$344,518,627**	**$0**	**$7,451,769**	**$0**	**$327,315,747**

Table G.2 FY 2020-21 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2019-20 Final Spending Authority	$503,255,278	0.0	$248,117,256	$0	$3,510,383	$0	$251,627,639
B	Annualization of HB 18-1326 Support for Transition from Institutional Settings	$617,816	0.0	$308,908	$0	$0	$0	$308,908
C	Annualization of FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$0	0.0	($289,618)	$0	$289,618	$0	$0
D	Annualization of JBC Action on IDD Enrollments	($1,770,579)	0.0	$2,114,711	$0	($3,000,000)	$0	($885,290)
E	Annualization of FY 2019-20 R-13 Provider Rate Adjustments	$690,632	0.0	$345,316	$0	$0	$0	$345,316
F	Total FY 2020-21 Spending Authority	$502,793,147	0.0	$250,596,573	$0	$800,001	$0	$251,396,573
	Adult Supported Living Services							
G	FY 2019-20 Final Spending Authority	$86,732,157	0.0	$45,959,837	$0	$2,676,085	$0	$38,096,235
H	Annualization of FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$0	0.0	$0	$0	$0	$0	$0
I	Annualization of FY 2019-20 R-13 Provider Rate Adjustments	($859,118)	0.0	($426,763)	$0	$604	$0	($432,959)
J	Annualization of Long Bill Personal Care and Homemaker Rate Increases	$245,821	0.0	$122,911	$0	$0	$0	$122,910
K	Annualization of SB 19-238 Home Care Wages	$853,065	0.0	$426,533	$0	$0	$0	$426,532
L	Total FY 2020-21 Spending Authority	$86,971,925	0.0	$46,082,518	$0	$2,676,689	$0	$38,212,718
M	**SLS Services**	$76,836,006	0.0	$37,895,166	$0	$728,122	$0	$38,212,718
N	**SLS State-Only**	$10,135,919	0.0	$8,187,352	$0	$1,948,567	$0	$0
	Children's Extensive Support Services							
O	FY 2019-20 Final Spending Authority	$27,062,419	0.0	$13,531,210	$0	$0	$0	$13,531,209
P	Annualization of FY 2019-20 R-13 Provider Rate Adjustments	($21,329)	0.0	($10,665)	$0	$0	$0	($10,664)
Q	Annualization of SB 19-238 Home Care Wages	$39,485	0.0	$19,742	$0	$0	$0	$19,743
R	Total FY 2020-21 Spending Authority	$27,080,575	0.0	$13,540,287	$0	$0	$0	$13,540,288
	Case Management							
S	FY 2019-20 Final Spending Authority	$45,206,293	0.0	$23,571,393	$0	$150,346	$0	$21,484,554
P	Annualization of FY 2019-20 R-13 Provider Rate Adjustments	$37,028	0.0	$19,285	$0	$125	$0	$17,618
U	Annualization of FY 2018-19 R-17 Single Assessment Tool Financing	$3,260,155	0.0	$1,630,077	$0	$0	$0	$1,630,078
V	SB 16-192 Needs Assessment for Persons Eligible for LTSS Annualization	($3,260,156)	0.0	($1,630,078)	$0	$0	$0	($1,630,078)
W	Total FY 2020-21 Spending Authority	$45,243,320	0.0	$23,590,677	$0	$150,471	$0	$21,502,172
X	**Targeted Case Management**	$33,399,855	0.0	$16,605,945	$0	$135,002	$0	$16,658,908
Y	**QA, UR and SIS**	$9,686,530	0.0	$4,827,797	$0	$15,469	$0	$4,843,264
Z	**Case Management - State Only**	$2,156,935	$0	$2,156,935	$0	$0	$0	$0
	Family Support Services							
AA	FY 2019-20 Final Spending Authority	$7,811,600	0.0	$7,196,645	$0	$614,955	$0	$0
AB	Annualization FY 2019-20 R-13 Provider Rate Adjustments	$6,140	0.0	$6,140	$0	$0	$0	$0
AC	Annualization R-16 Employment First Initiatives and State Programs for People with IDD	$0	0.0	$0	$0	$0	$0	$0
AD	Total FY 2020-21 Spending Authority	$7,817,740	0.0	$7,202,785	$0	$614,955	$0	$0
	Preventive Dental Hygiene							
AE	FY 2019-20 Final Spending Authority	$65,445	0.0	$65,445	$0	$0	$0	$0
AF	Annualization of R-13 Provider Rate Adjustments	$54	0.0	$54	$0	$0	$0	$0
AG	Total FY 2020-21 Spending Authority	$65,499	0.0	$65,499	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
AH	FY 2019-20 Final Spending Authority	$3,197,573	0.0	$3,197,573	$0	$0	$0	$0
AI	Annualization of FY 2019-20 R-13 Provider Rate Adjustments	$2,630	0.0	$2,630	$0	$0	$0	$0
AJ	Total FY 2020-21 Spending Authority	$3,200,203	0.0	$3,200,203	$0	$0	$0	$0
AK	**PASRR**	$0	0.0	$0	$0	$0	$0	$0
AL	**Medicaid Eligibility Determination**	$3,200,203	0.0	$3,200,203	$0	$0	$0	$0
	Children's Habilitation Residential Program Waiver							
AM	FY 2019-20 Final Spending Authority	$5,152,220	0.0	$2,576,110	$0	$0	$0	$2,576,110
AN	Annualization of FY 2019-20 R-13 Provider Rate Adjustments	$3,358	0.0	$1,679	$0	$0	$0	$1,679
AO	Total FY 2020-21 Spending Authority	$5,155,578	0.0	$2,577,789	$0	$0	$0	$2,577,789
	Supported Employment Provider & Certification Reimbursement							
AP	FY 2019-20 Final Spending Authority	$303,158	0.0	$303,158	$0	$0	$0	$0
AQ	Total FY 2020-21 Spending Authority	$303,158	0.0	$303,158	$0	$0	$0	$0
	Supported Employment Pilot Program							
AR	FY 2019-20 Final Spending Authority	$500,000	0.0	$0	$0	$500,000	$0	$0
AS	Total FY 2020-21 Spending Authority	$500,000	0.0	$0	$0	$500,000	$0	$0
AT	**Grand Total FY 2020-21 Spending Authority**	**$679,131,145**	**0.0**	**$347,159,489**	**$0**	**$4,742,116**	**$0**	**$327,229,540**

Table G.3 FY 2021-22 Office of Community Living Appropriation Build								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
	Adult Comprehensive Services							
A	FY 2020-21 Final Spending Authority	$502,793,147	0.0	$250,596,573	$0	$800,001	$0	$251,396,573
B	Annualization of HB 18-1326 Support for Transition from Institutional Settings	$596,263	0.0	$298,132	$0	$0	$0	$298,131
C	Annualization of FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$0	0.0	$0	$0	$0	$0	$0
D	Total FY 2021-22 Spending Authority	$503,389,410	0.0	$250,894,705	$0	$800,001	$0	$251,694,704
	Adult Supported Living Services							
D	FY 2020-21 Final Spending Authority	$86,971,925	0.0	$46,082,518	$0	$2,676,689	$0	$38,212,718
E	Annualization of FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$0	0.0	$0	$0	$0	$0	$0
F	Total FY 2021-22 Spending Authority	$86,971,925	0.0	$46,082,518	$0	$2,676,689	$0	$38,212,718
G	**SLS Services**	$76,836,006	0.0	$37,895,166	$0	$728,122	$0	$38,212,718
H	**SLS State-Only**	$10,135,919	0.0	$8,187,352	$0	$1,948,567	$0	$0
	Children's Extensive Support Services							
I	FY 2020-21 Final Spending Authority	$27,080,575	0.0	$13,540,287	$0	$0	$0	$13,540,288
J	Total FY 2021-22 Spending Authority	$27,080,575	0.0	$13,540,287	$0	$0	$0	$13,540,288
	Case Management							
K	FY 2020-21 Final Spending Authority	$45,243,320	0.0	$23,590,677	$0	$150,471	$0	$21,502,172
L	Total FY 2021-22 Spending Authority	$45,243,320	0.0	$23,590,677	$0	$150,471	$0	$21,502,172
M	**Targeted Case Management**	$33,399,855	0.0	$16,605,945	$0	$135,002	$0	$16,658,908
N	**QA, UR and SIS**	$9,686,530	0.0	$4,827,797	$0	$15,469	$0	$4,843,264
O	**Case Management - State Only**	$2,156,935	$0	$2,156,935	$0	$0	$0	$0
	Family Support Services							
P	FY 2020-21 Final Spending Authority	$7,817,740	0.0	$7,202,785	$0	$614,955	$0	$0
Q	Total FY 2021-22 Spending Authority	$7,817,740	0.0	$7,202,785	$0	$614,955	$0	$0
	Preventive Dental Hygiene							
R	FY 2020-21 Final Spending Authority	$65,499	0.0	$65,499	$0	$0	$0	$0
S	Total FY 2021-22 Spending Authority	$65,499	0.0	$65,499	$0	$0	$0	$0
	Eligibility Determination and Waitlist Management							
T	FY 2020-21 Final Spending Authority	$3,200,203	0.0	$3,200,203	$0	$0	$0	$0
U	Total FY 2021-22 Spending Authority	$3,200,203	0.0	$3,200,203	$0	$0	$0	$0
V	**PASRR**	$0	0.0	$0	$0	$0	$0	$0
W	**Medicaid Eligibility Determination**	$3,200,203	0.0	$3,200,203	$0	$0	$0	$0
	Children's Habilitation Residential Program Waiver							
X	FY 2020-21 Final Spending Authority	$5,155,578	0.0	$2,577,789	$0	$0	$0	$2,577,789
AA	Total FY 2021-22 Spending Authority	$5,155,578	0.0	$2,577,789	$0	$0	$0	$2,577,789
	Supported Employment Provider & Certification Reimbursement							
AB	FY 2020-21 Final Spending Authority	$303,158	0.0	$303,158	$0	$0	$0	$0
AC	Total FY 2021-22 Spending Authority	$303,158	0.0	$303,158	$0	$0	$0	$0
	Supported Employment Pilot Program							
AD	FY 2020-21 Final Spending Authority	$500,000	0.0	$0	$0	$500,000	$0	$0
	Annualization of FY 2019-20 R-16 Employment First Initiatives and State Programs for People with IDD	$75,000	0.0	$0	$0	$75,000	$0	$0
AE	Total FY 2021-22 Spending Authority	$575,000	0.0	$0	$0	$575,000	$0	$0
AF	**Grand Total FY 2021-22 Spending Authority**	**$679,802,408**	**0.0**	**$347,457,621**	**$0**	**$4,817,116**	**$0**	**$327,527,671**

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-06 Improve Customer Service

Dept. Approval By: _____

OSPB Approval By: _____

____	**Supplemental FY 2019-20**
____	**Budget Amendment FY 2020-21**
X	**Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$128,851,273**	**$0**	**$126,559,473**	**$3,428,079**	**$1,337,925**
	FTE	500.0	0.0	504.1	4.3	4.5
	GF	$37,351,066	$0	$37,162,956	$1,046,792	$441,515
	CF	$13,734,606	$0	$13,831,821	$552,719	$227,448
	RF	$2,823,317	$0	$2,710,606	$8	$0
	FF	$74,942,284	$0	$72,854,090	$1,828,560	$668,962

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$258,142**	**$268,480**
	FTE	500.0	0.0	504.1	4.3	4.5
	GF	$13,478,948	$0	$14,470,561	$85,187	$88,598
	CF	$3,571,232	$0	$3,714,633	$43,884	$45,642
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$129,071	$134,240
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$43,448**	**$45,189**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$14,338	$14,912
	CF	$421,237	$0	$525,947	$7,386	$7,682
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$21,724	$22,595

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$66,598**	**$0**	**$72,132**	**$390**	**$407**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$24,002	$0	$26,864	$129	$134
	CF	$5,301	$0	$5,495	$66	$69
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$195	$204
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$1,984,802**	**$0**	**$2,182,512**	**$11,488**	**$11,948**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$722,807	$0	$812,689	$3,791	$3,943
	CF	$159,398	$0	$166,329	$1,953	$2,031
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$5,744	$5,974
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,984,802**	**$0**	**$2,182,512**	**$11,488**	**$11,948**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$722,807	$0	$812,689	$3,791	$3,943
	CF	$159,398	$0	$166,329	$1,953	$2,031
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$5,744	$5,974
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	**Total**	**$2,506,384**	**$0**	**$2,273,794**	**$26,677**	**$4,275**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,014,866	$0	$939,016	$8,803	$1,411
	CF	$243,961	$0	$197,797	$4,535	$727
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$13,339	$2,137
01. Executive Director's Office, (A) General Administration, (1) General Administration - Payments to OIT	**Total**	**$8,377,137**	**$0**	**$7,352,674**	**$2,501,670**	**$995,678**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,263,023	$0	$3,191,250	$825,552	$328,574
	CF	$893,637	$0	$635,619	$425,285	$169,266
	RF	$0	$0	$0	$0	$0
	FF	$4,220,477	$0	$3,525,805	$1,250,833	$497,838

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$75,000**	**$0**
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,015,380	$0	$4,503,802	$24,750	$0
	CF	$2,615,231	$0	$2,547,721	$12,750	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$37,500	$0
	Total	**$48,948,646**	**$0**	**$48,332,662**	**$499,776**	**$0**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - Colorado Benefits Management Systems, Operating & Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$10,408,786	$0	$10,194,988	$80,451	$0
	CF	$5,665,211	$0	$5,871,951	$54,907	$0
	RF	$2,563	$0	$2,569	$8	$0
	FF	$32,872,086	$0	$32,263,154	$364,410	$0

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	Impacts Other Agency

Department Priority: R-6
Request Detail: Improve Customer Service

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$3,428,079**	**$1,337,925**
FTE	0.0	4.3	4.5
General Fund	$0	$1,046,792	$441,515
Cash Funds	$0	$552,719	$227,448
Reappropriated Funds	$0	$8	$0
Federal Funds	$0	$1,828,560	$668,962

Summary of Request:

The Department requests $3,428,079 total funds, including $1,046,792 General Fund and 4.3 FTE in FY 2020-21 and $1,337,925 total funds, including $441,515 General Fund and 4.5 FTE in FY 2021-22 to improve service provided to members. The Department is committed to improving members' experience with Health First Colorado and the Child Health Plan *Plus* (CHP+). This request is the next phase of incremental improvements to provide members with adequate levels of service needed to obtain important information about their health care coverage and access their benefits. The request includes funding for increasing staffing and technology improvements in the Department's Member Contact Center (MCC) to reduce average speed to answer and decrease call abandonment rates and to contract with a vendor to make recommendations on consolidating the Department's contact points into a single phone number for all customer needs. The request also includes one-time funding to implement member surveys. The request is less than a 0.5 percent increase from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

The Department provides Medicaid services to 1.2 million eligible members; Health First Colorado covers more people than any single health insurance program in the state. The Department operates an internal Member Contact Center (MCC) and contracts for other customer service functions. The MCC is responsible for benefit and billing questions but also serves as the main point of contact for any inquiry related to Medicaid and CHP+ when members are not sure who to call or when they cannot get through to other partners.

In 2013, the Department made investments to improve customer service by moving from a Microsoft Access database to a cloud-based Customer Relationship Management (CRM) and Interactive Voice Response (IVR) systems. This change was needed to give the Department insight to the actual customer demand and more appropriately address and track that demand. Leveraging the new tools, the Department identified that the demand was drastically higher than estimated and requested funding to hire 25 additional staff to address rising call volumes. These staff included agents and managers to provide operational and administrative support to the MCC. These staff were approved by the General Assembly in FY 2015-16 and have helped the Department manage the increased call volume as a result of significant caseload increases due to SB 13-200, "Expand Medicaid Eligibility." Since that time, abandonment rates and hold times have been drastically reduced. In 2018, the member abandonment rate was reduced from 25 percent to 7 percent and the average speed of answer was reduced from 59 minutes to 25 minutes.

The Department's FY 2019-20 budget request R-10 "Improve Customer Experience" included funding for implementing improved technology and operations. Current work includes effective knowledge library and training to aid agents in responding more accurately and more quickly to calls, centralizing customer contact tools and resources into a single CRM (Healthy Communities consolidation) and artificial intelligence and an automated online chat to handle basic inquiries.

In addition to more call representatives, the Department has taken steps to improve the customer experience, including implementing cloud-based CRM and IVR technology which enable a single-phone number for members to call, with intelligent routing to the following community partners: Denver Health Eligibility and Enrollment Vendor, Arapahoe County, El Paso County, and the Delta County Region (which includes Archuleta, Delta, LaPlata, Ouray and San Miguel counties). These community partners are currently leveraging the Department's MCC technology instead of implementing and managing independent solutions which has led to efficiencies in reporting, better information available to agents and a more seamless customer experience. Partners that leverage the Department's technology reduce the operational workload of managing the IT systems and interfaces, take advantage of the shared knowledge and resources available to help customers and reduces the redundancy of each partner developing their own training and knowledge resources. Additionally, the partners share the same customer record logs, so all partners serving customers can view the customer contact history and provide the best service to customers.

Additional improvements in customer service that have been accomplished within existing appropriations include contracting with a temporary staffing agency to help supplement the incoming call demands. As a

result, the Department has realized a reduction in hold times. The Department also shortened the time the MCC was available to customers from 9 ½ hours to 8 ½ hours, supporting a higher density of staffing across the day. Agent performance management continues to be refined, ensuring every agent meets at least 88 percent quality assurance and 50 calls per day. Agent retention strategies allow high performing agents to earn the opportunity for flexible work place, earn a monthly gift card, and learn different and more complex skills which has led to increased retention of staff. To assist in staff retention, and in collaboration with the Department of Personnel and Administration, all agents are being reclassified from the Technician series to the Administrator series. This creates a structured career and promotion path for individuals who want to transition from the MCC into the Department's policy, program, and operational positions. Additionally, discussions continue with the Colorado Department of Human Services (CDHS) and with county offices on how customer service can be streamlined and improved across public assistance programs.

In addition to its work to improve the MCC, the Department has worked to improve the member experience by reaching out to members directly. As a result of these efforts, The Department created two Member Experience Advisory Councils (MEACs) for Medicaid and Child Health Plan *Plus* (CHP+) members to participate in; one in-person council and one virtual advisory council. The purpose of the MEACs are to engage the voices of members, their families and caregivers in making recommendations about changes in Department communications, policies, and procedures. The perspectives received through the MEACs have given the Department new information about member experience and member perspectives that are important in prioritizing work and implementing new changes and programs. The Department-facilitated Member Experience Advisory Councils (MEACs) have received national recognition and offer a direct input into how to improve the member experience. Monthly meetings with the in-person MEAC (up to 20 members) aid the Department in uncovering systemic problems that members experience and collaborating on viable solutions. Monthly surveys sent to the virtual MEAC (over 1,000 members) aid the Department in confirming the issues on a broader scale and testing the solutions. Some of the Department's partners are beginning to seek member feedback into their operations. Adams and Lake Counties are the first counties to pioneer this work to gain customer insights and input. The Regional Accountable Entities (RAEs) are also in the early stages of developing or commencing member councils.

Problem or Opportunity:

Despite the improvements made in recent years, the Department is still not providing the level of customer service that members need in order to receive timely information about their health coverage. Additional resources are needed to continue to make improvements in this area. The Department continues to struggle to answer the high volume of calls in a timely manner in its MCC because the level of staffing is not enough to handle the volume of calls received daily. The MCC continues to receive between 1,000 and 1,300 calls per day on average with agents handling up to 50 calls per day. Calls handled per agent will vary, as specific call reasons from members can range from very basic to very complex issues and agents handle multiple languages. Because of the nature of work MCC agents perform and the complexity of issues they handle along with multiple systems used makes for a stressful work environment. Handling back-to-back calls with little break times between calls can drive down agent performance and lead to attendance issues. This results in a smaller workforce to handle member calls, increased hold times for members to reach MCC agents and

an increase in abandoned calls thus increasing repeat callers to the MCC. In comparison, the Departments contracted provider call center's agents average 25 calls handled per day which falls more in line with similar call centers in the health care industry.

County offices have reported varying average hold times for their customer service centers, ranging from 30 minutes to over 2 hours. The Department has attempted to augment current staffing with temporary employees using existing funding, but this solution is not financially sustainable within the current budget and is only serving as a short-term stopgap to improve customer service. Being consistently understaffed has led to difficult working conditions in the MCC making it harder to attract and retain staff in Denver's competitive labor market. When members cannot get through to obtain information about their health coverage, it can lead to escalated health situations which may require emergency care or lead to adverse health outcomes and increased costs.

The MCC receives calls for all aspects of the Department's programs and ends up routing this information to the appropriate party, leading to increased call volumes and hold times. There are many reasons customers reach out to the MCC, mostly requesting assistance with touchpoints that are inefficient or cause confusion. Approximately 40% of incoming calls are related to eligibility issues and updates which require transfers to the appropriate county. Additionally, calls are received for public assistance programs overseen by Colorado Department of Human Services (CDHS) and administered by county offices. Customers frequently reach the MCC stating they are unable to get through to their county or are having trouble making updates in the Program Eligibility Application Kit (PEAK), the self-service portal for public assistance programs.

Looking up this information for members is too time consuming because there are many other systems that do not interface with the CRM. This requires agents to become trained on all these systems and to log into other systems, requiring members to wait on hold while information is obtained. In addition to the CRM software, agents are required to collect and utilize information from different and unique systems for each of the following types of information:

1. Home and Community-Based Services (HCBS) prior authorizations
2. Pharmacy billing and prior authorizations
3. Drug formulary and provider fee schedules
4. Medical prior authorizations
5. Medical billing
6. Dental enrollment and prior authorizations
7. Member premiums and co-pays
8. Eligibility information, history and, changes

Taken together, these factors show that further investments in customer services are still needed in order to ensure that members can receive timely information.

Proposed Solution:

The Department requests $3,428,079 total funds, including $1,046,792 General Fund and 4.3 FTE in FY 2020-21 and $1,337,925 total funds, including $441,515 General Fund and 4.5 FTE in FY 2021-22 to improve service provided to members in order to answer their inquiries timelier and more efficiently. The request links to member health and customer service goals in the Department's performance plans. When members can get the information they need timely about their health coverage, they can better access services they need for prevention and management of chronic health conditions.

The request includes funding to hire 4.5 FTE for two years in its MCC, and funding for technology necessary to support the increased staffing. The request also includes additional technology innovations to improve the wait and call times, including integrating systems that members frequently call about into the customer relationship management (CRM) system that agents use so that they can more quickly and accurately obtain information needed at point of call, additional functionality for artificial intelligence and automated chat to reduce call volume, and implementing online member surveys through the Program Eligibility Application Kit (PEAK) to better understand member experiences with the online tools. Additionally, the request includes one-time contractor funding to study customer service improvements.

Member Contact Center Staffing

To achieve a better response time for customers, the Department requests funding to hire 4.5 FTE in the MCC for FY 2020-21 and FY 2021-22. This includes 2.5 agents, one lead, and one quality assurance reviewer. The staff request is time limited because it will take time for the technology improvements to impact call statistics. The Department would continue to monitor call volumes and average speed to answer and utilize the budget process to request any changes in staffing needs ongoing. This funding would expire after FY 2021-22; the Department would evaluate the success of the additional resources during this period and, if necessary, use the budget process to request further resources for FY 2022-23.

Technology

Workload management software

The Department requests funding to procure workload management software for the MCC. Currently the MCC manually assesses hourly demand and schedules staff using Excel spreadsheets and calculations. Workload management software would enable the MCC to better to meet customer demand in a satisfactory timeframe. Workload management software is used by larger and private industry contact centers and integrates the data to forecast workload and provide insights at the day of the month, day of the week, time of day down to the hourly and half-hourly call demand. It includes the call demand as well as the average handle times, providing a daily and hourly schedule to assist the MCC in meeting customer needs. Scheduling functionality in addition to increasing staffing would better equip the MCC to achieve service-level goals because it increases the chances that agents are available to handle incoming calls.

CRM System Integration

To improve the speed with which agents can answer questions, the Department requests funding to integrate and interface important and more common issues data into the CRM, thus reducing the number of systems and logins that an agent must use. The Department intends to start with the systems that members most

frequently call about, the interChange, the Department's claims system, and the system used by providers and the Department's utilization vendor for Prior Authorization Requests (PARs).

Artificial Intelligence and Automated Chat

The Department requests funding to continue improvements to artificial intelligence and automated chat processes already under way. Phase 1 of the Artificial Intelligence and Automated Chat (AI/AC) initiative, which was approved in the FY 2019-20 R-10 "Transform Customer Experience" request, will include setting up the basic infrastructure on the Department's customer websites and implementing some basics such as offering general benefit information and ordering medical ID cards. General benefit information can be programmed from the Member Handbooks and other resources available on the websites. Phase 2 of the AI/AC initiative would include services that need greater authentication and querying such as verifying eligibility/coverage for a member's date of service, sending a provider notification letter, and explaining eligibility letters.

Surveys

The Department requests funding for a member survey tool and results would help identify issues and prioritize solutions. Over 1,000 individuals participate in Department-issued customer surveys to improve different aspects of the customer experience through the Departments virtual MEAC. Direct customer input has proven invaluable in making impactful changes. The Department is requesting funding to implement an online survey tool through Salesforce Marketing Cloud and the MCC that can be used by the virtual MEAC as well as by the MCC, to continually monitor issues and target areas for improvements. Currently the MCC does not have a feedback tool for calls or chats and the MEAC uses the general Survey Monkey account with the Department. Placing a more robust survey tool that crosses both the MEAC and the MCC would allow the Department to better record individual customer experiences, tying the results to certain parts of the customer process and to the customer record.

Other Member Initiatives

Single Phone Number

The Department requests one-time funding to contract with a vendor to provide recommendations on how the number of contact points for members could be streamlined, with the goal to get to a single phone number that members would call for any needs which would route calls to the appropriate party. Although the Department has done some research within existing resources, dedicated funding is needed to further study the issue and make recommendations to inform future budget requests. The Department proposes to start with streamlining across all its contact points but is interested in the future in looking across all public assistance programs in Colorado, to make gaining information about public benefits more user friendly for Coloradans.

Anticipated Outcomes:

Increasing staffing and improving technology would support the Department in its MCC service goals of improving average speed to answer. Although the level of staffing requested would likely not be enough to reduce average speed to answer, along with other initiatives requested and currently underway, the

Department anticipates that customers would begin to receive improved level of service. Increased staffing would also allow for agents to have a more stable working environment, allowing time off the phones for needed training and one on one meetings with managers without impacting call center performance because coverage would be available. The Department would continue to monitor call volume and key call metrics to measure the outcome of the additional staffing and technology improvements.

Assumptions and Calculations:

Detailed calculations and a timeline can be found in Appendix A and B. The Department assumes administrative costs would be eligible for 50 percent Federal Financial Participation (FFP) and would be requested in the federally required Public Assistance Cost Allocation Plan (PACAP). The Salesforce Marketing Cloud system costs would be eligible for 75 percent enhanced FFP by submitting an Advanced Planning Document (APD) for federal approval of enhanced funding. If federal approval is not received, the Department would utilize the budget process to request any changes in funding. The Department assumes the state share of administrative costs would be allocated between General Fund and Healthcare Affordability and Sustainability Fee Cash Fund based on caseload.

MCC Staffing

The Department assumes FTE would be hired July 1, 2020 and would be trained to begin taking calls by September 1, 2020.

Technology

The Department assumes it would enter into an interagency agreement for system integration with the Office of Information Technology (OIT) for the CRM integration and AI/AC for the MCC. The funding for the Salesforce Marketing Cloud changes would be added to the Department's contract with OIT and Deloitte. The system development estimates were provided by OIT and the work would begin July 1, 2020 and would be completed by June 30, 2021 with ongoing funding needed for continued operations and improvements.

Other Member Initiatives

The Department assumes a competitive solicitation would not be required and that it could contract with a vendor by September 1, 2020 for the study on streamlining customer service phone numbers.

Appendix A: FTE Descriptions

Title	FTE	Duties
Contact Center Agent	2.5	Position would serve traditional role of answering inbound calls, chats, callbacks to improve average speed to answer and reduce abandonment rate.
Contact Center Lead	1	The position exists to serve as a resource to agents; providing direction, guidance, information and coaching when needed. This position is responsible for ensuring established work procedures at a fully operational level and serves as a Subject Matter Expert for agents within the Member Contact Center (MCC). Position would work skillfully in multiple system applications, policies, procedures, practices, and methods in order to resolve consumer inquiries. Position would also assist agents to help members navigate a complex health care environment by telephone, in person, internet chat, fax, e-mail or through written correspondence. This incorporates customers applying for or participating in the State Medicaid program, Colorado Indigent Care Program, and coordinating programs such as Medicare, CHP+, Connect for Health, etc. Job duties would also include researching complex member inquiries and assisting with proper resolution, Interpreting and applying program policies, procedures, and established standard guidelines to assist the member and provider. Job duties also include advising, counselling, and directing agents towards community resources and health care options for the uninsured. The position would also be responsible for identifying possible policy changes and make suggestions to management.
Quality Assurance Analyst	1	Position exists to monitor quality assurance (Q&A) of representatives and agents of the MCC. The Q&A reviews are completed on an individual level, with the purpose of providing regular performance feedback to the MCC managers and the QA and Training Lead to identify error trends which will be used to inform the training platform, agent development and center performance. Position partners with team supervisor and leads to develop and ensure agents meet Department key performance indicators (KPIs). Position monitors recorded and/or live calls for consistency in adherence to Department guidelines and provide direct feedback to representatives regarding call quality strengths and weaknesses. Position must possess a strong working knowledge of standard call center operations, quality monitoring and feedback and training development for the purpose of creating long term effective and improved performance within the MCC. Management seeks the recommendations of this position based on the findings of the quality review data.

Table 1.1 FY 2020-21 R-6 Improve Customer Service Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$258,142	4.3	$85,187	$43,884	$0	$129,071	Table 2.1 Row B
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$43,448	0.0	$14,338	$7,386	$0	$21,724	Table 6.1 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$390	0.0	$129	$66	$0	$195	Table 6.1 Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$11,488	0.0	$3,791	$1,953	$0	$5,744	Table 6.1 Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$11,488	0.0	$3,791	$1,953	$0	$5,744	Table 6.1 Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$26,677	0.0	$8,803	$4,535	$0	$13,339	Table 6.1 Row F
G	(1) Executive Director's Office, (A) General Administration, Payments to OIT	$2,501,670	0.0	$825,552	$425,285	$0	$1,250,833	Table 2.1 (Row F + G + Row H)
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$75,000	0.0	$24,750	$12,750	$0	$37,500	Table 2.1 Row K
I	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$499,776	0.0	$80,451	$54,907	$8	$364,410	Table 2.1 Row I
J	**Total Request**	**$3,428,079**	**4.3**	**$1,046,792**	**$552,719**	**$8**	**$1,828,560**	Sum of Rows A thru I

Table 1.2 FY 2021-22 R-6 Improve Customer Service Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$268,480	4.5	$88,598	$45,642	$0	$134,240	Table 2.2 Row B
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$45,189	0.0	$14,912	$7,682	$0	$22,595	Table 6.2 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$407	0.0	$134	$69	$0	$204	Table 6.2 Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$11,948	0.0	$3,943	$2,031	$0	$5,974	Table 6.2 Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$11,948	0.0	$3,943	$2,031	$0	$5,974	Table 6.2 Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$4,275	0.0	$1,411	$727	$0	$2,137	Table 6.2 Row F
G	(1) Executive Director's Office, (A) General Administration, Payments to OIT	$995,678	0.0	$328,574	$169,266	$0	$497,838	Table 2.2 (Row F+ Row G + Row H)
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0	Table 2.2 Row K
I	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$0	0.0	$0	$0	$0	$0	Table 2.2 Row I
J	**Total Request**	**$1,337,925**	**4.5**	**$441,515**	**$227,448**	**$0**	**$668,962**	Sum of Rows A thru I

Table 1.3 FY 2022-23 R-6 Improve Customer Service Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$0	0.0	$0	$0	$0	$0	Two year time limited
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$0	0.0	$0	$0	$0	$0	Two year time limited
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$0	0.0	$0	$0	$0	$0	Two year time limited
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	Two year time limited
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	Two year time limited
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$0	0.0	$0	$0	$0	$0	Two year time limited
G	(1) Executive Director's Office, (A) General Administration, Payments to OIT	$726,348	0.0	$239,695	$123,480	$0	$363,173	Table 2.3 (Row F + Row G + Row H)
H	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0	Table 2.3 (Row K)
I	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses	$0	0.0	$0	$0	$0	$0	Table 2.3 Row I
J	**Total Request**	**$726,348**	**0.0**	**$239,695**	**$123,480**	**$0**	**$363,173**	Sum of Rows A thru I

Table 2.1 FY 2020-21 R-6 Improve Customer Service Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	***Contact Center Staffing- Total Request***	**$351,633**	**4.3**	**$116,039**	**$59,777**	**$0**	**$175,817**	**50%**	Row B + Row C + Row D
B	New FTE-Personal Services,Salary, PERA and Medicare	$258,142	4.3	$85,187	$43,884	$0	$129,071	50%	Table 6.1 Row A
C	New FTE- HLD, STD, AED, SAED	$66,814	0.0	$22,049	$11,358	$0	$33,407	50%	Table 6.1 Row B through E
D	New FTE- Operating Expenses	$26,677	0.0	$8,803	$4,535	$0	$13,339	50%	Table 6.1 Row F
E	***OIT Funds for Technology Improvements- Total Request***	**$3,001,446**	**0.0**	**$906,003**	**$480,192**	**$8**	**$1,615,243**	Various	Row F + Row G + Row H + Row I
F	OIT-Call Center Technology	$245,870	0.0	$81,137	$41,798	$0	$122,935	50%	Table 7.1 Row O
G	Include Member Data In CRM	$899,250	0.0	$296,753	$152,873	$0	$449,624	50%	Table 3.1 Row I
H	Expand Artificial Intelligence- Chatbot	$1,356,550	0.0	$447,662	$230,614	$0	$678,274	50%	Table 4.1 Row J
I	Member Surveys	$499,776	0.0	$80,451	$54,907	$8	$364,410	75%	Table 5.1 Row F
J	***Other Member Improvements - Total Request***	**$75,000**	**0.0**	**$24,750**	**$12,750**	**$0**	**$37,500**	NA	Row K
K	Contract to Study Streamlining Customer Service Phone Numbers	$75,000	0.0	$24,750	$12,750	$0	$37,500	50%	Department Estimate for a contractor to prepare a report
L	**Total Request**	**$3,428,079**	**4.3**	**$1,046,792**	**$552,719**	**$8**	**$1,828,560**	NA	Row A + Row E + Row J

Table 2.2 FY 2021-22 R-6 Improve Customer Service Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	***Contact Center Staffing- Total Request***	**$342,247**	**4.5**	**$112,941**	**$58,182**	**$0**	**$171,124**	**50%**	Row B + Row C + Row D
B	FTE-Personal Services,Salary, PERA and Medicare	$268,480	4.5	$88,598	$45,642	$0	$134,240	50%	Table 6.2 Row A
C	FTE- HLD, STD, AED, SAED	$69,492	0.0	$22,932	$11,813	$0	$34,747	50%	Table 6.2 Row B through E
D	FTE- Operating Expenses	$4,275	0.0	$1,411	$727	$0	$2,137	50%	Table 6.2 Row F
E	***OIT Funds for Technology Improvements- Total Request***	**$995,678**	**0.0**	**$328,574**	**$169,266**	**$0**	**$497,838**	Various	Row F + Row G + Row H + Row I
F	OIT-Call Center Technology for New FTE	$257,103	0.0	$84,844	$43,708	$0	$128,551	50%	Table 7.1 Row O
G	Include Member Data In CRM	$349,125	0.0	$115,211	$59,351	$0	$174,563	50%	Table 3.1 Row I
H	Expand Artificial Intelligence- Chatbot	$389,450	0.0	$128,519	$66,207	$0	$194,724	50%	Table 4.1 Row J
I	Member Surveys	$0	0.0	$0	$0	$0	$0	75%	Table 5.1 Row F
J	***Other Member Improvements - Total Request***	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	NA	Row K
K	Contract to Study Streamlining Customer Service Phone Numbers	$0	0.0	$0	$0	$0	$0	50%	One time funding
L	**Total Request**	**$1,337,925**	**4.5**	**$441,515**	**$227,448**	**$0**	**$668,962**	50%	Row A + Row E + Row J

Table 2.3 FY 2022-23 R-6 Improve Customer Service Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	***Contact Center Staffing- Total Request***	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**50%**	Row B + Row C + Row D
B	FTE-Personal Services,Salary, PERA and Medicare	$0	0.0	$0	$0	$0	$0	50%	Staff are two year time limited
C	FTE- HLD, STD, AED, SAED	$0	0.0	$0	$0	$0	$0	50%	Staff are two year time limited
D	FTE- Operating Expenses	$0	0.0	$0	$0	$0	$0	50%	Staff are two year time limited
E	***OIT Funds for Technology Improvements- Total Request***	**$726,348**	**0.0**	**$239,695**	**$123,480**	**$0**	**$363,173**	Various	Row F + Row G + Row H + Row I
F	OIT-Call Center Technology for New FTE	$257,103	0.0	$84,844	$43,708	$0	$128,551	50%	Table 7.1 Row O
G	Include Member Data In CRM	$221,175	0.0	$72,988	$37,600	$0	$110,587	50%	Table 3.1 Row I
H	Expand Artificial Intelligence- Chatbot	$248,070	0.0	$81,863	$42,172	$0	$124,035	50%	Table 4.1 Row J
I	Member Surveys	$0	0.0	$0	$0	$0	$0	75%	Table 5.1 Row F
J	***Other Member Improvements - Total Request***	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	NA	Row K
K	Contract to Study Streamlining Customer Service Phone Numbers	$0	0.0	$0	$0	$0	$0	50%	One-time funding
L	**Total Request**	**$726,348**	**0.0**	**$239,695**	**$123,480**	**$0**	**$363,173**	50%	Row A + Row E + Row J

Table 3.1 Customer Relationship Management (CRM) Development Costs					
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Ongoing**	**Comments**
A	Project Management	$117,000	$117,000	$0	Estimate from OIT
B	Business Analyst/User Acceptance	$110,250	$27,563	$16,538	Estimate from OIT
C	User Interface (UI)/User Experience	$36,750	$0	$0	Estimate from OIT
D	Quality Assurance (QA)	$36,750	$9,188	$5,513	Estimate from OIT
E	SalesForce Developers	$150,000	$0	$37,500	Estimate from OIT- develop salesforce and support on the API side
F	Integrations Developer	$337,500	$84,375	$50,625	Estimate from OIT
G	Mulesoft Production Cores	$54,000	$54,000	$54,000	Cores split between Data in CRM and AI Phase 2
H	Mulesoft Non-Prod Cores	$57,000	$57,000	$57,000	Cores split between Data in CRM and AI Phase 2
I	**Total Request**	**$899,250**	**$349,125**	**$221,175**	Sum of Rows A through H

Table 4.1 Artificial Intelligence Development Costs					
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Ongoing**	**Comment**
A	Project Management	$117,000	$117,000	$0	Estimate from OIT
B	Business Analyst/User Acceptance Testing (UAT)	$36,750	$9,188	$5,513	Estimate from OIT
C	User Interface (UI)/User Experience (UX) Analyst	$36,750	$0	$0	Estimate from OIT
D	Quality Assurance (QA)	$22,050	$5,513	$3,308	Estimate from OIT
E	SalesForce Developers	$285,000	$0	$47,500	Estimate from OIT. Adding the Chat Bot text to the Salesforce App
F	Integrations Developer	$135,000	$33,750	$20,250	Estimate from OIT
G	Artificial Intelligence (AI)	$650,000	$150,000	$97,500	Estimate from OIT. Vendor development
H	Mulesoft Production Cores	$36,000	$36,000	$36,000	Estimate from OIT. Cores split between this and Data in CRM Tab
I	Mulesoft Non-Prod Cores	$38,000	$38,000	$38,000	Estimate from OIT. Cores split between this and Data in CRM Tab
J	**Total Request**	**$1,356,550**	**$389,450**	**$248,070**	**Sum of Rows A through I**

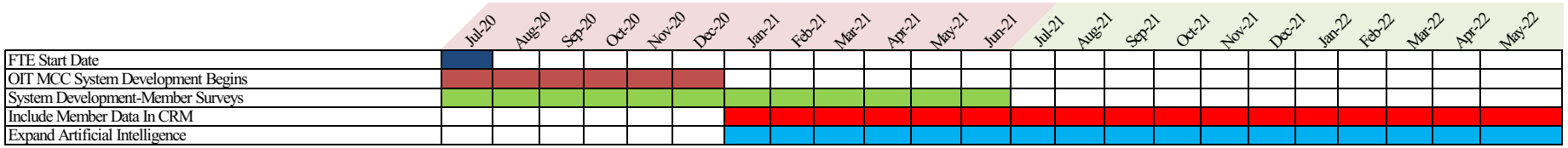
Table 5.1 Member Survey Development costs					
Row	**Label**	**Hours**	**Rate**	**Cost**	**Source/Calcuation**
A	Business Requirements	232	$134	$31,088	Estimate from OIT
B	Design	391	$134	$52,394	Estimate from OIT
C	Development	1,881	$134	$252,054	Estimate from OIT
D	System Integration Testing	610	$134	$81,740	Estimate from OIT
E	Customer Experience Measurement Pilot	616	$134	$82,500	Estimate from OIT
F	**Total Request**	**3,730**	**NA**	**$499,776**	Row A + Row B + Row C + Row D + Row E

Table 6.1 FTE Costs- Member Contact Center FY 2020-21							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$258,142	4.3	$85,187	$43,884	$0	$129,071
B	Health, Life and Dental	$43,448	0.0	$14,338	$7,386	$0	$21,724
C	Short-term Disability	$390	0.0	$129	$66	$0	$195
D	SB 04-257 Amortization Equalization Disbursement	$11,488	0.0	$3,791	$1,953	$0	$5,744
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$11,488	0.0	$3,791	$1,953	$0	$5,744
F	Operating Expenses- includes additional headsets and monitors	$26,677	0.0	$8,803	$4,535	$0	$13,339
G	**Total**	**$351,633**	**4.3**	**$116,039**	**$59,777**	**$0**	**$175,817**

Table 6.2 FTE Costs- Member Contact Center FY 2021-22 and ongoing							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Healthcare Affordability and Sustainability Fee Cash Fund**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$268,480	4.5	$88,598	$45,642	$0	$134,240
B	Health, Life and Dental	$45,189	0.0	$14,912	$7,682	$0	$22,595
C	Short-term Disability	$407	0.0	$134	$69	$0	$204
D	SB 04-257 Amortization Equalization Disbursement	$11,948	0.0	$3,943	$2,031	$0	$5,974
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$11,948	0.0	$3,943	$2,031	$0	$5,974
F	Operating Expenses	$4,275	0.0	$1,411	$727	$0	$2,137
G	**Total**	**$342,247**	**4.5**	**$112,941**	**$58,182**	**$0**	**$171,124**

Table 7.1 Technology for Member Contact Center					
Row	Label	FY 2020-21	FY 2021-22	FY 2022-23	Source/Calculation
A	Number of Customer Relationship Management (CRM) Licenses	4.5	4.5	4.5	FTE Count
B	Cost Per License	$1,564	$1,564	$1,564	Estimate from Office of Information Technology (OIT)
C	**Estimated Cost- CRM**	**$7,037**	**$7,037**	**$7,037**	Row A * Row B
D	Number of Interactive Voice Response (IVR) licenses	4.5	4.5	4.5	FTE Count
E	Cost Per License	$2,388	$2,388	$2,388	Estimate from OIT
F	Workforce Management (WFM)	$432	$432	$432	Estimate from OIT
G	Dashboard	$330	$330	$330	Estimate from OIT
H	**Estimated Cost- IVR**	**$14,175**	**$14,175**	**$14,175**	Row D * (Row E + Row F + Row G)
I	**Estimated Cost- Increased Minutes**	**$224,658**	**$235,891**	**$235,891**	Estimate from OIT
O	**Total Request**	**$245,870**	**$257,103**	**$257,103**	Row C + Row H + Row I

PROJECT TIMELINE



Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-07 Pharmacy Pricing and Technology

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$146,418,641**	**$0**	**$151,804,782**	**$4,561,775**	**$4,078,936**
	FTE	500.0	0.0	504.1	5.0	5.0
	GF	$33,651,934	$0	$34,807,035	$1,152,570	$1,263,138
	CF	$13,561,310	$0	$14,287,287	$654,693	$677,870
	RF	$2,832,958	$0	$2,720,241	$0	$0
	FF	$96,372,439	$0	$99,990,219	$2,754,512	$2,137,928

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$38,610,714**	**$0**	**$40,590,766**	**$506,630**	**$526,916**
	FTE	500.0	0.0	504.1	5.0	5.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	GF	$13,478,948	$0	$14,470,561	$167,188	$173,883
	CF	$3,571,232	$0	$3,714,633	$86,127	$89,576
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$253,315	$263,457
	Total	**$4,790,328**	**$0**	**$6,054,935**	**$50,210**	**$50,210**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	GF	$1,700,447	$0	$2,211,097	$16,569	$16,569
	CF	$421,237	$0	$525,947	$8,536	$8,536
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$25,105	$25,105

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$766**	**$797**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$253	$264
	CF	$5,301	$0	$5,495	$130	$135
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$383	$398
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$22,546**	**$23,450**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$7,441	$7,738
	CF	$159,398	$0	$166,329	$3,833	$3,987
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$11,272	$11,725
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$22,546**	**$23,450**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$7,441	$7,738
	CF	$159,398	$0	$166,329	$3,833	$3,987
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$11,272	$11,725
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$28,265**	**$4,750**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$1,014,866	$0	$939,016	$9,330	$1,567
	CF	$243,961	$0	$197,797	$4,805	$808
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$14,130	$2,375
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$2,878,845**	**$3,449,363**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	GF	$6,015,380	$0	$4,503,802	$869,277	$1,055,379
	CF	$2,615,231	$0	$2,547,721	$473,284	$570,841
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$1,536,284	$1,823,143

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$74,893,151**	**$0**	**$80,930,645**	**$1,051,967**	**$0**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,972,677	$0	$11,030,317	$75,071	$0
	CF	$6,385,552	$0	$6,963,036	$74,145	$0
	RF	$12,204	$0	$12,204	$0	$0
	FF	$58,522,718	$0	$62,925,088	$902,751	$0

Auxiliary Data

Requires Legislation?	YES		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-7
Request Detail: Pharmacy Pricing and Technology

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$7,135,879**	**$4,561,775**	**$4,078,936**
FTE	0.0	5.0	5.0
General Fund	$1,408,842	$1,152,570	$1,263,138
Cash Funds	$325,528	$654,693	$677,870
Reappropriated Funds	$0	$0	$0
Federal Funds	$5,401,509	$2,754,512	$2,137,928

Summary of Request:

The Department requests an increase of $7,135,879 total funds, including $1,408,842 General Fund, $325,528 cash funds, $5,401,509 federal funds in FY 2019-20; an increase of $4,561,775 total funds, including $1,152,570 General Fund, $654,693 cash funds, $2,754,512 federal funds and 5.0 FTE in FY 2020-21; and an increase of $4,078,936 total funds, including $1,263,138 General Fund, $677,870 cash funds, $2,137,928 federal funds and 5.0 FTE in FY 2021-22, in order to work on several initiatives tied to controlling pharmacy and physician administered drug expenditure and ensuring appropriate utilization of drugs. The Department's requested funding includes the Healthcare Affordability and Sustainability Fee cash fund, Children's Basic Health Plan Trust fund, and Breast and Cervical Cancer Prevention and Treatment fund. This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation. The request includes: revising the rate setting methodologies for the pharmacy and physician administered drug (PAD) benefits; incorporating data from the state's prescription drug monitoring program (PDMP) into the pharmacy claims processing system; trueing up funding for a prescriber tool, which is one of the requirements of SB 18-266 "Controlling Cost under Colorado Medical Assistance Act", adding roll forward authority for design and development of the tool, and adding administrative resources to facilitate pharmaceutical appeals and to work on various Department initiatives to control pharmacy costs.

Current Program:

The Department spent $1,110,263,303 ($360,287,215 net of drug rebates) on prescription drugs and physician administered drugs in FY 2018-19. Drug costs have increased consistently year over year, putting pressure on the State's limited financial resources. The Department is responsible for processing pharmaceutical claims for eligible members, setting appropriate rates for prescription drugs and physician administered drugs, improving member health outcomes, and ensuring that the Department is in compliance with state and federal regulations.

Drug Pricing Methodologies

The Department currently uses the Average Acquisition Cost (AAC) pricing methodology to determine its rates for the pharmacy benefit; however, when insufficient acquisition cost data exists for pharmacy drugs the Department defaults to paying based on the Wholesale Acquisition Cost (WAC) methodology. The Department currently uses the Average Sale Price methodology plus 2.5% (ASP) to determine the rates for the Physician Administered Drug (PAD) benefit.[1]

Prescription Drug Monitoring Program

Effective October 1, 2021, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requires that Medicaid providers utilize data from the Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances.[2] A PDMP is an electronic database that tracks prescription drug utilization in an effort to help reduce prescription drug misuse, abuse, and diversion. The State has a PDMP housed at the Department of Regulatory Agencies (DORA). The PDMP receives daily uploads of prescriptions for controlled medications from pharmacies.[3] The PDMP records all the data collected from these pharmacies and then uses an interface with providers to help providers make better clinical decisions based on the patient's drug history. The Department currently only has Medicaid-paid claims for controlled medications and is unable to collect data on prescriptions attained by Medicaid patients outside of the Medicaid claims processing system. This hinders the Department from being able to analyze the effects of various policies without understanding the full impact. Additionally, the Department may be missing opportunities to coordinate care for individuals with substance use disorders if they are unable to identify these issues. The Department is unable to access the data due to restrictions at section 12-42.5-404(3), C.R.S. which limits the program's availability to a specified list of persons or groups of persons. Additionally, the Centers for Medicare and Medicaid Services (CMS) published guidance that if State Medicaid programs incorporate Prescription Drug Monitoring Program (PDMP) data into the claims processing system, they could receive enhanced federal financial participation for systems integration costs.[4]

Prescriber Tool

The Department received funding through SB 18-266 "Controlling Cost under Colorado Medical Assistance Act" to implement a Prescriber tool that would provide information to prescribers about the Department's

[1]For Drug Pricing Definitions visit: https://www.keionline.org/book/economics-of-creativity-and-knowledge/data-points-on-prices-of-medical-technologies/glossary-of-pharmacy-and-drug-price-terms

[2] https://www.congress.gov/115/bills/hr6/BILLS-115hr6eah.pdf

[3] See section 12-42.5-401 et. seq., C.R.S.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/faq051519.pdf

drug cost information, preferred drug listing (PDL) information, Prior Authorization Requirements (PAR), and member-based risk factors based on diagnosis. The Department is currently in the process of securing a vendor to create and maintain the provider tool through a competitive bidding process.

At the same time that work is ongoing for the Prescriber tool, the Department of Human Services (DHS) has received funding for the Joint Agency Interoperability (JAI) project to provide information on the State's programs that help provide financial and social support to members and their families, which when utilized can lower health care costs and connect members to programs that can improve their lives. The Office of Information Technology (OIT), DHS and the Department have implemented the initial phase of the project which connected four primary systems: Colorado Benefit Management System (CBMS), Trails, Childcare Automated Tracking System (CHATS), and Automated Child Support Enforcement Services (ACSES). The JAI project will be in the next stage of development in FY 2019-20 and FY 2020-21, when the agencies will use the JAI program infrastructure to provide interfaces to additional systems.

The Department has reached out to gather information through a request for information (RFI) and posted an Invitation to Negotiate (ITN) for potential vendors in June 2019. The Department is soliciting vendors who will be able to provide the required information about prescription drugs and leverage new technological opportunities afforded by the JAI to provide information about other public assistance programs in the same tool.

Administrative Resources

The Department's pharmacy office consists of 12 FTE, including 2 pharmacists. The Department's pharmacy office oversees the pharmacy, physician administered drugs, and durable medical equipment benefits. Staff in this section ensure that members receive appropriate access to drugs and that the Department is in compliance with all state and federal rules and regulations. They also create innovative solutions for drug cost containment. These staff are responsible for policy and clinical management of the drug benefits, pharmacy claims system, contract management of the pharmacy benefit management system (PBMS) vendor, and rate setting for the pharmacy benefit. Finally, some staff in the office are responsible for the implementation of SB 19-005 "Import Prescription Drugs from Canada."

Problem or Opportunity:

Prescription drug expenditure has grown significantly in the last few years, putting pressure on the State's limited financial resources. In FY 2018-19, pharmacy and physician administered drug program expenditure was $1,110,263,303 ($360,287,215 net of drug rebates). The Department must come up with new strategies for controlling drug costs, reducing inappropriate utilization, and holding providers accountable for the appropriate utilization of drugs. Additionally, Medicaid providers must comply with the SUPPORT Act's provision requiring them to check the State's Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances by October 1, 2021.

The Department has identified several opportunities to reduce the cost of prescription drugs, increase administrative oversight of a growing program, and provide access to tools of transformation and information that would help providers make more informed clinical and financial decisions.

Drug Pricing Methodologies

During FY 2020-21 the Department will be reprocuring its contract with the vendor responsible for calculating Average Acquisition Cost (AAC) rates for the pharmacy benefit, with an effective date of July 1, 2021. The Department has an opportunity to utilize this reprocurement process to add additional scopes of work to the existing contract under the same entity. The Department contracted with a vendor to investigate several options for different pricing strategies to more appropriately price certain drugs. The Department can leverage the reprocurement to implement new pricing strategies as additional scopes of work for the Department's AAC rate calculation vendor. By utilizing different pricing strategies for drugs, the Department has the opportunity to set more appropriate rates and reduce total expenditure.

Prescription Drug Monitoring Program

CMS issued guidance on how states may utilize enhanced federal match opportunities to support enhanced system changes for Prescription Drug Monitoring Programs (PDMPs) passed in the SUPPORT Act. The SUPPORT Act allows states to claim a 90% federal match to incorporate the PDMP as a part of the mechanism for claims processing and information retrieval. Additionally, CMS issued guidance that the ongoing operation of system integration is eligible for a 75% federal match. Based on this guidance, the Department has an opportunity to build system enhancements to create an interface with Medicaid providers that would allow the Department to both integrate PDMP data into the current system and allow the Department to monitor the use of the PDMP data with existing Medicaid providers at a lower cost to the State. The Department has an opportunity to gain access to the PDMP to help the Department better analyze the effects of various policy impacts like utilization management (UM), prior authorization requirements, and other various policies the Department has enacted tied to controlling pharmacy costs. The Department has an opportunity to use this data to help inform more targeted care coordination by using the data from the PDMP. The PDMP data is a valuable tool the Department could utilize to help providers make better clinical decisions for Medicaid members.

The SUPPORT Act requires that state Medicaid providers check a prescription drug monitoring program (PDMP) for an enrollee's prescription drug history before prescribing a controlled substance beginning October 1, 2021. CMS has not issued guidance yet on how the Department should enforce this requirement in the SUPPORT Act, but the Department currently does not have access to the PDMP, and has no way of enforcing this requirement passed through the SUPPORT Act. The Department is restricted from accessing the PDMP by section 12-42.5-404(3), C.R.S. and would need this statute changed to gain access to the PDMP.

Prescriber Tool

The Department is currently in the process of implementing a prescriber tool and requires additional resources to fully develop and administer the tool. In SB 18-266, the Department was provided funding to develop and administer a prescriber tool to be accessible by all Medicaid providers. The Department estimated that the tool would be available starting July 1, 2019; however, the timeline has been delayed due to insufficient contractor funding. The Department is currently in the process of securing a vendor through the competitive bidding process and plans to implement the tool on July 1, 2020, contingent on receiving sufficient funding.

The Department was appropriated $1,000,000 to implement all the provider tools required through SB 18-266, and needs $500,000 of that to implement the other requirements of the bill. Based on recent information, the Department has determined that the remaining $500,000 is insufficient to maintain the prescriber tool. The Department's budget includes a reduction of $5,336,522 each year starting in FY 2019-20 based on costs avoided from implementation of the provider tool. The Department cannot achieve these savings if additional funding is not provided for the ongoing administration of the prescriber tool.

The Department also has an opportunity to incorporate additional information into the prescriber tool from other State agencies through the Joint Agency Interoperability (JAI) project. The Department can incorporate information about other state programs that help provide financial and social support to members and their families, which when utilized can lower health care costs. This would provide information on whether a member is eligible for one of the social services programs within these systems. For example, if a member is eligible but not enrolled in the Supplemental Nutrition Assistance Program (SNAP), that information can be sent to the prescriber tool. Then while visiting with the member, the physician will have that information readily available through the prescriber tool and can recommend that the member apply for the benefit. The Department envisions that the prescriber tool would have information on the various financial and social programs, so the clinician can help explain how the program could increase or maintain the health of the member.

Additional Administrative Resources

The Department has identified a need for four new positions that would allow the Department to address customer service gaps, add more clinical expertise to the pharmacy program, and provide capacity for the Department to lead more innovative efforts on pharmacy cost containment. The Department can address these issues and opportunities by hiring a pharmacy appeals officer to handle pharmacy-related appeals, a clinical pharmacist manager to provide clinical expertise on Department initiatives tied to pharmacy cost containment, and two pharmacy cost containment staff to research and work on innovative ideas for how to control pharmacy expenditure.

Proposed Solution:

The Department requests an increase of $7,135,879 total funds, including $1,408,842 General Fund in FY 2019-20; an increase of $4,561,775 total funds, including an increase of $1,152,570 General Fund in FY 2020-21; and an increase of $4,078,936 total funds, including $1,263,138 General Fund in FY 2021-22 to develop new rates methodologies for the physician administered drug and pharmacy benefits, to procure administrative resources to implement the prescriber tool and keep pace with innovations within the pharmacy industry, and to establish access to the Prescription Drug Monitoring Program (PDMP). The Department also requests roll forward authority for all contractor funding for design and development of the prescriber tool.

This request would help the Department achieve its goals outlined in the FY 2019-20 Performance Plan. In particular, it would help the Department meet goals to control Medicaid costs by ensuring the right services are delivered to the right people at the right prices. This would be accomplished by hiring staff dedicated to

cost control efforts and implementing new methodologies to set rates more appropriately. Additionally, approving this request would help the Department reach the performance goals to improve member health by providing tools to providers that would help providers make the best clinical decision when prescribing drugs. Finally, the Department anticipates that several of these proposed changes would lead to future decreases in the amount of General Fund needed by the Department and would ensure that Colorado obtains the maximum amount of federal funding that is available to the State.

If the request is not approved, the Department would miss an opportunity to mitigate increasing drug costs and lose an opportunity to provide informative resources to providers that could help them prescribe the most appropriate drugs to patients based on their condition and risk for developing addictions.

Drug Pricing Methodologies

The Department requests one FTE in FY 2020-21 and ongoing and contractor resources to implement a MAC rates methodology for the pharmacy benefit and the AAC rate methodology for the PAD benefit.

Maximum Allowable Cost Methodology for Prescription Drugs

The Department requests one FTE and ongoing contractor resources to calculate MAC rates for the pharmacy drug benefit and a reduction in pharmacy expenditure as a result of implementing the rate methodology change.

The Department currently uses the Average Acquisition Cost (AAC) methodology for the pharmacy benefit to set the rates paid for each drug. The Department uses a vendor to collect AAC data. However, when there are insufficient quantities of data regarding the acquisition cost of drugs the Department defaults to pricing drugs under the Wholesale Acquisition Cost (WAC) methodology. The MAC rate methodology is based on discounts from WAC rates that were derived from the National Average Drug Acquisition Cost (NADAC) equivalency results published by CMS[5]. The Department proposes paying the MAC rates, which would be set lower than the current WAC rates, when there is insufficient data for the AAC rates calculations. Revising the rate setting methodology may reduce costs. If the Department does not act, the Department would continue to pay higher rates for some drugs, particularly for newer specialty drugs.

Average Acquisition Cost Methodology for Physician Administered Drugs

The Department requests contractor resources to calculate AAC rates for the PAD benefit, create an interface to incorporate the rates, and implement system changes necessary to load the rates into the Department's fee schedule. The Department currently uses the Average Sales Price (ASP) plus 2.5% rate setting methodology to set the rates for physician administered drugs. The AAC rates represent the average cost to acquire a drug for a physician or other provider, while the ASP plus 2.5% reflects the average price a manufacturer sells a drug plus a 2.5% mark up. The costs associated with the ASP pricing methodology are higher for some drugs and lower for other drugs compared to the AAC, but overall, they are higher as ASP rates are not as closely aligned with Colorado market conditions. Revising the rates setting methodology may reduce expenditure by paying on average lower rates for the AAC rates compared to the ASP rates. If the Department does not

[5] https://www.medicaid.gov/medicaid/prescription-drugs/retail-price-survey/index.html

switch to the AAC rate methodology, the Department would continue to pay higher rates based on the ASP methodology.

Prescription Drug Monitoring Program

The Department requests contractor resources to implement system changes needed to interface with the PDMP data housed at DORA and the Department's pharmacy claims processing system, to pay DORA's current vendors to provide ongoing access to the PDMP, and to pay the Department's current pharmacy claims processing vendor to maintain the PDMP data for ongoing use. The Department proposes to use the data to inform care coordination activities performed by Regional Accountable Entities (RAEs) and to analyze policy impacts with a complete prescription utilization data set. The Department will work to introduce standalone legislation to amend section 12-42.5-404 C.R.S to allow the Department to access data pertaining to the recipients of Medicaid benefits established under the "Colorado Medical Assistance Act". Joint Budget Committee members and staff will be updated on the status of such legislation.

Prescriber Tool

The Department requests contractor resources to implement system changes needed to create an interface with the prescriber tool and existing data sources, to pay existing vendors for incorporating and sending the necessary data to the prescriber tool, and to pay a vendor to develop and deliver a prescriber tool to prescribing physicians. Due to the uncertain nature of the timeline to complete the design and development work, the Department is requesting roll forward authority for the design and development funding for the prescriber tool in FY 2019-20. Implementation of the prescriber tool requires coordination between several different contractors building interfaces to the tool simultaneously to incorporate all of the necessary data fields. Roll forward authority for the contractor funding would provide the Department with flexibility to complete the development phase in FY 2020-21 if some of the work is delayed under the existing budget. The Department also proposes an increase in funding in FY 2019-20 to account for the savings that are no longer achievable from SB 18-266 as a result in a delayed implementation timeline.

The JAI project provides information on the State's programs that provide financial and social support to members and their families, which when utilized can lower health care costs. In partnership with the Governor's Office of Information Technology (OIT), CDHS and HCPF have implemented the initial phase of the project, which connected four primary systems: CBMS, Trails, Childcare Automated Tracking System (CHATS), and Automated Child Support Enforcement Services (ACSES). In the next phase being developed in FY 2019-20 and FY 2020-21, the agencies will use the JAI program infrastructure to provide interfaces to additional systems, including the prescriber tool. This would provide information if a member is eligible for one of the social services programs within these systems. For example, if a member is eligible but not enrolled in Supplemental Nutrition Assistance Program (SNAP), that information can be sent to the prescriber tool. Then while visiting with the member, the physician would have that information readily available through the tool and can recommend that the member apply for the benefit. The Department envisions that the prescriber tool would have information on the various financial and social programs, so the clinician can help explain how the program could help improve the health of the member.

The Department plans to add performance measures to the incentive payment program with the Department's seven Regional Accountable Entities (RAEs) and penalty measures within the Department's Hospital Transformation Program (HTP) to ensure that all providers are using the prescriber tool when prescribing medication.

Additional Administrative Resources

The Department requests four FTE in FY 2020-21 and ongoing to provide clinical expertise for initiatives tied to cost containment and health improvement for members, to work on pharmacy appeals claims made by members to the Department, and to provide administrative support for initiatives tied to cost containment.

Pharmacy Appeals Officer

The Department requests one FTE in FY 2020-21 and ongoing to work on pharmacy-related appeals. Prior to the Affordable Care Act (ACA) expansion the Department did not have any staff dedicated to pharmacy appeals as the quantity of pharmacy-related appeals was relatively small. As the Department's caseload expanded the Department's quantity of pharmacy appeals expanded. Currently, the Department does not have any staff dedicated to handling pharmacy appeals. The Department had 222 pharmacy appeals in 2018 which were handled by staff that had to prioritize appeals work over their existing job duties. In contrast, the Department currently has two staff dedicated to handling appeals for medical claims, with a workload of 338 appeals for those two staff members combined. The quantity of pharmacy appeals is expected to rise even more, as the Department is placing more prior authorization requirements on drugs. If the Department does not address this staffing shortage, the Department would continue to work on appeals with existing staff, and existing staff would be unable to perform work under their job scope. This may lead to unnecessary delays in members receiving important medications.

Clinical Pharmacist Manager

The Department requests one FTE in FY 2020-21 and ongoing to provide clinical expertise for initiatives tied to cost containment. The Department's pharmacy expenditure is continually growing. The Department is adapting to new pharmaceutical products on the market, providing innovative ideas to control costs, and implementing new changes that are passed through legislation. The Department currently only has two pharmacists on staff who can address the clinical aspects of all these changes. The Department proposes to add clinical expertise to keep pace with the innovation and changes that takes place in the pharmacy benefit every year. If the Department does not address this staffing issue the Department will be forced into limiting the amount of strategic work the Department can engage in.

Pharmacy Cost Containment Initiative Staff

The Department requests two FTE in FY 2020-21 and ongoing to assist the Department by providing administrative help for initiatives tied to cost containment. The Department proposes to hire additional staff to keep up with innovation in the pharmaceutical market by hiring staff to work on initiatives tied to controlling cost. The Department is currently working on several initiatives to control pharmaceutical expenditure, but the pharmaceutical market is continually evolving. The Department has an opportunity to dedicate staff to researching and working on innovative ideas to control costs for prescription drugs. If the

Department does not address this staffing issue the Department would be more limited in the number of strategic initiatives the Department could engage in.

Anticipated Outcomes:

The Department anticipates that these initiatives would lead to greater cost containment of the Department's pharmacy and physician administered drug benefits in the long run by changing the way it pays for drugs. The request would lead to better utilization management of drugs by connecting physicians to a prescriber tool and the RAEs to the PDMP, both of which help to ensure members are receiving the most appropriate drugs and services. The prescriber tool would also connect members to additional benefits when appropriate. The Department anticipates that by hiring FTE to focus on cost containment efforts, it would remain on the forefront of innovative ways to reduce costs in clinically appropriate ways.

The Department would evaluate the effect of the MAC rate methodology program by estimating the difference in cost of the rates of the WAC methodology and the MAC rate methodology. The Department would see only cost savings for this revision as the MAC rates would be set as a ceiling price level below the WAC rates. If savings occur, the Department would account for any reduction in cost through the regular budget process.

The Department would evaluate the effect of the AAC rate methodology for the PAD program by estimating the difference in cost of the rates for the ASP plus 2.5% rate methodology and the AAC rate methodology. The Department anticipates a cost savings as a result of this rate methodology change over time. If savings occur, the Department would account for any reduction in cost through the regular budget process.

The Department would use opioid prescription use per capita as a measure for the effectiveness of the PDMP. The Department currently has access to claims data on the Medicaid opioid prescription use, and can create metrics that would evaluate the effectiveness of the program. The Department can use information from the PDMP, which includes all controlled substances prescriptions, to analyze the effectiveness of various policies the Department has implemented across prescribers as well.

The Department proposes to use metrics on the utilization of the prescriber tool to evaluate whether providers are using the prescriber tool when prescribing medications. It would use this information as part of existing incentive programs to ensure providers are actively checking the tool before prescribing drugs.

Assumptions and Calculations:

Please see Appendix A for detailed calculations and tables.

Drug Pricing Methodologies

Contractor Resources

The Department is currently going through a competitive bidding process for July 1, 2021 to conduct rates analysis for the Department's pharmacy AAC drug pricing methodology. Within this procurement process, the Department is adding additional optional scopes of works for the vendor for the pharmacy benefit's MAC rate methodology and for the Department's PAD AAC rate methodology, dependent on approval of those

initiatives. The Department assumes that an additional competitive bidding processes would not be necessary as the scope of work would be built into the bidding process with the vendor procuring the scope of work starting July 1, 2021.

Department Staff
The Department requests one Rate/Financial Analyst III FTE starting July 1, 2020 as the Rates Analyst/ Contract Manager for the drug pricing methodologies. This position would also oversee the contract with the vendor for the PAD and pharmacy benefits. This position would be responsible for amending contracts, enacting options for additional scopes of work when necessary, and following the states procurement rules and guidelines to support the Department's business needs with the rates vendor. The FTE would have additional responsibilities pertaining to the MAC drug pricing methodology.

Maximum Allowable Cost Methodology for Prescription Drugs
Contractor Resources
The Department estimates that it would cost $250,000 total funds in contractor funding in FY 2021-22 and ongoing to have a contractor calculate the MAC rates based on current contracts the Department has with a similar scope of work based on an estimated 1,250 hours of work at an average rate of $200 per hour.

The Department assumes that it could absorb the workload to build a data interface to bring the rates into the pharmacy claims processing system within the Department's existing pool hours for PBMS system changes.

The Department estimates that it could begin paying the MAC rates starting January 1, 2022 based on the estimated time it takes to complete state plan amendments (SPAs), review and revise rules, build a data interface with PBMS and the vendor, and to exercise the option to calculate MAC rates with the Department's vendor. The Department estimates that it would take between 6 to 8 months for the Department to draft, submit, and receive approval for the required SPA and rule change. The Department would start contracting with the vendor starting July 1, 2021 when the new contract is effective. The Department assumes that the vendor would begin collecting data, setting rates, and loading the rates into PBMS. The Department estimates that the rates would be ready to be effective by January 1, 2022.

Department Staff
The requested Rates Analyst/Contract Manager position would be responsible for amending the State Plan to align with the MAC program, coordinating any needed rule changes, overseeing the system changes that would occur in PBMS, and analyzing the drug reimbursement cost information for the MAC rates. This position would be responsible for developing analysis to ensure that MAC rates are being made appropriately and reasonably. This position would be responsible for ensuring that system changes incorporate the necessary functionality for prescription drug claims processing for the MAC rates methodology. This position would also be responsible for researching federal and state policy to ensure that the MAC rates methodology aligns with state and federal policy. This position would determine when a State Plan Amendment or rule change is necessary to implement the new rate methodology for prescription drugs. Additionally, this position would be responsible for conducting quarterly analysis on the savings achieved through the new rate methodology.

Savings

There may be savings beginning in FY 2021-22 from implementing the MAC rates methodology as a result of lower pharmacy costs. There is uncertainty around the magnitude of the savings that would be achieved as a result of the revision to the pricing methodology as it depends on how the Department sets the MAC rates; therefore, the Department is not requesting a reduction to its budget with this request. The Department would use the regular budget process to account for any savings achieved from implementation of the new drug reimbursement methodology.

Average Acquisition Cost Methodology for Physician Administered Drugs

Contractor Resources

The Department estimates that it would need $300,000 total funds in FY 2021-22 and ongoing to have a contractor conduct regular surveys with physician administered drug service providers, collect data on the average acquisition cost, and calculate rates based on the data collected. The total estimated cost was developed based on current contracts with similar scope of work.

The Department estimates that it would cost $138,000 total funds in FY 2020-21 to configure changes for the AAC rates into the claims system for reporting based on an estimate 1,000 hours of work at an average rate of $138 per hour.

The Department estimates that it could begin paying the AAC rates starting July 1, 2022 based on the estimated timeline to complete state plan amendments, review and revise rules, the timeline necessary to build a data interface with the claims system and the vendor, and for the vendor to conduct survey analysis on the average acquisition cost for the PAD benefit. The Department assumes that it would take approximately six months to develop the programmatic details based on prior experience with similar programs. The Department assumes that it would take approximately six months to draft, submit, and receive approval for state plan amendments based on the Department's prior experience with pharmacy reimbursement changes. The Department assumes that it would take approximately six months to revise rules and submit revisions to the Medical Services Board based on the Department's experience. The Department assumes that it would take six months for the vendor to conduct surveys, collect data, and load the rates into the claims processing system based on prior experience with the Department's pharmacy AAC rate methodology. The Department estimates that it would take 6 to 12 months to build a data interface with the claims system and the vendor based on prior experience with similar programs. The Department assumes that the system changes can occur simultaneous with revising rules, and the vendor collecting data to calculate the AAC rates.

Department Staff

The Department assumes that it could absorb the workload of analyzing the rates calculated by the vendor with the existing staff that works on the Average Sales Price (ASP) drug pricing methodology. The Department would also be able to absorb the additional workload associated with amending the State Plan to align with the AAC pricing methodology.

Savings

There may be savings beginning in FY 2022-23 from implementing the AAC pricing methodology from lower physician administered drug costs. There is uncertainty around the magnitude of the savings that would be achieved as a result of the revision to the pricing methodology, as it depends on how the Department sets the AAC rates; therefore, the Department is not requesting savings with this request. The Department would use the regular budget process to account for any savings achieved from implementation of the new drug reimbursement methodology.

Prescription Drug Monitoring Program

Contractor Resources

The Department requests contractor resources for three vendors to create an interface in its claims system that would incorporate data from the PDMP, to build an interface between relevant system components for claims processing, and to pay the PDMP vendor to send patient history data and patient risk scores.

The Department estimates it would cost $870,142 total funds in contracting funding in FY 2020-21, $411,974 total contractor funding in FY 2021-22 and $424,334 total contractor funding in FY 2022-23 ongoing for the Department's current vendor to incorporate drug history files and risk scores for opioid prescriptions from the PDMP, to use the drug history and risk scores for claims payment processing, and to create reporting within the current system to allow the Department to track denied claims based on a contractor estimate for this scope of work.

The Department estimates that it would need $37,000 total funds in contractor funding in FY 2020-21 to build an interface with the Department's interChange system and with the PDMP vendor based on an estimated 250 hours of work at an average rate of $148 per hour.

The Department assumes the cost of setting up the interface between the claims system and the PDMP would be eligible for a 90 percent federal financial participation (FFP) rate as allowed by section 1944(f) of the SUPPORT Act, which allows states to incorporate the PDMP as a part of the mechanism for claims processing and information retrieval as defined in 42 CFR 433.111(b). The Department's ongoing operation of system integration is eligible for a 75% federal match per CMS issued guidance. In order to claim this enhanced funding, the Department would need to submit an advance planning document (APD) to CMS with implementation details.

Savings

There may be long-term savings from using the PDMP to better coordinate care for individuals with substance use disorders. The Regional Accountable Entities (RAEs) could use the data from the PDMP to help providers make better clinical decisions. After the inception of the Florida PDMP,[6] overall drug-related deaths fell by 6.3%. It is uncertain how this would correlate to savings within the Medicaid program, therefore

[6] https://www.ncjrs.gov/pdffiles1/bja/247133.pdf

the Department is not requesting short-term savings. The Department would adjust through the regular budget process if there are costs avoided from implementation of the PDMP.

Prescriber Tool

The Department is requesting contractor resources to design and develop the program tool and create interfaces between the tool and existing data sources. The Department would need funding for system changes to incorporate the provider tool data for utilization tracking. The Department assumes it would need ongoing contractor resources to continue the current work of maintaining the data interface between the Department's systems and the Department's prescriber tool vendor. The Department assumes that additional ongoing contractor funding would be needed to have a vendor maintain and deliver a prescriber tool to interface with the Department's physicians.

Design and Development Costs

The Department is requesting $1,799,357 in total funds in FY 2019-20, all of which is federal funds, and $406,800 total funds in FY 2020-21 for the design and development costs for the prescriber tool. This is in addition to the Department's current funding for this work.

The Department estimates that it would cost $2,249,357 total funds for contractor funding in FY 2019-20 for design and development of the prescriber tool based on a similar scope of work for the development of a single assessment tool from SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities". The Department estimates that it would cost $50,000 total funds in FY 2019-20 for the Department's pharmacy system vendor to design and develop the necessary data fields and functions to populate the Department's prescriber tool based on a contractor estimate for the scope of work.

The Department estimates that it would cost $406,800 total funds in FY 2020-21 to build interfaces from the MMIS, CBMS, or the Joint Agency Interoperability (JAI) project to the prescriber tool. The cost to building the two interfaces between the MMIS, CBMS, or the Joint Agency Interoperability (JAI) project to the prescriber tool is based on the average cost of interfaces built from MMIS and CBMS since the Department cannot determine which system would need to build an interface to the prescriber tool at this time. The average MMIS interface is $165,600 for configuration costs to the prescriber tool based on an estimated 1,200 hours of work at an average rate of $138.00 per hour. The average CBMS interface is $241,200 for configuration costs to the prescriber tool based on an estimates 1,800 hour at an average rate of $134.00 per hour. The Department would need to provide various program and enrollment information to the prescriber tool so when a clinician is using the tool they could readily identify which programs the member is eligible for and which programs or beneficial services the member could receive. It is critical that this information be provided accurately and timely to the clinician or user of the prescriber tool, so they can direct the member to the identified programs and services, which would increase the member's health and reduce costs to the Medicaid program.

The Department assumes the cost of the design and development stage for the prescriber tool would be eligible for a 90 percent federal financial participation (FFP) rate as allowed by 42 CFR § 433.15(b)(3) for

design, development, or installation of mechanized claims processing and information retrieval systems. The Department has received federal approval for an APD in order to receive enhanced FFP.

The Department currently has $500,000 total funds ongoing, funded at a standard match, appropriated to the Department for the prescriber tool from SB 18-266. Since the Department is eligible for a 90% match for the design and development stage of this project, the Department estimates it would be able to draw down $2,049,357 in federal funds to pay for the design and development phase of the project.

Ongoing Operational Costs

The Department estimates that it would cost $2,675,000 total funds in contractor funding to provide ongoing maintenance and operations for the Department's prescriber tool. The Department assumes this is a reasonable estimated cost based on similar scopes of work estimated for ongoing maintenance of the Care/Case Management System Implementation Project SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities". The Department assumes that this scope of work is similar as a vendor would be working on providing maintenance and operational assistance for a Medicaid-wide evaluation tool. The Department estimated the ongoing operations of that tool would cost $2,445,230 in the fiscal note for SB 16-192. The Department estimates that the ongoing cost for the prescriber tool would be higher, as the vendor must maintain interfaces with the new JAI project to provide information about state programs that can assist members. The vendor would be responsible for maintaining all the necessary data fields to ensure that patient risk scores, Department's recommended drugs, and cost information is obtainable at the point of sale (POS) for all prescribers. The vendor would be responsible for maintaining the provider tool and outreaching to providers to ensure that providers have the adequate training to utilize the tool. The vendor would be responsible for ongoing support to providers.

The Department estimates that it would cost $303,870 total funds in FY 2020-21, $312,389 total funds in FY 2021-22, and $321,163 total funds in FY 2022-23 and ongoing in contractor funding for the Department's PBMS vendor to maintain the data interface between the PBMS data system and the pharmacy tool based on vendor estimates. The vendor would be responsible for maintaining the database and sending data to the Department's prescriber tool vendor.

Incentive Payments and Penalties

The Department assumes that it could achieve statewide adaption of the prescriber tool by providing incentive payments and penalties to providers based on their utilization of the provider tool. The Department assumes that it could address the adaptation of Primary Care Medical Providers (PCMPs) through an existing incentive payment program with the Department's seven Regional Accountable Entities. The Department assumes that it could address adaptation of the prescriber tool for providers in a hospital setting through the Department's supplemental payment program. The Department assumes that the prescriber tool vendor would supply the Department with utilization data for the Department to calculate any incentive payment or penalty. The details of each proposal are outlined below.

Incentive Payments for Regional Accountable Entities

The Department plans to provide incentive payments for the utilization of the prescriber tool within existing resources. The Department currently withholds $4.00 PMPM from the RAE payments that can be earned back based on performance on Key Performance Indicators. All funds unearned and not distributed to the RAEs are pooled together (performance pool). The performance pool funds are flexible and are used to reinforce and align evolving program goals and to focus contractor attention on Department priority program outcomes. The Department plans to align a portion of the performance pool dollars with utilization of the prescriber tool and assumes it will achieve adaptation of the prescriber tool amongst PCMP with no additional cost to the State.

Penalties for Providers within a Hospital Setting

The Department plans to build utilization measures for the prescriber tool within the Department's existing Hospital Transformation Program (HTP). The Department would gather utilization data for providers within a hospital system and calculate whether the hospital has utilized the Department's prescriber tool. If a hospital system does not adequately adapt the tool the Department would add a penalty to the hospital's supplemental payments. The Department assumes that adding this measure to the existing HTP would ensure that prescribers in a hospital setting are utilizing the prescriber tool.

Savings

The Department did not calculate any additional savings as a result of the prescriber tool in FY 2020-21 since the Department assumed savings in SB 18-266 "Controlling Cost under Colorado Medical Assistance Act". The Department assumed 1.0% savings on pharmacy expenditure in FY 2019-20 and ongoing in SB 18-266. The Department is requesting additional funding in FY 2019-20 for the savings estimated in that year for the Prescriber Tool, as the Department will be unable to achieve those savings due to the delay in implementation of the tool. The Department estimates that the savings appropriated in SB 18-266 would be achievable starting July 1, 2020 if additional funding is appropriated through this request for the ongoing management of the prescriber tool.

There may be additional long-term savings from connecting individuals on Medicaid to other financial assistance programs as the Department incorporates information from the JAI project into the prescriber tool. Physicians would be able to provide information on various other financial and social programs that the member is eligible for that could improve the health of the member during the member's visit. For example, physicians would receive information on the Women, Infants, and Children (WIC) program and would be able to discuss the benefits of the program with their patients. Connecting members to programs such as WIC may lead to better health outcomes overall, thereby leading to lower expenditure on medical services through Medicaid. The WIC program reduces low birth rates and extremely low birth weights by 25% and 44% respectively.[7] Studies show that low birth weights correspond to significantly higher annual expenditure compared to babies born with normal birthweights.[8] It is uncertain how this would correlate to short-term savings within the Medicaid program, therefore the Department is not requesting any further budgetary

[7] https://www.gao.gov/assets/160/151746.pdf

[8] https://www.marchofdimes.org/news/premature-babies-cost-employers-127-billion-annually.aspx

reductions. The Department would use the regular budget process to account for any savings achieved from incorporating additional information from other State programs in the prescriber tool.

Additional Administrative Resources

Pharmacy Appeals Officer

The Department requests 1.0 Administrator IV FTE starting July 1, 2020 as the Pharmacy Appeals Officer to manage member pharmaceutical appeals. This position would be responsible for overseeing the process of appeals and representing the Department in proceedings in front of the Office of Administrative Courts. The Department had 222 pharmacy appeals in 2018, which were handled by staff who had to prioritize resolving appeals over their existing job duties. In contrast, the Department currently has two staff dedicated to handling appeals for medical claims, with a workload of 338 appeals for those two staff members combined in 2018. This position would ensure appeals are processed consistent with the requited timelines. This position would be responsible for creating project plans for each case, coordinating clinical reviews of the pharmacy appeals, and coordinating the delivery of services in cases where the denial of services had been reversed This position would be responsible for communicating with stakeholders, drafting motions and preparing documents to deliver for the office of administrative courts. The staff would assemble, prepare, and submit all medical documentation relating to the appeal as well as submit needed requests for dismissals, continuances, and exceptions.

Clinical Pharmacist Manager

The Department requests 1.0 Pharmacist III FTE starting July 1, 2020 as the Clinical Pharmacy Manager to provide subject matter expertise as a pharmacist in relation to various cost containment initiatives. The requested position would be responsible for providing clinical expertise for developing pharmacy clinical policies of the pharmacy benefit and coordinating the development and implementation of pharmacy program and the PAD benefit. This position would be responsible for establishing and maintaining written and oral communications with the Department's management, other state departments, federal agencies, state boards, associations, providers, and members. This position would be responsible for communicating with members, manufacturers, advocacy groups, and the public regarding new policy. This position would be responsible for negotiating technical and clinical adjustments with providers and drug manufacturers, to contracts and regulations as needed. This position would also be responsible for conducting meeting with internal and external stakeholders related to policy development, information sharing, and the coordination of operations of Department initiatives.

Pharmacy Cost Containment Initiative Staff

The Department requests 2.0 Administrator IV FTE starting July 1, 2020 as the Pharmacy Cost Containment Initiative Staff to provide administrative support to the Department's pharmacy team. These positions would be responsible for identifying opportunities for savings within the pharmacy benefit, reviewing industry innovations and emerging technologies, and assisting in the ongoing implementation of existing cost containment projects such as value-based drug contracts. These positions would support the clinical pharmacist manager by providing research and support for various initiatives. These positions would be

responsible for implementing contract amendments, changing the State Plan, and researching federal policy under the guidance of the Clinical Pharmacist Manager.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

Department received new information about the implementation timeline for the prescriber tool approved in SB 18-266 and the potential to gain an enhanced federal match for design and development of the prescriber tool. The Department was unable to proceed with implementing a prescriber tool due to inadequate funding in FY 2019-20 and ongoing for operations of the prescriber tool. Implementing a prescriber tool is part of the Governor's priority in reducing medical expenditure. Due to the delay in the implementation timeline, the Department is requesting supplemental funding to true up the savings estimated in SB 18-266 as a result of the prescriber tool. In addition, the Department is requesting supplemental funding and roll forward authority to true up the funding splits estimated for the design and development costs based on federal approval of an advanced planning document.

Table 1.1 FY 2019-20 Administrative Pharmacy Request Cost Estimates with Fund Splits by Appropriation									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$0	0.0	$0	$0	$0	$0	50.00%	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$0	0.0	$0	$0	$0	$0	50.00%	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$0	0.0	$0	$0	$0	$0	50.00%	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	50.00%	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	50.00%	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$0	0.0	$0	$0	$0	$0	50.00%	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$1,799,357	0.0	$0	$0	$0	$1,799,357	NA	Table 2.1, Row B
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$0	0.0	$0	$0	$0	$0	50.00%	NA
I	(2) Medical Services Premiums	$5,336,522	0.0	$1,408,842	$325,528	$0	$3,602,152	NA	Table 2.1, Row D
J	**Total**	**$7,135,879**	**0.0**	**$1,408,842**	**$325,528**	**$0**	**$5,401,509**	**NA**	**Sum Row A through Row I**

Table 1.2 FY 2020-21 Administrative Pharmacy Request Cost Estimates with Fund Splits by Appropriation									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$506,630	5.0	$167,188	$86,127	$0	$253,315	50.00%	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$50,210	0.0	$16,569	$8,536	$0	$25,105	50.00%	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$766	0.0	$253	$130	$0	$383	50.00%	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$22,546	0.0	$7,441	$3,833	$0	$11,272	50.00%	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$22,546	0.0	$7,441	$3,833	$0	$11,272	50.00%	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$28,265	0.0	$9,330	$4,805	$0	$14,130	50.00%	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$2,878,845	0.0	$869,277	$473,284	$0	$1,536,284	NA	Table 2.2, Row B + Row D + Row I + Row K +Row M
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$1,051,967	0.0	$75,071	$74,145	$0	$902,751	NA	Table 2.2, Row E + Row G + Row H + Row L
I	(2) Medical Services Premiums	$0	0.0	$0	$0	$0	$0	NA	NA
J	**Total**	**$4,561,775**	**5.0**	**$1,152,570**	**$654,693**	**$0**	**$2,754,512**	**NA**	**Sum Row A through Row I**

Table 1.3 FY 2021-22 Administrative Pharmacy Request Cost Estimates with Fund Splits by Appropriation									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$526,916	5.0	$173,883	$89,576	$0	$263,457	50.00%	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$50,210	0.0	$16,569	$8,536	$0	$25,105	50.00%	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$797	0.0	$264	$135	$0	$398	50.00%	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$23,450	0.0	$7,738	$3,987	$0	$11,725	50.00%	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$23,450	0.0	$7,738	$3,987	$0	$11,725	50.00%	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$4,750	0.0	$1,567	$808	$0	$2,375	50.00%	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$3,449,363	0.0	$1,055,379	$570,841	$0	$1,823,143	50.00%	Table 2.3, Row B + Row D + Row I + Row K +Row M
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$0	0.0	$0	$0	$0	$0	NA	Table 2.3, Row E + Row G + Row H + Row L
I	(2) Medical Services Premiums	$0	0.0	$0	$0	$0	$0	NA	NA
J	**Total**	**$4,078,936**	**5.0**	**$1,263,138**	**$677,870**	**$0**	**$2,137,928**	**NA**	**Sum Row A through Row I**

Table 1.4 FY 2022-23 Administrative Pharmacy Request Cost Estimates with Fund Splits by Appropriation									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$526,916	5.0	$173,883	$89,576	$0	$263,457	50.00%	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$50,210	0.0	$16,569	$8,536	$0	$25,105	50.00%	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$797	0.0	$264	$135	$0	$398	50.00%	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$23,450	0.0	$7,738	$3,987	$0	$11,725	50.00%	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$23,450	0.0	$7,738	$3,987	$0	$11,725	50.00%	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$4,750	0.0	$1,567	$808	$0	$2,375	50.00%	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$3,461,723	0.0	$1,057,222	$572,224	$0	$1,832,277	50.00%	Table 2.4, Row B + Row D + Row I + Row K +Row M
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$0	0.0	$0	$0	$0	$0	NA	Table 2.4, Row E + Row G + Row H + Row L
I	(2) Medical Services Premiums	$0	0.0	$0	$0	$0	$0	NA	NA
J	**Total**	**$4,091,296**	**5.0**	**$1,264,981**	**$679,253**	**$0**	**$2,147,062**	**NA**	**Sum Row A through Row I**

Table 2.1: FY 2019-20 Administrative Pharmacy Request Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
Pharmacy Provider Tool									
A	Current Contractor Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 5.1, Row E
B	Development and Design Costs[1]	$1,799,357	0.0	$0	$0	$0	$1,799,357	NA	Table 5.1 Row A + Row B + Row C - Row G
C	Prescriber Tool Vendor Cost	$0	0.0	$0	$0	$0	$0	50.00%	Table 5.1 Row D
D	Savings Adjustment	$5,336,522	0.0	$1,408,842	$325,528	$0	$3,602,152	NA	See Narrative
E	**Total Pharmacy Provider Tool Cost**	**$7,135,879**	**0.0**	**$1,408,842**	**$325,528**	**$0**	**$5,401,509**	**NA**	**Sum Row A through Row D**
F	**Total**	**$7,135,879**	**0.0**	**$1,408,842**	**$325,528**	**$0**	**$5,401,509**	**NA**	**Row E**

[1] The Department Requests Rollforward Authority for the Design and Develop Costs of the Prescriber Tool

Table 2.2: FY 2020-21 Administrative Pharmacy Request Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
Maximum Allowable Cost Methodology for Prescription Drugs									
A	Program Manager - Rates Analyst	$124,813	1.0	$41,191	$21,218	$0	$62,404	50.00%	FTE Calculation
B	Contractor Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 3.2, Row A
C	**Total Maximum Allowable Cost Methodology for Prescription Drugs Cost**	**$124,813**	**1.0**	**$41,191**	**$21,218**	**$0**	**$62,404**	**NA**	**Sum Row A through Row B**
Average Acquisition Cost Methodology Change For Physician Administered Drugs									
D	Contractor Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 3.2, Row B
E	Changes to MMIS	$138,000	0.0	$20,572	$15,009	$0	$102,419	NA	Table 3.2, Row C
F	**Total Average Acquisition Cost Methodology Change For Physician Administered Drugs Cost**	**$138,000**	**0.0**	**$20,572**	**$15,009**	**$0**	**$102,419**	**NA**	**Sum Row D through Row E**
Prescription Drug Monitoring Program									
G	PDMP Development Costs	$470,167	0.0	$28,035	$30,421	$0	$411,711	NA	Table 4.1, Row A
H	Changes to MMIS	$37,000	0.0	$2,206	$2,394	$0	$32,400	NA	Table 4.1, Row B
I	Contractor Costs	$399,975	0.0	$59,625	$43,501	$0	$296,849	75.00%	Table 4.1, Row C
J	**Total Prescription Drug Monitoring Program Cost**	**$907,142**	**0.0**	**$89,866**	**$76,316**	**$0**	**$740,960**	**NA**	**Sum Row G through Row I**
Presciber Tool									
K	Current Contractor Costs	$303,870	0.0	$100,277	$51,658	$0	$151,935	50.00%	Table 5.2, Row E
L	Development and Design Costs	$406,800	0.0	$24,258	$26,321	$0	$356,221	90.00%	Table 5.2, Row A + Row B + Row C
M	Prescriber Tool Vendor Cost	$2,175,000	0.0	$709,375	$378,125	$0	$1,087,500	50.00%	Table 5.2, Row D - Row G
N	**Total Presciber Tool Cost**	**$2,885,670**	**0.0**	**$833,910**	**$456,104**	**$0**	**$1,595,656**	**NA**	**Sum Row K through Row M**
Additional Administrative Resources									
O	Pharmacy Manager	$181,031	1.0	$59,742	$30,775	$0	$90,514	50.00%	FTE Calculation
P	Pharmacy Appeals Officer	$108,373	1.0	$35,765	$18,423	$0	$54,185	50.00%	FTE Calculation
Q	Pharmacy Cost Containment Staff	$108,373	1.0	$35,762	$18,424	$0	$54,187	50.00%	FTE Calculation
R	Pharmacy Cost Containment Staff	$108,373	1.0	$35,762	$18,424	$0	$54,187	50.00%	FTE Calculation
S	**Total Additional Administrative Resources Cost**	**$506,150**	**4.0**	**$167,031**	**$86,046**	**$0**	**$253,073**	**50.00%**	**Sum Row O through Row R**
T	**Total**	**$4,561,775**	**5.0**	**$1,152,570**	**$654,693**	**$0**	**$2,754,512**	**NA**	**Row C + Row F + Row J + Row N + Row S**

Table 2.3: FY 2021-22 Administrative Pharmacy Request Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
Maximum Allowable Cost Methodology for Prescription Drugs									
A	Program Manager - Rates Analyst	$124,475	1.0	$41,078	$21,160	$0	$62,237	50.00%	FTE Calculation
B	Contractor Costs	$250,000	0.0	$82,500	$42,500	$0	$125,000	50.00%	Table 3.2, Row A
C	**Total Maximum Allowable Cost Methodology for Prescription Drugs Cost**	**$374,475**	**1.0**	**$123,578**	**$63,660**	**$0**	**$187,237**	**NA**	**Sum Row A through Row B**
Average Acquisition Cost Methodology Change For Physician Administered Drugs									
D	Contractor Costs	$300,000	0.0	$99,000	$51,000	$0	$150,000	50.00%	Table 3.2, Row B
E	Changes to MMIS	$0	0.0	$0	$0	$0	$0	50.00%	Table 3.2, Row C
F	**Total Average Acquisition Cost Methodology Change For Physician Administered Drugs Cost**	**$300,000**	**0.0**	**$99,000**	**$51,000**	**$0**	**$150,000**	**NA**	**Sum Row D through Row E**
Prescription Drug Monitoring Program									
G	PDMP Development Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 4.2, Row A
H	Changes to MMIS	$0	0.0	$0	$0	$0	$0	75.00%	Table 4.2, Row B
I	Contractor Costs	$411,974	0.0	$61,415	$46,110	$0	$304,449	NA	Table 4.2, Row C
J	**Total Prescription Drug Monitoring Program**	**$411,974**	**0.0**	**$61,415**	**$46,110**	**$0**	**$304,449**	**NA**	**Sum Row G through Row I**
Presciber Tool									
K	Current Contractor Costs	$312,389	0.0	$103,089	$53,106	$0	$156,194	50.00%	Table 5.3, Row E
L	Development and Design Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 5.3, Row A + Row B + Row C
M	Prescriber Tool Vendor Cost	$2,175,000	0.0	$709,375	$378,125	$0	$1,087,500	50.00%	Table 5.3, Row D - Row G
N	**Total Presciber Tool Cost**	**$2,487,389**	**0.0**	**$812,464**	**$431,231**	**$0**	**$1,243,694**	**NA**	**Sum Row K through Row M**
Additional Administrative Resources									
O	Pharmacy Manager	$182,952	1.0	$60,375	$31,102	$0	$91,475	50.00%	FTE Calculation
P	Pharmacy Appeals Officer	$107,382	1.0	$35,434	$18,257	$0	$53,691	50.00%	FTE Calculation
Q	Pharmacy Cost Containment Staff	$107,382	1.0	$35,436	$18,255	$0	$53,691	50.00%	FTE Calculation
R	Pharmacy Cost Containment Staff	$107,382	1.0	$35,436	$18,255	$0	$53,691	50.00%	FTE Calculation
S	**Total Additional Administrative Resources Cost**	**$505,098**	**4.0**	**$166,681**	**$85,869**	**$0**	**$252,548**	**50.00%**	**Sum Row O through Row R**
T	**Total**	**$4,078,936**	**5.0**	**$1,263,138**	**$677,870**	**$0**	**$2,137,928**	**NA**	**Row C + Row F + Row J + Row N + Row S**

Table 2.4 FY 2022-23 Administrative Pharmacy Request Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
Maximum Allowable Cost Methodology for Prescription Drugs									
A	Program Manager - Rates Analyst	$124,475	1.0	$41,078	$21,160	$0	$62,237	50.00%	FTE Calculation
B	Contractor Costs	$250,000	0.0	$82,500	$42,500	$0	$125,000	50.00%	Table 3.2, Row A
C	**Total Maximum Allowable Cost Methodology for Prescription Drugs Cost**	**$374,475**	**1.0**	**$123,578**	**$63,660**	**$0**	**$187,237**	**NA**	**Sum Row A through Row B**
Average Acquisition Cost Methodology Change For Physician Administered Drugs									
D	Contractor Costs	$300,000	0.0	$99,000	$51,000	$0	$150,000	50.00%	Table 3.2, Row B
E	Changes to MMIS	$0	0.0	$0	$0	$0	$0	50.00%	Table 3.2 Row C
F	**Total Average Acquisition Cost Methodology Change For Physician Administered Drugs Cost**	**$300,000**	**0.0**	**$99,000**	**$51,000**	**$0**	**$150,000**	**NA**	**Sum Row D through Row E**
Prescription Drug Monitoring Program									
G	PDMP Development Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 4.3, Row A
H	Changes to MMIS	$0	0.0	$0	$0	$0	$0	50.00%	Table 4.3, Row B
I	Contractor Costs	$424,334	0.0	$63,258	$47,493	$0	$313,583	NA	Table 4.3, Row C
J	**Total Prescription Drug Monitoring Program**	**$424,334**	**0.0**	**$63,258**	**$47,493**	**$0**	**$313,583**	**NA**	**Sum Row G through Row I**
Presciber Tool									
K	Current Contractor Costs	$312,389	0.0	$103,089	$53,106	$0	$156,194	50.00%	Table 5.4, Row E
L	Development and Design Costs	$0	0.0	$0	$0	$0	$0	50.00%	Table 5.4, Row A + Row B + Row C
M	Prescriber Tool Vendor Cost	$2,175,000	0.0	$709,375	$378,125	$0	$1,087,500	NA	Table 5.4, Row D - Row G
N	**Total Presciber Tool Cost**	**$2,487,389**	**0.0**	**$812,464**	**$431,231**	**$0**	**$1,243,694**	**NA**	**Sum Row K through Row M**
Additional Administrative Resources									
O	Pharmacy Manager	$182,952	1.0	$60,375	$31,102	$0	$91,475	50.00%	FTE Calculation
P	Pharmacy Appeals Officer	$107,382	1.0	$35,434	$18,257	$0	$53,691	50.00%	FTE Calculation
Q	Pharmacy Cost Containment Staff	$107,382	1.0	$35,436	$18,255	$0	$53,691	50.00%	FTE Calculation
R	Pharmacy Cost Containment Staff	$107,382	1.0	$35,436	$18,255	$0	$53,691	50.00%	FTE Calculation
S	**Total Additional Administrative Resources Cost**	**$505,098**	**4.0**	**$166,681**	**$85,869**	**$0**	**$252,548**	**50.00%**	**Sum Row O through Row R**
T	**Total**	**$4,091,296**	**5.0**	**$1,264,981**	**$679,253**	**$0**	**$2,147,062**	**NA**	**Row C + Row F + Row J + Row N + Row S**

Table 3.1 Contractor Costs						
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Assumptions/Calculations**
A	Pharmacy Rate Methodology Costs	$0	$138,000	$550,000	$550,000	Table 3.2, Row D
B	Prescriber Tool Costs	$1,799,357	$2,885,670	$2,487,389	$2,487,389	Table 6, Row H
C	Prescription Drug Monitoring Program Cost	$0	$907,142	$411,974	$424,334	Table 5, Row D
D	**Total Contractor Costs**	**$1,799,357**	**$3,930,812**	**$3,449,363**	**$3,461,723**	**Sum Row A through Row C**

Table 3.2 Pharmacy Reimbursement Contractor Costs						
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Assumptions/Calculations**
A	Pharmacy Price Agreement Vendor	$0	$0	$250,000	$250,000	The Department Estimates 1,250 Hours of Work at a Rate of $200.00 per Hour for Actuarial Analysis
B	Physician Administered Drugs Price Agreement Vendor	$0	$0	$300,000	$300,000	The Department Estimates 1,500 Hours of Work at a Rate of $200.00 per Hour for Actuarial Analysis
C	Building Interface for Rate Uploads for PAD Average Acquisition Costs	$0	$138,000	$0	$0	The Department Estimates 1,000 Hours of Work at a Rate of $138.00 per Hour for System Changes
D	**Total Pharmacy Rate Methodology Contractor Costs**	**$0**	**$138,000**	**$550,000**	**$550,000**	**Sum Row A through Row C**

Table 4.1: FY 2020-21 Prescription Drug Monitoring Program Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP[1]**	**Notes/Calculations**
A	PDMP Development Costs	$470,167	0.0	$28,035	$30,421	$0	$411,711	90.00%	Cost Estimate Provided by Current Vendor
B	Changes to MMIS	$37,000	0.0	$2,206	$2,394	$0	$32,400	90.00%	Estimated 250 Hours of Work at $148 per Hour.
C	Ongoing PDMP Operations Cost	$399,975	0.0	$59,625	$43,501	$0	$296,849	75.00%	Cost Estimate Provided by Current Vendor
D	**Total Prescription Drug Monitoring Program Cost**	**$907,142**	**0.0**	**$89,866**	**$76,316**	**$0**	**$740,960**	**NA**	**Sum Row A through Row C**

[1] FFP is approximately 90.00%. Calculation may vary based on the percentage of costs allocated to Title XXI eligible within Medicaid.

Table 4.2: FY 2021-22 Prescription Drug Monitoring Program Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	PDMP Development Costs	$0	0.0	$0	$0	$0	$0	90.00%	Cost Estimate Provided by Current Vendor
B	Changes to MMIS	$0	0.0	$0	$0	$0	$0	90.00%	Department Estimate
C	Ongoing PDMP Operations Cost	$411,974	0.0	$61,415	$46,110	$0	$304,449	75.00%	Cost Estimate Provided by Current Vendor
D	**Total Prescription Drug Monitoring Program Cost**	**$411,974**	**0.0**	**$61,415**	**$46,110**	**$0**	**$304,449**	**NA**	**Sum Row A through Row C**

Table 4.3: FY 2022-23 Prescription Drug Monitoring Program Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	PDMP Development Costs	$0	0.0	$0	$0	$0	$0	90.00%	Cost Estimate Provided by Current Vendor
B	Changes to MMIS	$0	0.0	$0	$0	$0	$0	90.00%	Department Estimate
C	Ongoing PDMP Operations Cost	$424,334	0.0	$63,258	$47,493	$0	$313,583	75.00%	Cost Estimate Provided by Current Vendor
D	**Total Prescription Drug Monitoring Program Cost**	**$424,334**	**0.0**	**$63,258**	**$47,493**	**$0**	**$313,583**	**NA**	**Sum Row A through Row C**

Table 5.1: FY 2019-20 Prescriber Tool Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Program Development	$2,249,357	0.0	$169,068	$75,932	$0	$2,004,357	90.00%	See Narrative
B	Magellan Development	$50,000	0.0	$3,467	$1,533	$0	$45,000	90.00%	Vendor Estimate
C	Cost to Build Interfaces	$0	0.0	$0	$0	$0	$0	90.00%	See Narrative
D	Ongoing Vendor Cost	$0	0.0	$0	$0	$0	$0	50.00%	Assumed Implementation of July 1, 2020- See Narrative
E	Magellan Ongoing	$0	0.0	$0	$0	$0	$0	50.00%	Vendor Estimate
F	**Total Prescriber Tool Cost**	**$2,299,357**	**0.0**	**$172,535**	**$77,465**	**$0**	**$2,049,357**	**NA**	**Sum Row A through Row E**
G	Funding Available	$500,000	0.0	$172,535	$77,465	$0	$250,000	50.00%	Funding available through SB 18-266
H	**Total Prescriber Tool Funding**	**$1,799,357**	**0.0**	**$0**	**$0**	**$0**	**$1,799,357**	**NA**	**Row F - Row G**

Table 5.2: FY 2020-21 Prescriber Tool Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Program Development	$0	0.0	$0	$0	$0	$0	90.00%	See Narrative
B	Magellan Development	$0	0.0	$0	$0	$0	$0	90.00%	Vendor Estimate
C	Cost to Build Interfaces	$406,800	0.0	$24,258	$26,321	$0	$356,221	90.00%	See Narrative
D	Ongoing Vendor Cost	$2,675,000	0.0	$882,750	$454,750	$0	$1,337,500	50.00%	Assumed Implementation of July 1, 2020- See Narrative
E	Magellan Ongoing	$303,870	0.0	$100,277	$51,658	$0	$151,935	50.00%	Vendor Estimate
F	**Total Prescriber Tool Cost**	**$3,385,670**	**0.0**	**$1,007,285**	**$532,729**	**$0**	**$1,845,656**	**NA**	**Sum Row A through Row E**
G	Funding Available	$500,000	0.0	$173,375	$76,625	$0	$250,000	50.00%	Funding available through SB 18-266
H	**Total Prescriber Tool Funding**	**$2,885,670**	**0.0**	**$833,910**	**$456,104**	**$0**	**$1,595,656**	**NA**	**Row F - Row G**

Table 5.3: FY 2021-22 Prescriber Tool Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Program Development	$0	0.0	$0	$0	$0	$0	90.00%	See Narrative
B	Magellan Development	$0	0.0	$0	$0	$0	$0	90.00%	Vendor Estimate
C	Changes to MMIS	$0	0.0	$0	$0	$0	$0	90.00%	Department Estimate
D	Ongoing Vendor Cost	$2,675,000	0.0	$882,750	$454,750	$0	$1,337,500	50.00%	Assumed Implementation of July 1, 2020- See Narrative
E	Magellan Ongoing	$312,389	0.0	$103,089	$53,106	$0	$156,194	50.00%	Vendor Estimate
F	**Total Prescriber Tool Cost**	**$2,987,389**	**0.0**	**$985,839**	**$507,856**	**$0**	**$1,493,694**	**NA**	**Sum Row A through Row E**
G	Funding Available	$500,000	0.0	$173,375	$76,625	$0	$250,000	50.00%	Funding available through SB 18-266
H	**Total Prescriber Tool Funding**	**$2,487,389**	**0.0**	**$812,464**	**$431,231**	**$0**	**$1,243,694**	**NA**	**Row F - Row G**

Table 5.4: FY 2022-23 Prescriber Tool Cost									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP or FMAP**	**Notes/Calculations**
A	Program Development	$0	0.0	$0	$0	$0	$0	90.00%	See Narrative
B	Magellan Development	$0	0.0	$0	$0	$0	$0	90.00%	Vendor Estimate
C	Changes to MMIS	$0	0.0	$0	$0	$0	$0	90.00%	Department Estimate
D	Ongoing Vendor Cost	$2,675,000	0.0	$882,750	$454,750	$0	$1,337,500	50.00%	Assumed Implementation of July 1, 2020- See Narrative
E	Magellan Ongoing	$321,163	0.0	$105,984	$54,598	$0	$160,581	50.00%	Vendor Estimate
F	**Total Prescriber Tool Cost**	**$2,996,163**	**0.0**	**$988,734**	**$509,348**	**$0**	**$1,498,081**	**NA**	**Sum Row A through Row E**
G	Funding Available	$500,000	0.0	$173,375	$76,625	$0	$250,000	50.00%	Funding available through SB 18-266
H	**Total Prescriber Tool Funding**	**$2,496,163**	**0.0**	**$815,359**	**$432,723**	**$0**	**$1,248,081**	**NA**	**Row F - Row G**

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
PHARMACIST III	$5,398	1.0	$134,948	1.0	$140,352
PERA			$14,709		$15,298
AED			$6,747		$7,018
SAED			$6,747		$7,018
Medicare			$1,957		$2,035
STD			$229		$239
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, #.# FTE		**1.0**	**$175,379**	**1.0**	**$182,002**
Classification Title	Biweekly Salary	FTE		FTE	
RATE/FINANCIAL ANLYST	$3,563	1.0	$89,062	1.0	$92,628
PERA			$9,708		$10,096
AED			$4,453		$4,631
SAED			$4,453		$4,631
Medicare			$1,291		$1,343
STD			$151		$157
Health-Life-Dental			$10,042		$10,042
Subtotal Position 2, #.# FTE		**1.0**	**$119,160**	**1.0**	**$123,528**
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR IV	$3,026	2.9	$226,929	3.0	$236,016
PERA			$24,735		$25,726
AED			$11,346		$11,801
SAED			$11,346		$11,801
Medicare			$3,290		$3,422
STD			$386		$401
Health-Life-Dental			$30,126		$30,126
Subtotal Position 3, #.# FTE		**2.9**	**$308,158**	**3.0**	**$319,293**
Subtotal Personal Services		4.8	**$602,698**	5.0	**$624,823**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	5.0	$2,500	5.0	$2,500
Telephone Expenses	$450	5.0	$2,250	5.0	$2,250
PC, One-Time	$1,230	5.0	$6,150	-	
Office Furniture, One-Time	$3,473	5.0	$17,365	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$28,265**		**$4,750**
TOTAL REQUEST		4.8	**$630,963**	5.0	**$629,573**

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-08 Accountability and Compliance Improvement Resources

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	**Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$151,501,915**	**$0**	**$156,888,056**	**$3,085,585**	**$3,110,009**
	FTE	500.0	0.0	504.1	11.5	12.0
	GF	$33,651,934	$0	$34,823,095	$658,086	$654,588
	CF	$14,609,481	$0	$15,325,148	$194,286	$198,093
	RF	$2,832,958	$0	$2,720,241	$0	$0
	FF	$100,407,542	$0	$104,019,572	$2,233,213	$2,257,328

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$882,686**	**$918,030**
	FTE	500.0	0.0	504.1	11.5	12.0
	GF	$13,478,948	$0	$14,470,561	$297,967	$309,903
	CF	$3,571,232	$0	$3,714,633	$118,699	$127,584
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$466,020	$480,543
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$120,504**	**$120,504**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$40,568	$40,568
	CF	$421,237	$0	$525,947	$16,093	$16,671
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$63,843	$63,265

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$1,336**	**$1,390**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$448	$469
	CF	$5,301	$0	$5,495	$180	$193
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$708	$728
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$39,284**	**$40,854**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$13,261	$13,791
	CF	$159,398	$0	$166,329	$5,282	$5,677
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$20,741	$21,386
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$39,284**	**$40,854**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$13,261	$13,791
	CF	$159,398	$0	$166,329	$5,282	$5,677
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$20,741	$21,386
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$149,086**	**$92,650**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$1,014,866	$0	$939,016	$53,467	$34,463
	CF	$243,961	$0	$197,797	$19,055	$11,577
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$76,564	$46,610
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$250,000**	**$250,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	GF	$6,015,380	$0	$4,503,802	$125,000	$125,000
	CF	$2,615,231	$0	$2,547,721	$0	$0
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$125,000	$125,000

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$74,893,151**	**$0**	**$80,930,645**	**$1,785,264**	**$1,824,202**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,972,677	$0	$11,030,317	$114,114	$116,603
	CF	$6,385,552	$0	$6,963,036	$88,107	$93,180
	RF	$12,204	$0	$12,204	$0	$0
	FF	$58,522,718	$0	$62,925,088	$1,583,043	$1,614,419
	Total	**$5,083,274**	**$0**	**$5,083,274**	**($181,859)**	**($178,475)**
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Administration	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$16,060	$0	$0
	CF	$1,048,171	$0	$1,037,861	($58,412)	($62,466)
	RF	$0	$0	$0	$0	$0
	FF	$4,035,103	$0	$4,029,353	($123,447)	($116,009)

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-8
Request Detail: Accountability and Compliance Improvement Resources

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$3,085,585**	**$3,110,009**
FTE	0.0	11.5	12.0
General Fund	$0	$658,086	$654,588
Cash Funds	$0	$194,286	$198,093
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$2,233,213	$2,257,328

Summary of Request:

The Department requests $3,085,585 total funds, including $658,086 General Fund, $194,286 cash funds, $2,233,213 federal funds and 11.5 FTE in FY 2020-21; and, $3,110,009 total funds, including $654,588 General Fund, $198,093 cash funds, $2,257,328 federal funds and 12.0 FTE in FY 2021-22 to provide increased stewardship of State resources through the implementation of operational compliance and program oversight measures. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund and Children's Basic Health Plan Trust. This represents an increase of less than 0.5% of the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

As the administrator of Health First Colorado (Colorado's Medicaid program) and the Child Health Plan *Plus* (CHP+), the Department is responsible for processing medical claims for eligible members, setting appropriate payment rates for services, working with stakeholders and providers to determine members benefit packages, improve member health outcomes, and ensuring that all payments are made in compliance with state and federal regulations. Utilizing contracted vendors and FTE, the Department provides program management and oversight measures to assure members receive appropriate services and payments go to the appropriate entities. The Department was appropriated over $10.6 billion in the FY 2019-20 Long Bill to provide services to eligible members; this represents the largest appropriation for any single agency for the State.

Problem or Opportunity:

Given the size of the Department's budget and the number of people served in the Department's programs, proper oversight is critical to ensuring that members are receiving the services that they need, and that taxpayers' resources are spent wisely in support of the Department's programs. As part of the Department's focus on continual improvement to provide sound stewardship of financial resources, the Department has identified administrative opportunities to expand and strengthen operational compliance, program oversight and accountability, and benefit management. The Department does not have sufficient administrative resources to successfully implement these initiatives. Without the necessary administrative resources, the Department could not implement these changes unless it diverts resources from other areas. Aligned with the Department's focus on continual process improvement and organizational efficiency and excellence, these opportunities would ensure the proper functionality and mission-critical operational systems and create a responsive and accountable framework that increases transparency and accountability.

Proposed Solution:

The Department requests $3,085,585 total funds, including $658,086 General Fund, $194,286 cash funds, $2,233,213 federal funds and 11.5 FTE in FY 2020-21; and, $3,110,009 total funds, including $654,588 General Fund, $198,093 cash funds, $2,257,328 federal funds and 12.0 FTE in FY 2021-22 to provide increased stewardship of State resources through the implementation of operational compliance and program oversight measures. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund and Children's Basic Health Plan Trust. The request to add dedicated FTE and contractor funding would provide for the following activities:

- Address operational compliance and oversight deficiencies across multiple programs
- Ensure quality assurance and drive more accountability to the Department's programs
- Improve benefit management

Operational Compliance & Oversight

The Department requests 7.0 FTE resources to address gaps in compliance and oversight in the areas of long-term services and supports, cost allocation, federal and state reporting, and benefit compliance.

Long-Term Services & Supports

The Department requests 4.0 FTE to perform federally required compliance oversight of Home- and Community-Based Service (HCBS) providers.

In 2012, the Office of Community Living (OCL) was created via Executive Order (D 2012-027); in 2013, OCL was officially created in statute via HB 13-1314. The goal of the office is to redesign all aspects of the long-term services and supports (LTSS) delivery system to better serve the over 70,000 Coloradans who need LTSS. The Department has worked in collaboration with community stakeholders and the General Assembly to transform the delivery of LTSS in Colorado. Since that time, there have been significant pieces of legislation impacting the office's work and enrollment into the programs that support members with disabilities have grown by about 21 percent over the last seven years. As enrollment has grown and program requirements have increased, staffing levels, particularly around compliance and program oversight have not kept pace. As a result, the Department is in a place where it can no longer effectively manage these programs without additional resources.

Subrecipient Monitoring

The request includes 1.0 FTE dedicated to subrecipient financial monitoring of Single Entry Point (SEP) entities. As part of the FY 2019-20 budget cycle, the Department received 1.0 FTE to focus on program oriented subrecipient monitoring and 1.0 FTE to focus on financial sub-recipient monitoring. As workloads have been calculated for scheduling reviews to perform the analyses of the twenty-four SEP entities, the Department determined that an insufficient workload capacity existed for the reviews. The Department does not have the resources to comply with federally mandated subrecipient monitoring requirements outlined in 2 C.F.R. § 200, Uniform Administrative Requirements. Subrecipient monitoring is a compliance requirement for any non-federal recipient of federal assistance that passes the award through to a non-federal entity. The Department considered a "pass-through entity" in federal regulations, is responsible for monitoring the federal subaward activities of entities who receive federal funding from the Department. Because the SEPs receive a subaward from the Department, they are deemed as "subrecipients" of a federal award.

The responsibilities of the pass-through entity begin with ensuring that every subaward is clearly identified to the subrecipient as a subaward and that the subrecipient agreement includes appropriate financial award identification data and mandatory terms and conditions set forth in 2 C.F.R. § 200.331. The financial data includes information such as the amount of federal funds obligated, performance period start and end dates, and federal award identification information. The terms and conditions include all requirements imposed by the pass-through entity on the subrecipient so that the federal award is used in accordance with federal regulations and the terms and conditions of the federal award. Further terms and conditions include any requirement that the pass-through entity imposes on the subrecipient for the pass-through entity to meet its own responsibility to the federal awarding agency including identification of any required financial and

performance reports. Likewise, pass-through entities are required to perform program-specific audits as outlined in C.F.R. § 200.507. Finally, the agreement must include an indirect cost rate and language granting the pass-through entity access to the records and financial statements of the subrecipient.

The FTE would assist with ongoing desk and onsite financial reviews of twenty-four subrecipients. This position would be responsible for conducting an annual subrecipient risk assessment, conduct desk and onsite financial reviews of each entity, draft, distribute and monitor financial review findings, issue management decision letters based on each entity's Corrective Action Plan and provide technical assistance as needed.

The Department also requests a supplemental travel budget for these FTE. As a regular component of the position's workload, regular overnight travel would be required. Based on historical travel budgets for similar positions, the Department requests an additional $6,250 per position annually.

Case Management Agency Oversight

The Department requests 1.0 FTE dedicated to Case Management Agency (CMA) oversight. There are 49 CMAs responsible for determining eligibility for, enrollment in, authorization of, and ongoing monitoring of LTSS for over 70,000 members with disabilities. The number of members needing LTSS has grown by approximately 21 percent over the past seven years and the Department does not have enough dedicated resources to provide adequate oversight of CMA functions and risks being out of state and federal compliance related to oversight. The staff would conduct daily oversight of case management operations, to include: addressing complaints of CMAs, researching member issues that require additional information for resolution, addressing identified concerns with CMAs, and assisting with member transitions to new providers when the closure of a provider occurs. This position is responsible for conducting case management member case reviews for HCBS waiver participants receiving case management benefits from one of Colorado's CMAs. The CMAs provide HCBS case management for ten HCBS waivers. When the Department receives a complaint or is made aware of a health or safety concern, a member case review is needed to assess the circumstances and provide sufficient follow up. There are times when the federal government, Colorado legislature, or others become aware of issues involving individuals in an HCBS waiver. This position would be dedicated to researching the elevated concerns and determining the next steps to ensure health and welfare. This position would track these issues, so the Department leadership can determine what policies must be changed to address systemic concerns; which CMAs need additional support; or which CMAs require additional corrective action. This position is responsible for ensuring HCBS waiver participants receive case management support while ensuring qualified service providers are arranged to provide waiver and/or home health services and supports. The Centers for Medicare and Medicaid Services (CMS) and Colorado Department of Public Health and Environment (CDPHE) informs the Department when provider agencies, either voluntarily or non-voluntarily, cease providing services. This position would coordinate efforts that protect members' health and safety. This position would be responsible to ensure CMAs are working to find new providers for members; would provide updates to CDPHE and Department leadership so all parties are aware of the status; and provide technical assistance to CMAs regarding finding new providers.

The Department also requests a supplemental travel budget for this FTE. As a regular component of the position's workload, regular overnight travel would be required. Based on historical travel budgets for similar positions, the Departments requests an additional $6,250 per position annually.

Provider Enrollment and Claim Research

The Department requests 1.0 FTE to actively monitor claims, prior authorizations, provider enrollments, and provider revalidation efforts specific to HCBS providers. The implementation of the federal screening rule has created ongoing provider enrollment review responsibilities for which the Office of Community Living does not have proper staffing to support. Contractor resources related to the reprocurement of the Department's claims processing system initially supplied the supplementary staffing necessary, but funding for those staff ended, and the existing staff cannot support the ongoing workload. In January 2019, there were 33 provider enrollment applications awaiting state review, 14 of which were older than 60 days. As of June 2019, that number of provider applications awaiting state review is 53, 37 of which were older than 60 days. Existing resources are insufficient to allow staff to adequately support operations necessary to update enrollment criteria and work with providers when new programs are introduced. Due to the specialized nature of this provider network, and the unique and diverse enrollment requirements for these providers, the Department needs analysts to provide a high level of technical assistance with the process, and to coordinate key areas within the Department.

In addition to supporting provider enrollment work, this position would be the lead on researching claim issues submitted by HCBS providers, nursing facilities, and intermediate care facility providers, and supporting the operational implementation of new programs. As well, this position would research and resolve prior authorization issues for HCBS providers. Currently the Department only has capacity to research claims or prior authorizations when a provider approaches the Department with escalated claims issues for HCBS providers only. This work often requires long hours reviewing claims and pulling data to advance resolutions. This position would take a proactive approach to researching claims, anticipating needed changes to the claims engine, and working across the Department to ensure that the changes get completed in alignment with policy rules. Further, the role would support staff in implementing new programs with work extending to updating billing manuals, updating web content, and providing as-needed provider enrollment support. This position would work to develop meaningful and actionable performance measures to ensure providers are providing services in the least restrictive and costly manners.

Wage Pass-Through Monitoring

The Department requests 1.0 FTE dedicated to conducting ongoing financial reviews of wage pass-through requirements for home care providers. SB 19-238 "Improve Wages and Accountability of Home Care Workers" required the Department to increase the reimbursement rate for certain home and community-based services and for provider agencies to pass-through the increased funding to the direct care staff providing the services and to report how the funds were used to the Department. The Department is required to monitor these 400 providers to ensure that the increases are being passed through and recover any funds that were not passed through as required. The Department does not have the capacity to monitor these providers with existing staff resources. The requested FTE would be responsible for developing a provider reporting tool,

monitoring and reviewing provider reports, and establishing requirements for and conducting ongoing financial reviews. Likewise, the requested FTE would be responsible for enforcing requirements for non-compliant agencies. This enforcement would include, but not be limited to, conducting desk and onsite reviews, making determinations of non-compliance, issuing corrective action, reviewing and responding to informal reconsiderations and appeals, and recoupment of funds as necessary. The requested FTE would work to ensure that the providers pass-through the funds, which ultimately benefits the direct care workforce.

The Department also requests a supplemental travel budget for these FTE. As a regular component of the position's workload, regular overnight travel would be required. Based on historical travel budgets for similar positions, the Departments requests an additional $6,250 annually.

Cost Allocation and Federal and State Reporting

The Department requests 2.0 FTE to address financial reporting oversight and compliance concerns. As the single state Medicaid agency, all funding that receives a federal Medicaid match must flow through the Department. The Department must also maintain a federally approved cost allocation plan for funds receiving federal financial participation. As other agencies begin to leverage federal Medicaid dollars, the financing of these programs becomes more complicated. If the funding is not properly accounted for or is not following the latest approved cost allocation plan the Department is at risk of having to pay back federal dollars, creating a potentially large General Fund impact to the State.

Cost Allocation Accountant

The Department requests 1.0 FTE to focus specifically on cost allocation. The Department does not currently have any dedicated resources performing this work. Due to the growing volume and complexity of the work, the Department needs dedicated staff to work on this work full time. Improper payments due to invalid or unapproved cost allocation plans would lead to potentially significant disallowances. Many departments around the state that manage cost allocation plans have their own unit to do so. For example, the Department of Human Services (CDHS) has a manager and six staff assigned to indirect cost accounting preparation and allocation. The Department is in a unique situation related to managing cost allocation plans due to the complexity of state financing along with the partnership with the federal government. As Department programs evolve and federal requirements change the complexity will only continue to grow.

Federal and State Reporting

The Department requests 1.0 FTE to supplement state and federal financial reporting efforts. The Department has a unit dedicated to all state and federal reporting. The functions of this unit include preparing and submitting quarterly federal reports for both Title XIX and Title XXI programs. After submission, this group is responsible for working with CMS on responding to the quarterly variance analysis and follow up questions which include audits of the Department's expenditures and the authority for those expenditures, some of which reside in the cost allocation plan. As requirements for funding have grown more complex, so too has reporting requirements. As a result, the Department has fielded an increasing number of questions year over year. In addition, the level of scrutiny from the federal level on administrative costs and claiming has increased tremendously. CMS staff are now routinely demanding that the Department provide supporting

documentation for administrative claiming. This includes scrutiny down to the individual contract and purchase order level. The regional CMS office has not historically requested this level of detail. Providing this information requires detailed reconciliation between the Public Assistance Cost Allocation Plan (PACAP) and reported administrative costs to ensure everything CMS requires is included. Reconciling between these sources and including items in the PACAP takes a tremendous amount of time. Increased CMS oversight has led to an increase in deferrals, where CMS denied federal funds until the Department can sufficiently answer questions about the expenditures. This requires additional resources and staff time to investigate and defend the Department's position. As federal reporting requirements continue to increase in complexity, the Department must develop new fiscal coding for administrative payments to meet the new system's criteria and the volume of work to complete this task is enormous. For example, for implementation of Phase II of the Accountable Care Collaborative (ACC), CMS has required a massive overhaul to the Department's reporting. This task is not just one time; once created, the fiscal coding must be maintained and adjusted for every policy change that affects fiscal reporting. The number of coding elements that would need to be maintained are more than 3,000. This workload cannot be absorbed within existing staff resources. This change would require the Department to create unique coding for each possible cost to differentiate between ACC Phase II costs and non-ACC Phase II costs. This effectively doubles the existing coding, which must be created manually.

Benefit Compliance

The Department requests 1.0 FTE to add a compliance and policy analyst to take on the additional work related to State Plan Amendments (SPAs), fiscal notes, and rule drafting and regulatory research.

Compliance and Policy Analyst

The Department currently has two compliance and policy analysts responsible for completing and submitting State Plan, waiver, and CHP+ amendments to the Centers for Medicare and Medicaid Services (CMS); CMS consults, and CMS Request for Additional Information (RAI) responses; coordinating and compiling fiscal note responses; providing guidance to staff to inform policy; ensuring policy is in compliance with state and federal regulations; addressing stakeholder feedback during the rule writing process; ensuring rules are written in plain language; easy to understand, and are enforceable; and ensuring the full breadth of the Administrative Procedure Act process is followed. In addition, these positions assist with the fee-for-service member appeals process.

Previously, the Compliance and Policy Analysts' work was limited to fee-for-service State Plan benefits. Policy staff within the Department were expected to lead the compliance work detailed above within their own areas but lacked the expertise and experience to successfully complete the work. Requests for compliance assistance have rapidly increased from across the Department and are continuing to increase. Additionally, during this time, state and federal requirements have changed, leading to more expansive and complex regulatory implementation that required more expertise. The current Compliance and Policy Analysts are leading all CMS state plan, waiver, and CHP+ amendments for the Department, as well as any Department rule requests and regulatory research. The team is overcapacity, working additional hours, and having to delay the start of work. With ever-evolving federal and state regulations and program expansions,

existing Department staff are unable to meet the demand for compliance and policy assistance across the Department. Existing staff cannot absorb this workload, as it requires specific legal education (such as a graduate law degree or specialized training). Going forward, this could result in delayed implementation of initiatives or not meeting CMS timelines on amendments or RAIs. Additionally, policy staff who lack the necessary expertise may be forced to perform the work, which may lead to: policy gaps; increased CMS RAIs, significant delays in State Plan amendment approvals; rules that are not easy to understand or as enforceable; rules not being approved by the Medical Services Board (MSB); or amendments and rules that do not align with regulations. To mitigate this problem, the Department requests to add a compliance and policy analyst to the team to absorb the workload that is increasing both in volume and complexity, to ensure all compliance requirements can be met and in a timely manner.

Quality Assurance & Accountability

The Department requests 3.0 FTE and contractor funding for resources to address quality assurance measures and drive more accountability to Department vendors.

County Scorecard and Performance Management

The Department requests 1.0 FTE in FY 2020-21 for county administration review and support to lead a Medicaid Management Evaluation (ME) program which would partner and align with the Colorado Department of Human Services (CDHS) county scorecard program.

County Administrative Review Manager

The Department seeks to increase internal resources to drive accountability within the counties for quality assurance, local administration and management of the Department's programs while providing regional support specific to quality, performance, and administrative and financial oversight. This is a direct result of recent audit findings by the Office of State Auditor in the 2018 Statewide Single Audit[1]. In addition, the Department made the following commitments to the Legislative Audit Committee (LAC) to ensure the Department has robust oversight of counties, including:

1. System changes
2. Scorecards for county partners
3. Additional trainers
4. Improved incentives to counties & financing

Implementation of this request supports the second, forth, and fifth commitments made to the LAC. In addition, this request aligns with the internal county accountability workgroup that has been working towards revamping how the Department oversees and manages county partners. This group has been meeting with the Executive Director to ensure these changes are implemented.

---

1 http://leg.colorado.gov/sites/default/files/documents/audits/1801f_statewide_single_audit_fiscal_year_ended_june_30_2018.pdf

The position would be responsible for implementing a shared management evaluation review process with CDHS' Supplemental Nutrition Assistance Program (SNAP). Since over 50% of SNAP cases also include Medicaid eligibility, a shared review process ensures that both state agencies are aligned in our oversight of counties. The FTE would work directly with other Department staff, CDHS and county partners to coordinate the review and compliance with county administrative requirements, quality and performance metrics and county expenditures for eligible reimbursements. The reviews of other administrative requirements that are placed on counties by the Department would also be included. Additionally, the FTE would work with the counties to implement and review Corrective Action Plans for administration, performance, quality and financial requirements. The position would work directly with county partners and coordinate the review of county expenditures for eligible reimbursements and the review of other administrative requirements that are placed on counties by the Department. Additionally, they would work with the counties to review process documentation for accuracy and completeness and ensure all required trainings are completed in a timely manner.

The Department also requests a $50,000 supplemental travel budget to address the travel costs that are anticipated with the implementation of the Management Evaluation program. The Department is in the planning/implementation stages of the ME program and expects to redirect existing FTE to focus on the ME program. These FTE are currently in various offices within the Department and are performing various oversight functions related to county work. They would continue to provide oversight of the counties, but in a more structured manner to align and partner with the CDHS SNAP ME program. Once these FTE begin to focus on the ME program, it is anticipated they would participate in more onsite reviews. This would result in more overnight stays and travel costs.

Contract and Rate Review

The Department requests 2.0 FTE and contractor funding in FY 2020-21 to drive more quality and accountability to the rate review and contract pricing processes.

MPRRAC Rate Review Analyst

Per SB 15-228 "Medicaid Provider Rate Review", the Department must review and provide recommendations for services to ensure provider retention, access to care, and quality of care. At any given time, the Department is working to implement prior year recommendations, conclude the most recent year of review, and prepare for the next year of review. The analyses results can be indicative of potential access issues, but are often not in-depth enough to be conclusive of whether there are access issues or determine the root cause of those access issues, both of which are critical for informing appropriate recommendations. Analyses typically generate more questions from the Department, Medicaid Provider Rate Review Advisory Committee (MPRRAC), and stakeholders, that require additional evaluation. Department staff do not have capacity to start the next year of review analyses, generate recommendations and draft the Recommendation Report, and complete multiple evaluation projects related to the current year of review.

Presently, the Department only has capacity to devote resources to current year review and preparation of the selected services for the next year. In the Department's statutorily required rate review reports due to the

Joint Budget Committee (JBC), the Department is rarely able to provide the detailed analysis that is appropriate because of the resource deficiency. The additional FTE would be dedicated to this in-depth research and evaluation and contribute findings to the May 1 Analysis Report, the November 1 Recommendation Report, and supplemental reports. Additionally, the FTE would be responsible for overseeing the implementation of all prior year recommendations implementation and status reports. This would allow for a more comprehensive evaluation and reporting, more informed recommendations, and quicker implementation of recommendations, all of which are desired by the MPRRAC, stakeholders and the Department. The position would also conduct additional stakeholder outreach and quantitative and qualitative research surrounding the rate review process.

The Department also requests a supplemental travel budget for this FTE. As a regular component of the position's workload, regular overnight travel would be required. Based on historical travel budgets for similar positions, the Departments requests an additional $6,250 per position annually.

MPRRAC Rate Review Contractor

The Department requests $250,000 total funds for contract funding to enhance quantitative and qualitative research and evaluation. For example, this funding would allow additional Medicaid-specific questions to be added to statewide surveys administered by other organizations, which can cost $14,000 per question, as well as funding Medicaid-specific data analysis for the Department by these same organizations conducting the research. Other examples include funding cold calls to evaluate acceptance of new Medicaid members or additional stakeholder engagement and renting facility space when convening stakeholders in different regions of the state. This would enable the Department to assess Medicaid-specific barriers to care, such as child care, cultural competency of providers, bus routes, etc., as well as populations-specific analysis, such as, individuals on waivers, or immigrants. These surveys and analysis are often very high level, but the additional funding would allow a more granular review. Current funding is used to contract with outside actuaries to conduct rate comparison activities.

Contract Rate Analyst

The Department requests 1.0 FTE in FY 2020-21 to serve as a contract rate pricing analyst. The Department is committed to developing a process to deliver consistent contract pricing across the Department. This process would ensure consistent coordination Department-wide and ensure contract costs reflect the deliverables and that deliverables are bundled correctly for the most cost-effective contracts to the State. Historically, the procurement process has been that the vendor would indicate the price needed to perform the work and the Department has accepted that price, without further verification or validation of market costs for those services. The Department anticipates that there are savings to be had if it takes a more active role in pricing and writing out contracts. The Department has created a process to consistently price vendor contracts. This process uses industry standards on costs and profits and allows the Department to negotiate contracts with a better idea of what the vendor costs are. This contract pricing structure allows for transparent pricing that can be easily tracked and documented, which ultimately translates into more accountability to the vendor. The model created is fluid so if the vendor does not believe the deliverables can be completed within the Department estimated budget, there is room for negotiation if the vendor is able to defend their

cost assumptions. The Department has approximately 400 contracts, each of which requires individual pricing to ensure appropriate reimbursement.

Systems Implementation & Management

The Department requests contractor funding in FY 2020-21 to drive more accountability and management when implementing Medicaid Management Information System (MMIS) changes. The Department requests contract funding for the MMIS vendor to hire six configuration staff members. Vendor configuration staff are responsible for documenting the policy and defining and implementing MMIS change request requirements. Configuration staff are critical to ensuring that MMIS system change requests are deployed quickly and correctly. Rapidly changing policy creates a challenge for the Department to design, test, and implement system changes as policy and interpretations change rapidly. The configuration staff that design and implement the changes are often tasked with handling multiple change orders concurrently. This may result in early deployment that does not solve the intended problem or delays on critical updates. This ultimately cause re-work, which delays the queue of system changes. The inability to implement these changes timely may result in state or federal penalties. Current staffing levels with the MMIS vendor only support the status quo and they do not have the available resources that can be dedicated to the additional level of detail the Department expects. Without this funding, the Department would continue to experience extended implementation timelines, as a result of staff re-work which would continue to further delay other projects. Delays on policy updates could result in improper payments. More timely updates to correct system configurations ultimately results in savings to the Department.

Benefit Management

The Department requests 2.0 FTE for resources to improve child health policy and benefit management. Because these resources are for the CHP+ program, the Department would transfer money from the dedicated Children's Basic Health Plan Administration line item resulting in no fiscal impact for these new staff.

Children's Basic Health Plan

The Department requests to add 2.0 FTE to more strategically advance managed care performance in the Children's Basic Health Plan, commonly referred to as the Child Health Plan Plus (CHP+). The addition of these resources would be budget neutral because the Department assumes a corresponding decrease to the Children's Basic Health Plan Administration appropriation as an offset of these two positions. The Department has an appropriation, primarily cash and federally funded to pay for administrative functions exclusively related to CHP+. The cash fund, Children's Basic Health Plan Trust (CHP+ Trust), with is primarily funded through tobacco settlement monies pays for the state's share of those costs. State statute permits expenses that support CHP+ to be paid for with those funds. Because these FTE would only support CHP+ activities and there is available funding within the appropriation to pay these costs, the Department can fund these two FTE through a realignment of funding between line items. Those FTE are responsible for managing the five managed care organization contracts and maintaining compliance with federal and state regulations. This leaves no resources for the Department to pursue and implement strategic enhancements to drive down costs while improving member outcomes.

CHP+ Benefit Specialist

One of the requested positions would be a CHP+ Benefit Specialist that would be charged with defining and managing the CHP+ benefit, including both the fee-for-service and managed care components. A major focus of the position would be to drive long-term affordability and sustainability. The CHP+ benefit has not received major redesign efforts in several years. With the program reauthorization last year for an extended ten-year period, the Department wants to leverage the extended timeframe to implement strategic enhancements that improve Department oversight and overall program efficiency. The benefits specialist would lead efforts to implement real-time, mandatory enrollment into the CHP+ MCOs, including for pregnant women, as well as the redesign of the State Managed Care Network (SMCN). The SMCN is essentially a fee-for-service delivery system where CHP+ members can receive services if they chose to opt out of an MCO or once they receive eligibility and have not chosen an MCO. The Department has identified opportunities for efficiencies and cost savings within the SMCN by either redesigning the current vendor run and managed benefit or by potentially managing the SMCN within the Department.

CHP+ Quality and Program Integrity Specialist

The Department seeks a CHP+ quality and program integrity resource to design and implement a quality and outcomes focused strategy to improve member health and reduce costs to the State. The FTE would lead efforts to implement new federally identified quality measures as well as an incentive payment program when quality goals are met. This position would also assist with aligning performance measurement and quality components of CHP+ managing contracts with the Accountable Care Collaborative (ACC) contracts and federal regulations. Additionally, this position would ensure CHP+ health plan compliance with the Mental Health Parity and Addiction Equity Act and recent federal and state regulations, including the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act and HB 19-1269 "Mental Health Parity Insurance Medicaid".

Connection to Department Performance Plan and Consequences if not Funded

This request ties directly to Pillar 5 of the Department's Performance Plan, Operational Excellence. Specifically, the resources requested drive compliant, efficient, and effective business practices that are person- and family-centered. The initiatives within this request also represent a direct implementation of Departmental core values, especially continuous improvement, transparency and accountability.

If this request is not approved, this would leave the Department with inadequate resources to effectively monitor the compliance of its programs. Failure to remain in compliance with federal requirements may result in the disallowance of federal funds, directly impacting state General Fund. The Department has tried to maintain the workload within existing resources, but it has become apparent that the growing programs can no longer be managed effectively within existing resources.

Anticipated Outcomes:

Approval of this request would put measures in place to ensure that Department's members have their medical needs met and that each member's well-being and quality of life are appropriately considered. The increase in compliance and oversight funding would also assure that providers are correctly billing the

Department for member services and that member benefits are correctly priced, both of which would reduce fraud, waste and abuse within the Medicaid program.

Assumptions and Calculations:

Where applicable, notable assumptions for each calculation have been shown in the 'Proposed Solution' section of this document. The Department has included detailed calculations used to determine the fiscal impact for each initiative in the appendix.

Table 1.1 FY 2020-21 Department FTE Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$882,686	11.5	$297,967	$118,699	$0	$466,020	4 - FTE Calculations Table
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$120,504	0.0	$40,568	$16,093	$0	$63,843	4 - FTE Calculations Table
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,336	0.0	$448	$180	$0	$708	4 - FTE Calculations Table
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$39,284	0.0	$13,261	$5,282	$0	$20,741	4 - FTE Calculations Table
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$39,284	0.0	$13,261	$5,282	$0	$20,741	4 - FTE Calculations Table
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$149,086	0.0	$53,467	$19,055	$0	$76,564	4 - FTE Calculations Table
G	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$250,000	0.0	$125,000	$0	$0	$125,000	Table 2.1, Row I
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information Systems Maintenance and Projects	$1,785,264	0.0	$114,114	$88,107	$0	$1,583,043	Table 2.1, Row K
I	(5) Indigent Care Program; Children's Basic Health Plan Administration	($181,859)	0.0	$0	($58,412)	$0	($123,447)	Table 2.1, Row N
J	**Total Request**	**$3,085,585**	**11.5**	**$658,086**	**$194,286**	**$0**	**$2,233,213**	**Sum of Rows A through I**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund and Children's Basic Health Plan Trust.

Table 1.2 FY 2021-22 Department FTE Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$918,030	12.0	$309,903	$127,584	$0	$480,543	4 - FTE Calculations Table
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$120,504	0.0	$40,568	$16,671	$0	$63,265	4 - FTE Calculations Table
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,390	0.0	$469	$193	$0	$728	4 - FTE Calculations Table
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$40,854	0.0	$13,791	$5,677	$0	$21,386	4 - FTE Calculations Table
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$40,854	0.0	$13,791	$5,677	$0	$21,386	4 - FTE Calculations Table
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$92,650	0.0	$34,463	$11,577	$0	$46,610	4 - FTE Calculations Table
G	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$250,000	0.0	$125,000	$0	$0	$125,000	Table 2.2, Row I
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information Systems Maintenance and Projects	$1,824,202	0.0	$116,603	$93,180	$0	$1,614,419	Table 2.2, Row K
I	(5) Indigent Care Program; Children's Basic Health Plan Administration	($178,475)	0.0	$0	($62,466)	$0	($116,009)	Table 2.2, Row N
J	**Total Request**	**$3,110,009**	**12.0**	**$654,588**	**$198,093**	**$0**	**$2,257,328**	**Sum of Rows A through I**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund and Children's Basic Health Plan Trust.

Table 1.2 FY 2022-23 & Ongoing Department FTE Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$918,030	12.0	$309,903	$127,584	$0	$480,543	4 - FTE Calculations Table
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$120,504	0.0	$40,568	$16,671	$0	$63,265	4 - FTE Calculations Table
C	(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,390	0.0	$469	$193	$0	$728	4 - FTE Calculations Table
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$40,854	0.0	$13,791	$5,677	$0	$21,386	4 - FTE Calculations Table
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$40,854	0.0	$13,791	$5,677	$0	$21,386	4 - FTE Calculations Table
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$92,650	0.0	$34,463	$11,577	$0	$46,610	4 - FTE Calculations Table
G	(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$250,000	0.0	$125,000	$0	$0	$125,000	Table 2.3, Row I
H	(1) Executive Director's Office; (C) Information Technology Contracts and Projects; Medicaid Management Information Systems Maintenance and Projects	$1,864,013	0.0	$119,148	$95,214	$0	$1,649,652	Table 2.3, Row K
I	(5) Indigent Care Program; Children's Basic Health Plan Administration	($178,475)	0.0	$0	($62,466)	$0	($116,009)	Table 2.3, Row N
J	**Total Request**	**$3,149,820**	**12.0**	**$657,133**	**$200,127**	**$0**	**$2,292,561**	**Sum of Rows A through I**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund and Children's Basic Health Plan Trust.

Table 2.1 FY 2020-21 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	**Compliance & Oversight**	**$701,393**	**6.7**	**$300,337**	**$50,351**	**$0**	**$350,705**	**50.00%**	**Sum of Rows B through Row E**
B	Long-Term Services & Support	$386,691	3.8	$193,338	$0	$0	$193,353	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
C	Cost Allocation	$102,436	1.0	$34,829	$16,389	$0	$51,218	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
D	Federal & State Reporting	$102,435	1.0	$34,828	$16,389	$0	$51,218	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
E	Benefits Compliance	$109,831	1.0	$37,342	$17,573	$0	$54,916	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
F	**Quality Assurance & Accountability**	**$2,384,192**	**2.9**	**$357,749**	**$143,935**	**$0**	**$1,882,508**	**78.96%**	**Sum of Row G through Row K**
G	County Scorecard & Performance Management - FTE	$166,081	1.0	$56,467	$26,573	$0	$83,041	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
H	MPRRAC Rate Review - FTE	$97,177	1.0	$33,040	$15,548	$0	$48,589	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
I	MPRRAC Rate Review - Contractor	$250,000	0.0	$125,000	$0	$0	$125,000	50.00%	Table 3.1, Row A
J	Contract Rate Analyst	$85,670	1.0	$29,128	$13,707	$0	$42,835	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
K	Business Analyst - Contractor	$1,785,264	0.0	$114,114	$88,107	$0	$1,583,043	88.67%	Table 3.2, Row D
L	**Benefits Management**	**$0**	**1.9**	**$0**	**$0**	**$0**	**$0**	**0.00%**	**Row M + Row N**
M	Children's Basic Health Plan Unit	$181,859	1.9	$0	$58,412	$0	$123,447	67.88%	4 FTE Calculations Tab - See Narrative for Methodology
N	Offset to CHP+ Administration	($181,859)	0.0	$0	($58,412)	$0	($123,447)	67.88%	- (Row M)
O	**Total Request**	**$3,085,585**	**11.5**	**$658,086**	**$194,286**	**$0**	**$2,233,213**	**72.38%**	**Row A + Row F + Row L**

Table 2.2 FY 2021-22 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	**Compliance & Oversight**	**$691,405**	**7.0**	**$295,888**	**$49,809**	**$0**	**$345,708**	**50.00%**	**Sum of Rows B through Row E**
B	Long-Term Services & Supports	$380,097	4.0	$190,043	$0	$0	$190,054	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
C	Cost Allocation	$101,207	1.0	$34,410	$16,193	$0	$50,604	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
D	Federal & State Reporting	$101,207	1.0	$34,410	$16,193	$0	$50,604	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
E	Benefits Compliance	$108,894	1.0	$37,025	$17,423	$0	$54,446	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
F	**Quality Assurance & Accountability**	**$2,418,604**	**3.0**	**$358,700**	**$148,284**	**$0**	**$1,911,620**	**79.04%**	**Sum of Row G through Row K**
G	County Scorecard & Performance Management - FTE	$165,145	1.0	$56,151	$26,423	$0	$82,571	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
H	MPRRAC Rate Review - FTE	$95,488	1.0	$32,465	$15,278	$0	$47,745	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
I	MPRRAC Rate Review - Contractor	$250,000	0.0	$125,000	$0	$0	$125,000	50.00%	Table 3.1, Row A
J	Contract Rate Analyst	$83,769	1.0	$28,481	$13,403	$0	$41,885	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
K	Business Analyst - Contractor	$1,824,202	0.0	$116,603	$93,180	$0	$1,614,419	88.50%	Table 3.2, Row D
L	**Benefits Management**	**$0**	**2.0**	**$0**	**$0**	**$0**	**$0**	**0.00%**	**Row M + Row N**
M	Children's Basic Health Plan Unit	$178,475	2.0	$0	$62,466	$0	$116,009	65.00%	4 FTE Calculations Tab - See Narrative for Methodology
N	Offset to CHP+ Administration	($178,475)	0.0	$0	($62,466)	$0	($116,009)	65.00%	- (Row M)
O	**Total Request**	**$3,110,009**	**12.0**	**$654,588**	**$198,093**	**$0**	**$2,257,328**	**72.58%**	**Row A + Row F + Row L**

Table 2.3 FY 2022-23 & Ongoing Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	**Compliance & Oversight**	**$691,405**	**7.0**	**$295,888**	**$49,809**	**$0**	**$345,708**	**50.00%**	**Sum of Rows B through Row E**
B	Long-Term Services & Supports	$380,097	4.0	$190,043	$0	$0	$190,054	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
C	Cost Allocation	$101,207	1.0	$34,410	$16,193	$0	$50,604	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
D	Federal & State Reporting	$101,207	1.0	$34,410	$16,193	$0	$50,604	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
E	Benefits Compliance	$108,894	1.0	$37,025	$17,423	$0	$54,446	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
F	**Quality Assurance & Accountability**	**$2,458,415**	**3.0**	**$361,245**	**$150,318**	**$0**	**$1,946,853**	**79.19%**	**Sum of Row G through Row K**
G	County Scorecard & Performance Management - FTE	$165,145	1.0	$56,151	$26,423	$0	$82,571	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
H	MPRRAC Rate Review - FTE	$95,488	1.0	$32,465	$15,278	$0	$47,745	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
I	MPRRAC Rate Review - Contractor	$250,000	0.0	$125,000	$0	$0	$125,000	50.00%	Table 3.1, Row A
J	Contract Rate Analyst	$83,769	1.0	$28,481	$13,403	$0	$41,885	50.00%	4 FTE Calculations Tab - See Narrative for Methodology
K	Business Analyst - Contractor	$1,864,013	0.0	$119,148	$95,214	$0	$1,649,652	88.50%	Table 3.2, Row D
L	**Benefits Management**	**$0**	**2.0**	**$0**	**$0**	**$0**	**$0**	**0.00%**	**Row M + Row N**
M	Children's Basic Health Plan Unit	$178,475	2.0	$0	$62,466	$0	$116,009	65.00%	4 FTE Calculations Tab - See Narrative for Methodology
N	Offset to CHP+ Administration	($178,475)	0.0	$0	($62,466)	$0	($116,009)	65.00%	- (Row M)
O	**Total Request**	**$3,149,820**	**12.0**	**$657,133**	**$200,127**	**$0**	**$2,292,561**	**72.78%**	**Row A + Row F + Row L**

Table 3.1: Rate Review Operating Funding						
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23 & Ongoing**	**FFP**	**Notes / Calcualations**
A	Contractor Funding	$250,000	$250,000	$250,000	50%	Estimate based on similar Deaprtment Contracts

Table 3.2: InterChange Configuration Staff Funding						
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FFP**	**Notes / Calcualations**
A	Configuration staff	6	6	6		Staff Requested
B	Cost per hour	$143.05	$146.17	$149.36		Hourly rate baed on current contract
C	Hours	2,080	2,080	2,080		Hours worked per FTE
D	Total Cost	$1,785,264	$1,824,202	$1,864,013	90%	Row A * Row B * Row C

Table 4: FTE Calculations

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR V	$3,073	1.0	$76,832	1.0	$79,908
PERA			$8,375		$8,710
AED			$3,842		$3,995
SAED			$3,842		$3,995
Medicare			$1,114		$1,159
STD			$131		$136
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, #.# FTE		**1.0**	**$104,178**	**1.0**	**$107,945**
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR IV	$2,456	2.9	$184,216	3.0	$191,592
PERA			$20,080		$20,884
AED			$9,211		$9,580
SAED			$9,211		$9,580
Medicare			$2,671		$2,778
STD			$313		$326
Health-Life-Dental			$30,126		$30,126
Subtotal Position 2, #.# FTE		**2.9**	**$255,828**	**3.0**	**$264,866**
Classification Title	Biweekly Salary	FTE		FTE	
ACCOUNTANT III	$2,832	1.9	$141,594	2.0	$147,264
PERA			$15,434		$16,052
AED			$7,080		$7,363
SAED			$7,080		$7,363
Medicare			$2,053		$2,135
STD			$241		$250
Health-Life-Dental			$20,084		$20,084
Subtotal Position 3, #.# FTE		**1.9**	**$193,566**	**2.0**	**$200,511**
Classification Title	Biweekly Salary	FTE		FTE	
POLICY ADVISOR V	$3,073	1.0	$76,832	1.0	$79,908
PERA			$8,375		$8,710
AED			$3,842		$3,995
SAED			$3,842		$3,995
Medicare			$1,114		$1,159
STD			$131		$136
Health-Life-Dental			$10,042		$10,042
Subtotal Position 4, #.# FTE		**1.0**	**$104,178**	**1.0**	**$107,945**

Classification Title	Biweekly Salary	FTE		FTE	
COMPLIANCE SPECIALIST III	$1,977	-	$0	-	$0
PERA			$0		$0
AED			$0		$0
SAED			$0		$0
Medicare			$0		$0
STD			$0		$0
Health-Life-Dental			$0		$0
Subtotal Position 5, #.# FTE		**-**	**$0**	**-**	**$0**
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR III	$1,977	1.0	$49,429	1.0	$51,408
PERA			$5,388		$5,603
AED			$2,471		$2,570
SAED			$2,471		$2,570
Medicare			$717		$745
STD			$84		$87
Health-Life-Dental			$10,042		$10,042
Subtotal Position 6, #.# FTE		**1.0**	**$70,602**	**1.0**	**$73,025**
Classification Title	Biweekly Salary	FTE		FTE	
POLICY ADVISOR IV	$2,456	-	$0	-	$0
PERA			$0		$0
AED			$0		$0
SAED			$0		$0
Medicare			$0		$0
STD			$0		$0
Health-Life-Dental			$0		$0
Subtotal Position 7, #.# FTE		**-**	**$0**	**-**	**$0**
Classification Title	Biweekly Salary	FTE		FTE	
ANALYST IV	$2,456	1.0	$61,405	1.0	$63,864
PERA			$6,693		$6,961
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$104		$109
Health-Life-Dental			$10,042		$10,042
Subtotal Position 8, #.# FTE		**1.0**	**$85,274**	**1.0**	**$88,288**
Classification Title	Biweekly Salary	FTE		FTE	
PROGRAM MANAGEMENT I	$3,073	1.0	$76,832	1.0	$79,908
PERA			$8,375		$8,710
AED			$3,842		$3,995
SAED			$3,842		$3,995
Medicare			$1,114		$1,159
STD			$131		$136
Health-Life-Dental			$10,042		$10,042
Subtotal Position 9, #.# FTE		**1.0**	**$104,178**	**1.0**	**$107,945**

Classification Title	Biweekly Salary	FTE		FTE	
COMPLIANCE SPECIALIST IV	$2,456	1.0	$61,405	1.0	$63,864
PERA			$6,693		$6,961
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$104		$109
Health-Life-Dental			$10,042		$10,042
Subtotal Position 11, #.# FTE		**1.0**	**$85,274**	**1.0**	**$88,288**
Classification Title	Biweekly Salary	FTE		FTE	
RATE/FINANCIAL ANLYST II	$2,285	1.0	$57,113	1.0	$59,400
PERA			$6,225		$6,475
AED			$2,856		$2,970
SAED			$2,856		$2,970
Medicare			$828		$861
STD			$97		$101
Health-Life-Dental			$10,042		$10,042
Subtotal Position 12, #.# FTE		**1.0**	**$80,017**	**1.0**	**$82,819**
Subtotal Personal Services		11.5	**$1,083,094**	12.0	**$1,121,632**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	12.0	$6,000	12.0	$6,000
Telephone Expenses	$450	12.0	$5,400	12.0	$5,400
PC, One-Time	$1,230	12.0	$14,760	-	
Office Furniture, One-Time	$3,473	12.0	$41,676	-	
Supplemental Travel	$6,250	13.0	$81,250	13.0	$81,250
Other					
Other					
Other					
Subtotal Operating Expenses			**$149,086**		**$92,650**
TOTAL REQUEST		11.5	**$1,232,180**	12.0	**$1,214,282**
	General Fund:		*$418,972*		*$412,985*
	Cash funds:		*$164,591*		*$167,379*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$648,617*		*$633,918*

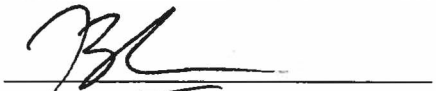
Schedule 13

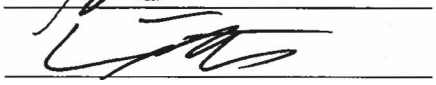
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-09 Bundled Payments

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,041,836,169**	**$0**	**$8,067,168,372**	**$743,065**	**$65,915**
	FTE	500.0	0.0	504.1	1.9	2.0
	GF	$2,319,338,108	$0	$2,329,173,946	$63,224	($35,320)
	CF	$997,104,608	$0	$998,896,068	$68,307	$53,276
	RF	$91,709,248	$0	$91,596,531	$0	$0
	FF	$4,633,684,205	$0	$4,647,501,827	$611,534	$47,959

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$142,306**	**$148,005**
	FTE	500.0	0.0	504.1	1.9	2.0
	GF	$13,478,948	$0	$14,470,561	$46,961	$48,841
	CF	$3,571,232	$0	$3,714,633	$24,192	$25,161
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$71,153	$74,003
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$20,084**	**$20,084**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$6,628	$6,628
	CF	$421,237	$0	$525,947	$3,414	$3,414
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$10,042	$10,042

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$215**	**$224**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$70	$74
	CF	$5,301	$0	$5,495	$37	$38
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$108	$112
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$6,333**	**$6,587**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$2,089	$2,173
	CF	$159,398	$0	$166,329	$1,077	$1,120
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$3,167	$3,294
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$6,333**	**$6,587**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$2,089	$2,173
	CF	$159,398	$0	$166,329	$1,077	$1,120
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$3,167	$3,294
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$6,530**	**$1,900**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$1,014,866	$0	$939,016	$2,155	$627
	CF	$243,961	$0	$197,797	$1,110	$323
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$3,265	$950
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$100,000**	**$100,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	GF	$6,015,380	$0	$4,503,802	$33,000	$33,000
	CF	$2,615,231	$0	$2,547,721	$17,000	$17,000
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$50,000	$50,000

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$74,893,151**	**$0**	**$80,930,645**	**$600,000**	**$60,000**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,972,677	$0	$11,030,317	$39,600	$9,900
	CF	$6,385,552	$0	$6,963,036	$20,400	$5,100
	RF	$12,204	$0	$12,204	$0	$0
	FF	$58,522,718	$0	$62,925,088	$540,000	$45,000
	Total	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($138,736)**	**($277,472)**
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($69,368)	($138,736)
	CF	$983,543,298	$0	$984,608,781	$0	$0
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($69,368)	($138,736)

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-9
Request Detail: Bundled Payments

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$743,065**	**$65,915**
FTE	0.0	1.9	2.0
General Fund	$0	$63,224	($35,320)
Cash Funds	$0	$68,307	$53,276
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$611,534	$47,959

Summary of Request:

The Department requests an increase of $743,065 total funds, including $63,224 General Fund, $68,307 cash funds, and 1.9 FTE in FY 2020-21 and $65,915 total funds, including a decrease of $35,320 General Fund, an increase of $53,276 cash funds, and 2.0 FTE in FY 2021-22 and ongoing to implement a bundled payment methodology for certain episodes of care. The Department's requested cash fund funding includes the Healthcare Affordability and Sustainability Fee cash fund. This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

Colorado's Medicaid program currently provides health care access to about 1.3 million people with a budget of $10.7 billion. The Department spends the majority of its budget to pay providers who deliver services to Medicaid members. Most providers are paid on a fee-for-service basis, meaning the Department pays for each incurred service based on a set rate.

In recent years, the General Assembly has authorized the Department to establish modern payment methodologies within the Medicaid program and created processes to ensure the adequacy of payment rates. Key examples include HB 12-1281, which created a process for the Department to implement payment reform pilot programs within the Accountable Care Collaborative, SB 15-228, which established the Medicaid Payment Rate Review Advisory Committee, and HB 17-1353 which defined the Accountable Care Collaborative in statute and authorized the Department to implement performance-based payments for Medicaid providers. As a result of these, and other initiatives, the Department has enrolled all members in a regional organization that helps members make sure they get the health care and services they need[1]; established a rate review advisory committee and analysis process to determine where rates are inadequate and are inhibiting access to care[2]; and, is developing new payment methodologies that move away from traditional fee-for-service payments and towards payment structures that provide payments based on the provider's performance.[3]

Further, the Department continues to provide resources to providers to help control costs and identify unnecessary or duplicative care. In SB 18-266, the General Assembly provided the Department resources to, among other things, provide information to providers participating in the Accountable Care Collaborative regarding the cost and quality of medical services provided by hospitals and other Medicaid providers. In FY 2018-19, the Department rolled out a suite of powerful cost and quality assessment capabilities through the PROMETHEUS Analytics tool to the seven Regional Accountable Entities (RAEs) responsible for coordinating care for Medicaid members, hospitals, and primary care providers. The tool identifies costs incurred for potentially avoidable complications (PACs) during episodes of care, which can then be rolled up to identify opportunities at the individual physician, primary care medical home, specialist, and hospital levels. Ultimately, this toolset enables providers to improve their referral patterns towards more cost effective, higher quality physicians and hospitals, enables hospitals to identify and self-correct inefficient, lower quality care delivery, and enables the Department to direct members seeking provider locator services to higher performing providers. PROMETHEUS Analytics explains, "PACs were created to determine the amount of unexplainable variation in total costs of care that could be reasonably attributed to complications under the control of providers and can be used to create incentives for both cost-saving and for quality analysis."[4]

---

[1] https://www.healthfirstcolorado.com/health-first-colorado-regional-organizations/

[2] https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

[3] https://www.colorado.gov/pacific/hcpf/primary-care-payment-reform-3

[4] http://prometheusanalytics.net/deeper-dive/potentially-avoidable-complications

Problem or Opportunity:

The implementation of complex payment methodologies, such as bundled payments, require additional administrative costs to calculate and administer. Without additional appropriations for staff and support, the Department is unable to alter payment methodologies. Aligning payment with high-value services are critical components in ensuring members have sufficient access to care, that quality outcomes are achieved, and that services provided are cost effective. The Department has an opportunity to address these goals by implementing bundled payment methodologies for certain episodes of care.

Proposed Solution:

The Department requests an increase of $743,065 total funds, including $63,224 General Fund and 1.9 FTE in FY 2020-21 and $65,915 total funds, including a decrease of $35,320 General Fund and 2.0 FTE in FY 2021-22 and ongoing to implement a bundled payment methodology for certain episodes of care. If this request is not funded, the Department would lack the resources necessary to implement bundled payments.

The Department would initially target maternity episodes for the bundled payments. A bundled payment methodology incentivizes providers to serve members in a more cohesive manner through a treatment episode and to reduce expenditure on potentially avoidable complications during that episode. Currently, Medicaid pays providers each time a service is delivered without regard to any other services the member is receiving for his or her condition. If a member is pregnant, for example, Medicaid pays the following providers separately: the obstetrician for prenatal visits, delivering the baby, and post-natal visits; the radiologist for ultrasounds; the laboratory for bloodwork and urine tests; and the hospital for the facility charges during the delivery. If separate physicians serve the member for prenatal visits and the delivery, the Department would pay for those claims separately. This creates silos in the care experience, even though they are all treating the same medical condition.

Under a bundled payment methodology, the Department would set a target budget for the entire maternity episode, including all services related to that condition. The Department would hold the main care provider accountable to that budget – for maternity services, this would likely be a hospital, but for another episode it might be a community mental health center or a physician. The budget would be based on historical average expenditure for the episode, with a targeted reduction to the costs associated with potentially avoidable complications (PACs) for that episode, as calculated by the PROMETHEUS Analytics tool. An example of a PAC for a maternity episode would be post-operative wound infection after a caesarean delivery. The budget set for a participating provider would include some target level of reduction in costs for these types of complications, incentivizing the provider to provide evidence-based treatment and refer members to the highest performing specialty providers in order to reduce expenditure on PACs in that year. This would result in costs avoided for the Department in the short term as providers adapt changes to their treatment plans to achieve the pre-determined budgets for the episodes.

The Department would continue to pay providers based on submitted claims, but after the episode is naturally completed, such as after the postpartum period for maternity, the Department would reconcile actual expenditures for each service to the budget. If expenditures were higher than the budget, the main care

provider would owe the Department all or part of the difference. If expenditures were lower than the budget, the Department would share savings with the main care provider.

The Department plans to implement maternity bundles in FY 2020-21. In FY 2021-22, the Department would reconcile expenditure on actual services incurred during the episode for those providers that participated. In that year, the Department would only include upside risk – i.e., there would be shared savings but no penalty if providers spent over the budget. Over time, the Department would incorporate more downside risk in the bundles. The Department would investigate other episodes to target in future years. The bundled payments would be an option for providers statewide, but would remain a voluntary contract arrangement.

Bundled payments incentivize providers to coordinate care and deliver evidence-based care to members, which fits with the Department's FY 2019-20 Performance Plan Pillar 3 to improve health outcomes for members. This methodology also ensures providers are delivering the right services to people at the right price, which fits with Pillar 2 to control costs in the Medicaid program.

Anticipated Outcomes:

The Department anticipates that implementing bundled payments for episodes of care would result in cost savings as participating providers coordinate care for their patients with other key providers to reduce expenditure on potentially avoidable complications from the episode. These savings would be realized in the short term as providers work to lower overall costs on services related to the episodes. This would also result in better health outcomes for members, as it shifts providers towards a more cohesive approach to treating the episode.

There is evidence that an episode-based payment system has been effective for maternity episodes. Harvard School of Medicine[5] conducted a difference-in-differences analysis of perinatal spending within large commercial insurance providers in Arkansas and neighboring control states before and after the Arkansas insurance providers implemented an episode-based payment model for perinatal services. The report concluded that after the model's implementation, intrapartum facility spending decreased by 6.6% and postpartum spending decreased by 15.9%, while all other changes to maternity spending were statistically insignificant. Since intrapartum facility spending accounted for half of spending and postpartum spending accounted for only small portion of spending before implementation, most of the savings resulted from changes to intrapartum facility spending.

The report further concluded that the decrease in intrapartum facility spending did not result from fewer services being provided but rather from the price of the services dropping due to primary providers referring members to lower priced secondary facilities. From previous studies that have found little correlation between

[5] (Harvard School of Medicine, 2018) Effects of Episode-Based Payment on Health Care Spending and Utilization: Evidence from Perinatal Care in Arkansas, https://scholar.harvard.edu/files/ccarroll/files/carroll_etal_ebp_2018.pdf

facility prices and health outcomes,[6] the report concludes that this change in referral patterns was unlikely to have affected health outcomes.

Among Medicaid programs that have an active or developing episode-based payment system, including Arkansas, Connecticut, Ohio, Oklahoma, New York, and Tennessee, all them offer or require the methodology to be used for maternity services. Data is available for Arkansas and Tennessee's programs. Based on preliminary data, Arkansas has seen a 3.8% drop in perinatal episode expenditure and Tennessee has seen a 7.7% drop.[7]

Assumptions and Calculations:

Please see Appendix A for detailed calculations on all components.

The Department is using existing funds in FY 2019-20 to begin working on implementing bundled payments for maternity services. The Department assumes that over the course of FY 2019-20, it would gain approval from the Centers for Medicare and Medicaid Services (CMS) for the methodology change, execute contracts with participating providers, set budgets for each provider, and be ready to implement the initiative on July 1, 2020. In FY 2021-22, the Department would reconcile expenditure for participating providers to the budgets. The Department assumes that in the first few years of implementation, only three large providers would participate. These providers would have the most potential for shared savings by participating. The Department would work on the planning and development for the next episode of care in FY 2020-21.

Administrative Resources

To implement bundled payments, the Department would need administrative resources to design the bundles, clear the methodology with CMS, contract with providers that want to participate, push relevant claims data to participating providers, and reconcile the payments retroactively. The Department would need two FTE to maintain the bundled payment methodology. The Department would also need funding to create a data interface between the reporting layer of the claims system and the participating providers, as well as contractor funding for an actuary to assist the Department with calculating the budgets for the bundles.

One FTE would be a rate/financial analyst. This position would set the budgets for the episodes, which requires in depth analysis of claims data of current payments for services related to an episode, separated by typical costs for the episode and expenditure on PACs. The position would work with the actuary to ensure the budget is reasonable and with affected providers to reach agreement on the budget. The position would

---

[6] 1. Cooper, Z., Craig, S., Gaynor, M., and Van Reenan, J. (2015). The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. NBER Working Paper, 21815.

2. Ho, K. and Pakes, A. (2014a). Hospital Choices, Hospital Prices, and Financial Incentives to Physicians. American Economic Review, 104(12):3841–3884.

3. Ho, K. and Pakes, A. (2014b). Physician Payment Reform and Hospital Referrals. American Economic Review: Papers and Proceedings, 104(5):200–205.

[7] http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf

also be responsible for reconciling payments with providers based on the set budget to actual performance and either making payments with shared savings or recouping money from the provider.

The second FTE would be a contract manager responsible for setting up contracts with the participating providers and monitoring performance of the providers to ensure appropriate access to care is maintained. This position would submit the State Plan Amendment (SPA) necessary to implement the payment methodology to CMS for each episode of care. In addition, the position would investigate other potential episodes that would benefit from a bundled payment methodology through research of Medicare and other states, as well as through stakeholder meetings with Medicaid provider groups.

For participating providers to be successful at ensuring costs remain within the set budget, they would need claims data for their members on all the claims related to their episode. The Department estimates that it would need $600,000 in FY 2020-21 to implement enhanced dynamic reporting in the claims system that can be restricted to the Medicaid members attributed to that provider. This would be based on the provider's authorization via multi-factor authentication. The Department would need to provision all participating providers with access to the reporting tool. The Department estimates that it would be able to receive a 90% enhanced federal match through an Advanced Planning Document (APD) for the build out phase of the project. In FY 2021-22 and ongoing, the Department estimates that it would need $60,000 per year to maintain the tool and configure it for any new episodes of care.

The Department estimates that it would need $100,000 each year in contractor funding for its actuary. This is based on an average rate of $200 per hour for an estimated 500 hours each year. The actuary would provide support with the model development to calculate the bundles for the episodes. This is based on the scope of work for the actuary to calculate per-member per-month rates as requested in FY 2018-19 R-7, "Primary Care Alternative Payment Models," which included 875 hours of work per year. Bundled payments would be less complicated as they rely heavily on the existing PROMETHEUS Analytics tool, and the Department adjusted its estimate downward accordingly.

Savings to Episodes of Care Payments

The Department assumes that it would spend less on episodes of care through a bundled payment methodology, because the budgets for the episodes would be set with a targeted reduction to expenditure on potentially avoidable complications (PACs) and the providers would be incentivized to reduce costs incurred by members on PACs during the episode, in the short term. For maternity episodes, for example, the hospitals may decide to check in regularly with the member during the postpartum period, with the goal of preventing the member from incurring complications that lead to hospital visits and other unnecessary treatments. In the first year of implementation for each episode, the Department would target a relatively low percentage reduction of PACs. The Department estimates that the budgets would include a 10% reduction to PACs in the first year, and that participating providers would target care to achieve the reduction. The Department estimates that the budgets would include larger reductions of 15% to PACs in the second year and 20% in the third year of implementation as providers develop more effective ways to reduce expenditure on unnecessary complications. The Department estimated savings for participating providers based on the total

expenditure spent on PACs for those practices, as calculated by the PROMETHEUS Analytics tool, and the target reduction to PAC expenditure each year.

The Department would reconcile expenditure after the conclusion of the first year. The Department would share savings with participating providers, meaning that if the provider successfully reduced costs on PACs by 10% the Department would pay some share of that to the provider. The Department assumes it would share 50% of savings in this manner through the reconciliation process. In future years, the Department would incorporate downside risk for the provider. That would mean that if the provider did not reduce costs on PACs to the budgeted amount, the provider would owe the Department a share of the expenditure. This would guarantee savings to the Department in future years, even if some providers do not successfully reduce costs.

R-9 Bundled Payments
Appendix A: Calculations and Assumptions

Table 1.1: FY 2020-21 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$142,306	1.9	$46,961	$24,192	$0	$71,153	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$20,084	0.0	$6,628	$3,414	$0	$10,042	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$215	0.0	$70	$37	$0	$108	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$6,333	0.0	$2,089	$1,077	$0	$3,167	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$6,333	0.0	$2,089	$1,077	$0	$3,167	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$6,530	0.0	$2,155	$1,110	$0	$3,265	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$100,000	0.0	$33,000	$17,000	$0	$50,000	Table 2.1 Row C
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$600,000	0.0	$39,600	$20,400	$0	$540,000	Table 2.1 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($138,736)	0.0	($69,368)	$0	$0	($69,368)	Table 2.1 Row D
J	**Total Request**	**$743,065**	**1.9**	**$63,224**	**$68,307**	**$0**	**$611,534**	**Sum Rows A through I**

R-9 Bundled Payments
Appendix A: Calculations and Assumptions

Table 1.2: FY 2021-22 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$148,005	2.0	$48,841	$25,161	$0	$74,003	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$20,084	0.0	$6,628	$3,414	$0	$10,042	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$224	0.0	$74	$38	$0	$112	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$6,587	0.0	$2,173	$1,120	$0	$3,294	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$6,587	0.0	$2,173	$1,120	$0	$3,294	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$1,900	0.0	$627	$323	$0	$950	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$100,000	0.0	$33,000	$17,000	$0	$50,000	Table 2.2 Row C
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$60,000	0.0	$9,900	$5,100	$0	$45,000	Table 2.2 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($277,472)	0.0	($138,736)	$0	$0	($138,736)	Table 2.2 Row D
J	**Total Request**	**$65,915**	**2.0**	**($35,320)**	**$53,276**	**$0**	**$47,959**	**Sum Rows A through I**

Table 2.1: FY 2020-21 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
Bundled Payments for Maternity Care									
A	Department Staff	$181,801	1.9	$59,992	$30,907	$0	$90,902	50.00%	FTE Calculations
B	Data Exchange	$600,000	0.0	$39,600	$20,400	$0	$540,000	90.00%	BIDM design and development costs
C	Contractor Funding	$100,000	0.0	$33,000	$17,000	$0	$50,000	50.00%	Actuary costs
D	Savings on Episodes of Care	($138,736)	0.0	($69,368)	$0	$0	($69,368)	50.00%	Table 3, Row J
E	**Total for Bundled Payments**	**$743,065**	**1.9**	**$63,224**	**$68,307**	**$0**	**$611,534**		**Row A + Row B + Row C + Row D**

Table 2.2: FY 2021-22 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
Bundled Payments for Maternity Care									
A	Department Staff	$183,387	2.0	$60,516	$31,176	$0	$91,695	50.00%	FTE Calculations
B	Data Exchange	$60,000	0.0	$9,900	$5,100	$0	$45,000	75.00%	Ongoing data exchange costs
C	Contractor Funding	$100,000	0.0	$33,000	$17,000	$0	$50,000	50.00%	Actuary costs
D	Savings on Episodes of Care	($277,472)	0.0	($138,736)	$0	$0	($138,736)	50.00%	Table 3, Row J
E	**Total for Bundled Payments**	**$65,915**	**2.0**	**($35,320)**	**$53,276**	**$0**	**$47,959**		**Row A + Row B + Row C + Row D**

Table 3
Estimated Savings from Bundled Payment Methodology for Maternity Episodes

Row	Item	FY 2020-21	FY 2021-22	FY 2022-23	Source/Comment
A	FY 2017-18 Amount Spent on Maternity Episodes	$31,300,360	$31,300,360	$31,300,360	Prometheus tool; includes three target providers
B	Projected Caseload Trend for Pregnant Adults	26.64%	26.64%	26.64%	February 15, 2019 Forecast
C	Total Projected Amount Spent on Maternity Episodes	$39,638,776	$39,638,776	$39,638,776	Row A * (1 + Row B)
D	Average Rate of Potentially Avoidable Costs	3.50%	3.50%	3.50%	Prometheus tool
E	Amount Spent on Potentially Avoidable Costs	$1,387,357	$1,387,357	$1,387,357	Row C * Row D
F	Target Reduction in Potentially Avoidable Costs	10.00%	15.00%	20.00%	Assumed, see narrative
G	Estimated Savings from Bundle	($138,736)	($208,104)	($277,471)	Row E * Row F * -1
H	Percentage of Savings Shared with Provider	50.00%	50.00%	50.00%	Assumed, see narrative
I	Estimated Payments from Shared Savings	$0	$69,368	$104,052	Prior year's row G * Row H * -1
J	**Total Net Savings from Maternity Episodes**	**($138,736)**	**($277,472)**	**($381,523)**	**Row G - Row H**

R-9 Bundled Payments
Appendix A: Calculations and Assumptions

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
RATE/FINANCIAL ANLYST III	$2,610	1.0	$65,259	1.0	$67,872
PERA			$7,113		$7,398
AED			$3,263		$3,394
SAED			$3,263		$3,394
Medicare			$946		$984
STD			$111		$115
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, #.# FTE		**1.0**	**$89,997**	**1.0**	**$93,199**
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR IV	$2,456	1.0	$61,405	1.0	$63,864
PERA			$6,693		$6,961
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$104		$109
Health-Life-Dental			$10,042		$10,042
Subtotal Position 2, #.# FTE		**1.0**	**$85,274**	**1.0**	**$88,288**
Subtotal Personal Services		1.9	**$175,271**	2.0	**$181,487**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	1.9	$962	2.0	$1,000
Telephone Expenses	$450	1.9	$865	2.0	$900
PC, One-Time	$1,230	1.0	$1,230	-	
Office Furniture, One-Time	$3,473	1.0	$3,473	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$6,530**		**$1,900**
TOTAL REQUEST		1.9	**$181,801**	2.0	**$183,387**

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-10 Provider Rate Adjustment

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	**Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$8,686,110,626**	**$0**	**$8,705,990,436**	**$2,090,599**	**($12,175,778)**
	FTE	0.0	0.0	0.0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	$2,651,346,925	$0	$2,662,681,957	$538,753	($6,788,148)
	CF	$1,012,452,127	$0	$1,010,827,684	$266,277	$330,730
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,933,435,284	$0	$4,943,604,505	$1,285,569	($5,718,360)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$88,984,286**	**$0**	**$89,064,515**	**$258,944**	**$266,065**
01. Executive Director's Office, (D) Eligibility Determinations and Client Services, (1) Eligibility Determinations and Client Services - County Administration	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$12,590,592	$0	$12,602,060	$36,638	$37,646
	CF	$21,423,565	$0	$21,442,848	$62,343	$64,057
	RF	$0	$0	$0	$0	$0
	FF	$54,970,129	$0	$55,019,607	$159,963	$164,362
	Total	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($2,328,261)**	**($17,306,564)**
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($1,677,922)	($9,365,812)
	CF	$983,543,298	$0	$984,608,781	$220,053	$283,699
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($870,392)	($8,224,451)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$10,244,233**	**$0**	**$10,252,750**	**($281,896)**	**($298,271)**
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,363,894	$0	$2,365,859	($65,991)	($69,441)
	CF	$533,495	$0	$533,939	($18,573)	($19,757)
	RF	$0	$0	$0	$0	$0
	FF	$7,346,844	$0	$7,352,952	($197,332)	($209,073)
	Total	**$503,255,278**	**$0**	**$502,793,147**	**$1,361,049**	**$1,515,017**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Adult Comprehensive Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$248,117,256	$0	$250,596,573	$680,525	$757,508
	CF	$3,510,383	$0	$800,001	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$251,627,639	$0	$251,396,573	$680,524	$757,509
	Total	**$86,732,157**	**$0**	**$86,971,925**	**$367,768**	**$546,607**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Adult Supported Living Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$45,959,837	$0	$46,082,518	$192,733	$283,154
	CF	$2,676,085	$0	$2,676,689	$2,038	$2,268
	RF	$0	$0	$0	$0	$0
	FF	$38,096,235	$0	$38,212,718	$172,997	$261,185
	Total	**$27,062,419**	**$0**	**$27,080,575**	**$125,774**	**$199,336**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Children's Extensive Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$13,531,210	$0	$13,540,287	$62,887	$99,668
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$13,531,209	$0	$13,540,288	$62,887	$99,668
	Total	**$45,206,293**	**$0**	**$45,243,320**	**$116,183**	**$129,326**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$23,571,393	$0	$23,590,677	$60,544	$67,393
	CF	$150,346	$0	$150,471	$416	$463
	RF	$0	$0	$0	$0	$0
	FF	$21,484,554	$0	$21,502,172	$55,223	$61,470

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Family Support Services	**Total**	**$7,811,600**	**$0**	**$7,817,740**	**$19,150**	**$21,316**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,196,645	$0	$7,202,785	$19,150	$21,316
	CF	$614,955	$0	$614,955	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Preventive Dental Hygiene	**Total**	**$65,445**	**$0**	**$65,499**	**$174**	**$194**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$65,445	$0	$65,499	$174	$194
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Eligibility Determination and Waiting List Management	**Total**	**$3,197,573**	**$0**	**$3,200,203**	**$8,427**	**$9,380**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,197,573	$0	$3,200,203	$8,371	$9,318
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$56	$62
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Children's Habilitation Residential Program	**Total**	**$5,152,220**	**$0**	**$5,155,578**	**$546,946**	**$726,050**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,576,110	$0	$2,577,789	$273,473	$363,025
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,576,110	$0	$2,577,789	$273,473	$363,025
07. Department of Human Services Medicaid-Funded Programs, (C) Division of Child Welfare - Medicaid Funding, (1) Division of Child Welfare - Medicaid Funding - Child Welfare Services	**Total**	**$12,981,594**	**$0**	**$12,981,594**	**$1,896,341**	**$2,015,766**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,490,796	$0	$6,490,796	$948,171	$1,007,883
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$6,490,798	$0	$6,490,798	$948,170	$1,007,883

Auxiliary Data			
Requires Legislation?	YES		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	Impacts Other Agency

Department Priority: R-10
Request Detail: Provider Rate Adjustments

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$2,090,599**	**($12,175,778)**
FTE	0.0	0.0	0.0
General Fund	$0	$538,753	($6,788,149)
Cash Funds	$0	$266,277	$330,730
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$1,285,569	($5,718,360)

Summary of Request:

The Department requests an increase of $2,090,599 total funds, including $538,753 General Fund in FY 2020-21 and a reduction of $12,175,778 total funds, including $6,788,149 General Fund in FY 2021-22 and ongoing to adjust provider rates across several service categories. The targeted rate adjustments include an increase for personal care and homemaker, a reduction to anesthesia rates, targeted adjustments based on Department recommendations in the Medicaid Provider Rate Review Recommendation Reports, and an increase to certain family planning rates. The Department is requesting an across-the-board rate increase for providers that are not impacted by any targeted rate adjustments. The Department also requests a change to statute to eliminate automatic rate increase provisions for nursing facilities; rate increases for nursing facilities would be subject to annual appropriation by the General Assembly, in a manner consistent with how most other providers receive increases. The requested change to cash funds impacts the Healthcare Affordability and Sustainability Fee, the Breast and Cervical Cancer Prevention and Treatment Fund, the Adult Dental Fund, and local funds.

Current Program:

Colorado's Medicaid program currently provides health care access to about 1.3 million people with a budget of $10.7 billion. The Department spends the majority of its budget to pay providers who deliver services to Medicaid clients. Most providers are paid on a fee-for-service basis, meaning the Department pays for each incurred service based on a set rate. In recent years, the General Assembly has authorized the Department to ensure the adequacy of payment rates. A key example is SB 15-228, which established the Medicaid Payment Rate Review process to determine whether rates are sufficient for provider retention and access to care[1]. Pursuant to section 25.5-4-401.5, C.R.S., the Department is required to periodically perform reviews of provider rates under the Colorado Medical Assistance Act. Section 25.5-4-401.5, C.R.S. also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC) to assist in the review of provider reimbursement rates.

Section 25.5-6-202, C.R.S. outlines a comprehensive methodology for the Department to set nursing facility rates. This methodology requires the Department to annually adjust nursing facility rates based on changes in provider costs. The increase in nursing facility rates is limited by section 25.5-6-202(9)(b), C.R.S, which states that: "Except for changes in the number of patient days, the general fund share of the aggregate statewide average of the per diem rate net of patient payment… shall be limited to an annual increase of three percent." As a result, the State's reimbursement for nursing facilities increases due to rate growth by approximately 3% each year.

Because of the detailed methodology in statute, the State is obligated to provide additional funding every year to account for growth in nursing facility rates. For example, in FY 2019-20, the Department's appropriation increased by approximately $19,903,227 total funds and by $9,951,614 General Fund to account for statutorily required growth in nursing facility rates.

Very few other providers in the Medicaid program receive automatic rate increases, and other than nursing facilities, no other providers in the Medicaid program receive automatic rate increases as a result of state law. Other providers that receive automatic increases, such as pharmacies and Federally Qualified Health Centers, receive these increase because of requirements in federal law. Rate increases for other providers are subject to annual appropriation by the General Assembly.

Problem or Opportunity:

Provider rates generally do not change year-over-year unless the General Assembly appropriates funding to adjust them[2]. Without additional appropriations, rates will not increase to keep pace with inflation or adjust to follow benchmarks, such as Medicare rates. Investing in adequate provider rates and aligning payment with high-value services are critical components in ensuring clients have sufficient access to care, that quality

[1] https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

[2] Exceptions include provider rates that are set pursuant to methodologies defined in federal or state law, such as rates for nursing facilities, federally qualified health centers, and pharmacies.

outcomes are achieved, and that services provided are cost effective. The Department has an opportunity to address these goals by through a series of provider rate adjustments.

The General Assembly and the Governor also have an opportunity to reclaim control over nursing facility rate growth by amending the nursing facility statute. In the absence of a statutory change, the General Assembly is obligated to provide enough funding to account for expected rate growth, and the Governor is constrained in making proactive budgetary proposals that balance the needs of all providers and members served by Medicaid. The current statute does not permit sufficient discretion to adjust rates for nursing facilities.

Proposed Solution:

The Department requests an increase of $2,090,599 total funds, including $538,753 General Fund in FY 2020-21 and a reduction of $12,175,778 total funds, including $6,788,149 General Fund in FY 2021-22 to adjust provider rates across several service categories. The Department is also working to identify the appropriate legislative route to eliminate the automatic increase of nursing facility rates beginning in FY 2020-21.

If this request is not funded, providers would not see inflationary or targeted rate increases for FY 2020-21, which may reduce providers willingness to participate in the Medicaid program. In addition, nursing facility rates will continue to grow by approximately 3% each year under the existing statutory methodology.

Providing adequate reimbursement to providers encourages participation in Medicaid and therefore increases member access, which aligns with the Department's FY 2019-20 Performance Plan Pillar 3 to improve health outcomes for members. Further, this request links to the Department's Performance Plan "pillar" of Medicaid Cost Control by reducing the amount of automatic fiscal growth in the Medicaid program.

Targeted Rate Adjustments

Personal Care and Homemaker Inflationary Adjustments

The Department requests an increase of $4,534,519 total funds, $2,267,259 General Fund, to implement a rate increase of 2.75% to personal care and homemaker services. This rate increase ensures that attendants' wages keep up with inflationary increases in the state minimum wage and are competitive to attract, grow, and retain a quality workforce to deliver critical services.

Attendants for these services are often paid at or near minimum wage. If the rates for these services do not keep pace with rising wages around the state, potential and existing attendants would likely choose other near-minimum wage jobs over direct support professional positions because these alternatives are not as challenging emotionally and physically. This creates an access-to-care problem for clients who need to receive these services.

The requested rate increase aligns with recent actions that raise wages for personal care and homemaker services. The State passed Amendment 70 in 2016, which raised Colorado's minimum wage each year starting in 2017 until it reaches $12 an hour by 2020. Beyond 2020, the State's minimum wage is set to

increase by the rate of inflation, measured through the Consumer Price Index (CPI). The General Assembly approved a one-time increase in personal care and homemaker rates through SB 19-238 "Improve Wages and Accountability Home Care Workers" for FY 2019-20 but did not approve an ongoing adjustment for these rates for future increases in the minimum wage, as requested by the Department in FY 2019-20 R-13, "Provider Rate Adjustments." Therefore, future rate increases for these services are dependent upon additional action from the General Assembly.

Other Targeted Rate Adjustments

Anesthesia Reduction to 100% of Medicare

The Department requests a reduction of $5,977,532 total funds, $1,789,672 General Fund, to decrease anesthesia rates to 100% of the rate comparison benchmark – the 2016 Medicare conversion factor. The results of the 2017 Medicaid Provider Rate Review Analysis Report[3] revealed that the Department's payments for anesthesia services were above 100% of the benchmark. This recommendation aligns with the MPRRAC's support of the Department recommendation to reduce anesthesia rates to 100% of the benchmark. The Department requested to reduce anesthesia rates to 100% of the benchmark as part of FY 2019-20 R-13, "Provider Rate Adjustments." The General Assembly approved a partial reduction, but the rates remain well above Medicare, at 120% of the benchmark rate. The Department is requesting an additional reduction to 100% of the benchmark, in line with the MPRRAC's support of the Department recommendation.

Rebalancing Rates to Benchmark

The Department requests an increase of $1,537,727 total funds, $858,532 General Fund, to increase rates for certain services that were below 80% of the benchmark rate to that level and to decrease rates for certain services that were above 100% of the benchmark rate to that level. The affected services include: durable medical equipment (DME) services that are not subject to the Upper Payment Limit established by section 1903(i)(27) of the Social Security Act; and fee-for-service behavioral health services. Residential Child Care Facilities (RCCFs) bill from this fee schedule. Overall, this would result in a net increase to expenditure for services provided in RCCFs, and a smaller reduction to expenditure for services provided in the behavioral health fee-for-service benefit and for DME services. The MPRRAC and stakeholders noted their support of this Department recommendation.[4]

In-Home Dialysis Payment Methodology Change

The Department requests a reduction of $929,537 total funds, $292,415 General Fund, to set the rate for in-home dialysis in line with Medicare. Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) are two types of in-home dialysis that require daily treatments. Medicare accounts for each day (seven days per week) a patient received CAPD or CCPD and then applies a unit conversion calculation to arrive at the number of days (three) per week that the patient would have visited a

[3] https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report%20-%20Physician%20Services%2C%20Surgery%2C%20and%20Anesthesia.pdf

[4] https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

clinic, had they received hemodialysis in a facility setting. Medicare then reimburses providers an equivalent rate. Colorado Medicaid reimburses the same facility rate for each day a patient receives CAPD or CCPD as it does for each visit to a dialysis facility. The result is that Medicaid currently pays the facility rate for four extra days per week of CAPD or CCPD treatment than for patients receiving hemodialysis facility treatments, compared to Medicare. The Department is requesting to use a unit conversion calculation in line with Medicare, which would reduce overall expenditure for in-home dialysis. The MPRRAC and stakeholders noted their support of this Department recommendation.[5]

Adding Services to Ambulatory Surgical Centers

The Department plans to add clinically appropriate procedures for reimbursement in Ambulatory Surgical Centers (ASCs), which could increase access and utilization to certain services but at a less expensive rate than if it was performed in the outpatient hospital setting. The MPRRAC and stakeholders noted their support of this Department recommendation.[6] Any changes would be budget neutral; the Department is not requesting increases to ASC rates beyond the across-the-board rate change discussed below.

Office of Community Living Waiver Services

The Department requests an increase of $7,670,040 total funds, $3,835,020 General Fund, to increase rates for certain Home and Community Based Services (HCBS) waiver services that have been identified as having significant gaps between the current set rate and the appropriate rate for the service. The rates for these services were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report[7], which found that they varied between 36.70% and 184.58% of their relevant benchmark comparisons. The Department recommended increasing rates for waiver services as identified through the ongoing rate setting process, with special attention to services that were identified by stakeholders through the rate review process and those that have the biggest gaps, between current rates and appropriate rates developed through the Department's rate setting methodology.[8]

The Department proposes reducing the gap by 18% for alternative care facility rates, which is a 6.4% increase to the rate, and by 25% for adult day programs, which is an average increase of 19.0% across services and waivers. These services received increases in rates in previous budget cycles but remain well below the appropriate rates developed through the rate setting methodology.

The Department also proposes to increase the rates for habilitation services provided through Residential Child Care Facilities (RCCFs) in the Children's Habilitation Residential Program (CHRP) waiver. RCCFs are residential settings designed to provide 24-hour services and intensive therapeutic supports to children and youth with extreme behavior support needs. These types of intensive supports are not available in the

---

[5] ibid.

[6] ibid.

[7] https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report%20-%20HCBS%20Waivers.pdf

[8] https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Recommendation%20Report%20November%202017.pdf

other residential setting available under CHRP. Currently, the RCCF rates are the same as group home rates for the CHRP waiver, but group homes do not provide the same level of intensive therapeutic supports as RCCFs and the costs for providing services in RCCFs are higher than the current $196.33 per diem. This is a barrier to access, because RCCFs may not accept CHRP clients as the per diem rate does not cover their costs. The Department proposes to increase the rates based on the support level needed by the client and to be more consistent with rates paid to the RCCFs by the Department of Human Services.

Family Planning Rates

The Department requests $97,092 total funds, $9,709 General Fund, to increase rates for two evaluation and management codes with family planning modifiers, which indicates that the services provided focus on family planning. The Department typically sets rates for services with the family planning modifier higher than the equivalent service without the modifier in order to incentivize providers to offer family planning services. In addition, the higher rate encourages providers to include the modifier on the claim when appropriate, which allows the Department to identify the service as family planning and claim an enhanced federal match of 90%. The two codes included in this request have rates that are set lower than the equivalent service without the modifier. The Department is requesting to increase the rates for these codes to be higher than the equivalent service without the modifier, in line with the rate setting methodology of other codes.

Across-the-Board Rate Increase

The Department requests $14,126,117 total funds, $5,134,233 General Fund to implement an across-the-board (ATB) provider rate increase of 0.29% for most services that are not addressed in the other components of this request. In aggregate, the increases would help address adequacy of payments.

Nursing Facilities Rate Change

The Department requests a reduction of $18,967,827 total funds, including $9,483,914 General Fund, to account for lower nursing facility rates as compared to the base budget. This includes a reduction of $21,003,749 total funds due to eliminating the 3% rate growth in FY 2020-21 and an increase of $2,035,922 to increase nursing facility rates by 0.29%, which aligns with the rate increase requested for other providers.

The Department continues to work to identify the appropriate legislative route to amend section 25.5-6-202, C.R.S. to remove the allowable growth factor for nursing facility per diem rates in FY 2020-21 and ongoing and specify that rate increases are subject to annual appropriation by the General Assembly.

The Department seeks this reduction because no other provider in the Medicaid program has statutory language which effectively requires rate increases. If approved, the request would not directly affect service delivery as nursing facilities would still be required to provide the same level of care as defined in both statue and regulations. This statutory change would provide parity between nursing facilities and other provider types with respect to the process through which payment rates are proposed and adopted by the Governor and the General Assembly.

Anticipated Outcomes:

Targeted Rate Adjustments and Across-the-Board Rate Increase

Implementing a provider rate increase would reduce the financial strain and risk to client access that stagnant provider rates represent. Additionally, targeted rate changes to specific services would more appropriately align incentives, encouraging positive outcomes for clients and allowing the Department to pay for value rather than volume of services. Increasing rates for personal care and homemaker services would help ensure that minimum wage requirements are satisfied and grow a competent workforce to deliver the services, thereby allowing members to continue to receive care in their homes and communities.

Personal care and homemaker attendants play a vital role in keeping Colorado's elders, aging parents and grandparents, and people with disabilities in their homes and communities. If there are not enough people in Colorado who are willing to perform these tasks, individuals cannot stay in their homes; the alternative care settings are more expensive, such as placement in nursing facilities or assisted living facilities. The State's Demographer indicated that the senior population in Colorado (ages 65 and over) increased by 43% from 2010-2017, compared to 14% for the rest of the State population, and is projected to increase by more than 60% by 2030. Supporting a workforce that can most efficiently care for this population, which will increase by approximately 500,000 people over this period, is critical to managing the State budget in future years. The effective management of Medicaid services to seniors is, and will continue to be one of the most pressing budget challenges the State will face, and this proposed rate increase is key to addressing this challenge. Access to care is a requirement under the Social Security Act and the Americans with Disabilities Act.

Nursing Facility Rates Change

By making rate increases subject to annual appropriation, nursing facility rate growth would be subject to overall statewide budget balancing, which is consistent with rate increases for most other providers. This, in turn, would create additional flexibility for both the Executive and the Legislative branches to make annual determinations about the appropriate level of funding for nursing facilities.

Assumptions and Calculations:

Please see Appendix A for detailed calculations on all components.

Targeted Rate Adjustments

For most services, the Department assumes that the requested rate adjustments would be effective July 1, 2020. This aligns with the Department's recent experience with receiving approval from the Centers for Medicare and Medicaid Services (CMS) for new rates in the Department's State Plan and loading the new rates into the Medicaid Management Information System (MMIS). The Department estimates that there would be an average one-month delay between the date in which a service occurs and the payment for that service. Therefore, the Department assumes 11 out of 12 months of the impact of the rate increases would be realized in FY 2020-21, and a full-year impact would be realized in FY 2021-22.

For targeted rate increases for HCBS waiver services, such as personal care and homemaker services, the Department assumes that it would take between 90 and 180 days to submit and receive CMS approval to

amend the waivers for the new rates. The Department estimates the FY 2020-21 impact for those services assuming an implementation date of October 1, 2020.

Across-the-Board Provider Rate Increase

Estimates are based on the Department's FY 2020-21 budget and prior year actuals. As the Department will be revising Medicaid caseload and per capita cost forecasts through future budget requests, adjustments to estimates may be necessary in the future. The Department calculated the percentage increase by estimating the cost to provide a 0.5% across-the-board increase, in line with the increase proposed in other areas of the Governor's budget, and allocating a portion of that funding to the targeted rate adjustments. The Department is requesting to use the remaining funding for the across-the-board increase of 0.29%.

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 expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract.
- Dental administrative payments are ineligible for rate increases because the contract was competitively procured, with payment rates agreed upon during the procurement.
- Reimbursement to pharmacies are not eligible for 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.
- 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.
- Rates for Federally Qualified Health Centers would be ineligible due to recent increases bringing reimbursement for this provider type to the upper limit of allowed amount under the current reimbursement methodology.
- Physical health managed care programs, including risk-based health maintenance organizations such as the providers for the Program of All-Inclusive Care for the Elderly (PACE), are negotiated within the parameters of their respective rate setting methodology and may or may not be impacted by rate increases.
- Risk-based physical health managed care programs for Medicaid and the Child Health Plan Plus (CHP+) and regional accountable entities (RAEs) would not receive direct rate increases as part of this change request. Rates are set in accordance with federal regulation and actuarial standards, which do not generally permit general provider rate increases. The Department notes, however, that RAE and CHP+ rates generally increase in response to provider cost, and rates for Medicaid managed care organizations would increase indirectly based on increases applied to fee-for-service rates.
- Services receiving targeted rate adjustments would not be eligible for the additional across-the-board rate increase.

Nursing Facility Rates Change

The Department's calculations for the effect of the eliminating automatic rate growth in nursing facility per diem rates are contained in Appendix A. The Department would absorb the work associated with changing regulations and calculating rates in FY 2020-21 to match the revised statutory language. If the General Assembly takes different action than proposed in this request, the Department may need additional resources. The Department would use the regular budget process if additional resources are needed.

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Table 1.1: FY 2020-21 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$258,944	0.0	$36,638	$62,343	$0	$159,963	Table 11.1 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($2,328,261)	0.0	($1,677,922)	$220,053	$0	($870,392)	Table 11.1 Row G +Table 2.1 Row A + Table 2.1 Row E + Table 2.1 Row R + + Table 2.1 Row F + Table 2.1 Row I + Table 2.1 Row K + Table 2.1 Row L + Table 2.1 Row N
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	($281,896)	0.0	($65,991)	($18,573)	$0	($197,332)	Table 5.1 Row F + Table 11.1 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Comprehensive Services	$1,361,049	0.0	$680,525	$0	$0	$680,524	Table 11.1 Row K
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Supported Living Services	$367,768	0.0	$192,733	$2,038	$0	$172,997	Table 11.1 Row M + Table 2.1 Row B
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Extensive Support Services	$125,774	0.0	$62,887	$0	$0	$62,887	Table 11.1 Row O + Table 2.1 Row C
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$116,183	0.0	$60,544	$416	$0	$55,223	Table 11.1 Row Q
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Habitation/Rehabilitation Program	$546,946	0.0	$273,473	$0	$0	$273,474	Table 11.1 Row S + Table 2.1 Row J
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Family Support Services	$19,150	0.0	$19,150	$0	$0	$0	Table 11.1 Row U
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Preventive Dental Hygiene	$174	0.0	$174	$0	$0	$0	Table 11.1 Row W
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Eligibility Determination and Waitlist Management	$8,427	0.0	$8,371	$0	$0	$56	Table 11.1 Row Y
L	(7) Department of Human Services Medicaid-Funded Programs, (C) Division of Child Welfare - Medicaid Funding, (2) Child Welfare Services	$1,896,341	0.0	$948,171	$0	$0	$948,170	Table 5.2 Row F
M	**Total Request**	**$2,090,599**	**0.0**	**$538,753**	**$266,277**	**$0**	**$1,285,569**	**Sum Rows A through L**

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Table 1.2: FY 2021-22 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	$266,065	$0	$37,646	$64,057	$0	$164,362	Table 11.2 Row B
B	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($17,306,563)	$0	($9,365,812)	$283,699	$0	($8,224,451)	Table 11.2 Row G +Table 2.2 Row A + Table 2.2 Row E + Table 2.2 Row R + + Table 2.2 Row F + Table 2.2 Row I + Table 2.2 Row K + Table 2.2 Row L + Table 2.2 Row N
C	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	($298,271)	$0	($69,441)	($19,757)	$0	($209,073)	Table 5.1 Row F + Table 11.2 Row I
D	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Comprehensive Services	$1,515,017	$0	$757,508	$0	$0	$757,509	Table 11.2 Row K
E	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Adult Supported Living Services	$546,606	$0	$283,154	$2,268	$0	$261,184	Table 11.2 Row M + Table 2.2 Row B
F	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Extensive Support Services	$199,336	$0	$99,668	$0	$0	$99,668	Table 11.2 Row O + Table 2.2 Row C
G	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Case Management	$129,326	$0	$67,393	$463	$0	$61,470	Table 11.2 Row Q
H	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Children's Habitation/Rehabilitation Program	$726,050	$0	$363,025	$0	$0	$363,026	Table 11.2 Row S + Table 2.2 Row J
I	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Family Support Services	$21,316	$0	$21,316	$0	$0	$0	Table 11.2 Row U
J	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Preventive Dental Hygiene	$194	$0	$194	$0	$0	$0	Table 11.2 Row W
K	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs, Eligibility Determination and Waitlist Management	$9,380	$0	$9,318	$0	$0	$62	Table 11.2 Row Y
L	(7) Department of Human Services Medicaid-Funded Programs, (C) Division of Child Welfare - Medicaid Funding, (2) Child Welfare Services	$2,015,766	$0	$1,007,883	$0	$0	$1,007,883	Table 5.2 Row F
M	**Total Request**	**($12,175,778)**	**$0**	**($6,788,148)**	**$330,730**	**$0**	**($5,718,360)**	**Sum Rows A through L**

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Table 2.1: FY 2020-21 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
Targeted Rate Adjustments									
Personal Care and Homemaker Inflationary Increases									
A	Medical Services Premiums Waivers	$4,356,298	0.0	$2,178,149	$0	$0	$2,178,149	50.00%	Table 3.1 Row D
B	Supportive Living Services Waiver	$125,539	0.0	$62,769	$0	$0	$62,770	50.00%	Table 3.1 Row C
C	Children's Extensive Support Waiver	$52,682	0.0	$26,341	$0	$0	$26,341	50.00%	Table 3.1 Row F
D	**Total for Personal Care and Homemaker**	**$4,534,519**	**0.0**	**$2,267,259**	**$0**	**$0**	**$2,267,260**		**Row A + Row B + Row C**
Anesthesia Reduction to 100% of Medicare Rate									
E	**Estimated Impact of Reduction to 100% of Medicare Rates**	**($5,977,532)**	**0.0**	**($1,789,672)**	**($320,397)**	**$0**	**($3,867,463)**	**64.70%**	**Table 4.1 Row E**
Rebalancing Up to 80% / Down to 100% of Benchmark									
F	Durable Medical Equipment	($49,244)	0.0	($17,432)	($3,733)	$0	($28,079)	57.02%	Table 5.3 Row F
G	Behavioral Health Fee-For-Service and Residential Child Care Facilities	$1,586,971	0.0	$875,964	($20,264)	$0	$731,271	46.08%	Table 5.1 Row F + Table 5.2 Row F
H	**Total for Rebalancing**	**$1,537,727**	**0.0**	**$858,532**	**($23,997)**	**$0**	**$703,192**		**Row F + Row G**
In-Home Dialysis Payment Methodology Change									
I	**Estimated savings from revised CAPD payment methodology**	**($929,537)**	**0.0**	**($292,415)**	**($34,471)**	**$0**	**($602,651)**	**64.83%**	**Table 6.2 Row H**
Office of Community Living Waiver Services									
J	Children's Habilitation Residential Program Waiver, Regional Child Care Facility Rate Increase	$532,361	0.0	$266,181	$0	$0	$266,181	50.00%	Table 7.1 Row C
K	Alternative Care Facility Rate Increase	$3,693,257	0.0	$1,846,629	$0	$0	$1,846,629	50.00%	Table 8.1 Row I
L	Adult Day Rate Increase	$3,444,422	0.0	$1,722,211	$0	$0	$1,722,211	50.00%	Table 9.1 Row Y
M	**Total for OCL Waiver Services**	**$7,670,040**	**0.0**	**$3,835,020**	**$0**	**$0**	**$3,835,020**	**50.00%**	Row J + Row K + Row L
Family Planning Rates									
N	**Estimated Increase to Office Visit Codes with Family Planning Modifier**	**$97,092**	**0.0**	**$9,709**	**$0**	**$0**	**$87,383**	**90.00%**	**Table 10.1 Row O**
Across the Board Increase									
O	**Across the Board Increase of 0.29%**	**$14,126,117**	**0.0**	**$5,134,233**	**$645,142**	**$0**	**$8,346,742**	**N/A**	**Table 11.1 Row Z Calculated as 0.29% ATB Increase**
Nursing Facilites Rate Change									
P	Reduction of 3.00% Rate Growth	($21,003,749)	0.0	($10,501,875)	$0	$0	($10,501,875)	50.00%	Table 12.1 Row D
Q	Increase of 0.29% Across-the-Board Rate Increase	$2,035,922	0.0	$1,017,961	$0	$0	$1,017,961	50.00%	Table 12.1 Row E
R	**Net Impact of Nursing Facilities Rate Change**	**($18,967,827)**	**0.0**	**($9,483,914)**	**$0**	**$0**	**($9,483,914)**	**50.00%**	**Row P + Row Q**
S	**Total Estimate**	**$2,090,599**	**0.0**	**$538,753**	**$266,277**	**$0**	**$1,285,569**	**N/A**	**Row D + Row E + Row H + Row I + Row M + Row N + Row O + Row R**

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Table 2.2: FY 2021-22 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
Targeted Rate Adjustments									
Personal Care and Homemaker Inflationary Increases									
A	Medical Services Premiums Waivers	$9,715,348	0.0	$4,857,674	$0	$0	$4,857,674	50.00%	Table 3.1 Row D
B	Supportive Living Services Waiver	$276,975	0.0	$138,488	$0	$0	$138,487	50.00%	Table 3.1 Row C
C	Children's Extensive Support Waiver	$117,976	0.0	$58,988	$0	$0	$58,988	50.00%	Table 3.1 Row F
D	**Total for Personal Care and Homemaker**	**$10,110,299**	**0.0**	**$5,055,150**	**$0**	**$0**	**$5,055,149**		**Row A + Row B + Row C**
Anesthesia Reduction to 100% of Medicare Rate									
E	**Estimated Impact of Reduction to 100% of Medicare Rates**	**($6,195,018)**	**0.0**	**($1,854,787)**	**($332,055)**	**$0**	**($4,008,176)**	**64.70%**	**Table 4.1 Row E**
Rebalancing Up to 80% / Down to 100% of Benchmark									
F	Durable Medical Equipment	($52,346)	0.0	($18,530)	($3,968)	$0	($29,848)	57.02%	Table 5.3 Row F
G	Behavioral Health Fee-For-Service and Residential Child Care Facilities	$1,686,913	0.0	$931,523	($21,639)	$0	$777,029	46.06%	Table 5.1 Row F + Table 5.2 Row F
H	**Total for Rebalancing**	**$1,634,567**	**0.0**	**$912,993**	**($25,607)**	**$0**	**$747,181**		**Row F + Row G**
In-Home Dialysis Payment Methodology Change									
I	**Estimated savings from revised CAPD payment methodology**	**($950,816)**	**0.0**	**($299,109)**	**($35,260)**	**$0**	**($616,447)**	**64.83%**	**Table 6.2 Row H**
Office of Community Living Waiver Services									
J	Children's Habilitation Residential Program Waiver, Regional Child Care Facility Rate Increase	$709,815	0.0	$354,908	$0	$0	$354,908	50.00%	Table 7.1 Row C
K	Alternative Care Facility Rate Increase	$4,924,342	0.0	$2,462,171	$0	$0	$2,462,171	50.00%	Table 8.1 Row I
L	Adult Day Rate Increase	$4,592,563	0.0	$2,296,282	$0	$0	$2,296,282	50.00%	Table 9.1 Row Y
M	**Total for OCL Waiver Services**	**$10,226,720**	**0.0**	**$5,113,360**	**$0**	**$0**	**$5,113,360**	**50.00%**	Row J + Row K + Row L
Family Planning Rates									
N	**Estimated Increase to Office Visit Codes with Family Planning Modifier**	**$101,313**	**0.0**	**$10,131**	**$0**	**$0**	**$91,182**	**90.00%**	**Table 10.1 Row O**
Across the Board Increase									
O	**Across the Board Increase of 0.29%**	**$15,871,511**	**0.0**	**$5,761,291**	**$723,652**	**$0**	**$9,386,568**	**N/A**	**Table 11.2 Row Z Calculated as 0.29% ATB Increase**
Nursing Facilites Rate Change									
P	Reduction of 3.00% Rate Growth	($45,028,808)	0.0	($22,514,404)	$0	$0	($22,514,404)	50.00%	Table 12.2 Row D
Q	Increase of 0.29% Across-the-Board Rate Increase	$2,054,454	0.0	$1,027,227	$0	$0	$1,027,227	50.00%	Table 12.2 Row E
R	**Net Impact of Nursing Facilities Rate Change**	**($42,974,354)**	**0.0**	**($21,487,177)**	**$0**	**$0**	**($21,487,177)**	**50.00%**	**Row P + Row Q**
S	**Total Estimate**	**($12,175,778)**	**0.0**	**($6,788,148)**	**$330,730**	**$0**	**($5,718,360)**	**N/A**	**Row D + Row E + Row H + Row I + Row M + Row N + Row O + Row R**

Table 3.1: Final Estimated Impact of Homemaker and Personal Care				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	IDD Homemaker and Personal Care Impact	$111,465	$247,169	SLS Share of Table 3.2 Row T + Row AB+ Row X
B	CDASS Impact	$14,074	$29,806	1% of Table 3.2 Rows H + P
C	**Total Impact to Supportive Living Services**	**$125,539**	**$276,975**	**Sum of Row A + B**
D	**Total Impact to Medical Services Premiums**	**$4,356,298**	**$9,715,348**	**(Table 3.2 Sum of Rows D, H, L, P, AF) - Table 3.1 Row B**
E	IDD Homemaker Impact	$52,682	$117,976	CES Share of Table 3.2 Rows T + AB
F	**Total Impact to Children's Extensive Support Services**	**$52,682**	**$117,976**	**Row E**
G	**Final Estimated Impact of Homemaker and Personal Care**	**$4,534,519**	**$10,110,299**	**Row C + Row D + Row F**

Table 3.2
Homemaker & Personal Care Wage Pass-Through Impact

Row	Item	FY 2020-21	FY 2021-22	Notes
	Personal Care			
A	Current Rate	$4.98	$4.98	FY 2019-20 Fee Schedule
B	Proposed Rate	$5.12	$5.12	Table 3.3 Row A
C	Estimated Utilization	17,038,029	39,423,114	Table 3.4 Personal Care Column
D	Estimated Impact	$2,385,324	$5,519,236	(Row B - Row A) * Row C
	CDASS - Personal Care			
E	Current Rate	$4.54	$4.54	FY 2019-20 Fee Schedule
F	Proposed Rate	$4.66	$4.66	Table 3.3 Row B
G	Estimated Utilization	7,386,504	15,643,138	Table 3.4 CDASS - Personal Care Column
H	Estimated Impact	$886,380	$1,877,177	(Row F - Row E) * Row G
	Homemaker			
I	Current Rate	$4.98	$4.98	FY 2019-20 Fee Schedule
J	Proposed Rate	$5.12	$5.12	Table 3.3 Row C
K	Estimated Utilization	3,760,779	8,011,211	Table 3.4 Homemaker Column
L	Estimated Impact	$526,509	$1,121,570	(Row J - Row I) * Row K
	CDASS - Homemaker			
M	Current Rate	$4.54	$4.54	FY 2019-20 Fee Schedule
N	Proposed Rate	$4.66	$4.66	Table 3.3 Row D
O	Estimated Utilization	4,341,876	9,195,224	Table 3.4 CDASS - Homemaker Column
P	Estimated Impact	$521,025	$1,103,427	(Row N - Row M) * Row O
	IDD Homemaker Basic			
Q	Current Rate	$4.49	$4.49	FY 2019-20 Fee Schedule
R	Proposed Rate	$4.61	$4.61	Table 3.3 Row G
S	Estimated Utilization	449,907	1,002,752	Table 3.4 IDD Homemaker Column
T	Estimated Impact	$53,989	$120,330	(Row R - Row Q) * Row S
	IDD Personal Care			
U	Current Rate	$5.84	$5.84	FY 2019-20 Fee Schedule
V	Proposed Rate	$6.00	$6.00	Table 3.3 Row F
W	Estimated Utilization	175,878	378,348	Table 3.4 IDD Personal Care Column
X	Estimated Impact	$28,140	$60,536	(Row V - Row U) * Row W
	Homemaker Enhanced			
Y	Current Rate	$7.28	$7.28	FY 2019-20 Fee Schedule
Z	Proposed Rate	$7.48	$7.48	Table 3.3 Row E
AA	Estimated Utilization	410,092	921,395	Table 3.4 Homemaker Enhanced Column
AB	Estimated Impact	$82,018	$184,279	(Row Z - Row Y) * Row AA
AD	Proposed Rate	$5.12	$5.12	Table 3.3 Row H
AE	Estimated Utilization	255,670	618,721	Table 3.4 Pediatric Personal Care Column

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Row	Service	CY 2020	CY 2021	CY 2022	Notes
A	Personal Care	$4.98	$5.12	$5.12	
D	CDASS - Homemaker	$4.54	$4.66	$4.66	
E	Homemaker Enhanced	$7.28	$7.48	$7.48	The CY 2021 rates include a proposed
F	IDD Personal Care	$5.84	$6.00	$6.00	2.75% increase from the CY 2020 rates
G	IDD Homemaker Basic	$4.49	$4.61	$4.61	
H	Pediatric Personal Care	$4.92	$5.12	$5.12	

Table 3.4
Projected Utilization for Homemaker & Personal Care Services

Row	Item	Personal Care	CDASS - Personal Care	Homemaker	CDASS - Homemaker	IDD Personal Care	IDD Homemaker	Homemaker Enhanced	Pediatric Personal Care	Calculation
A	FY 2018-19 Utilization	31,680,975	13,175,255	6,630,207	7,744,573	304,045	724,553	649,894	349,252	MMIS Claims data from FY 2016-17 through FY 2018-19
B	Selected Growth Rate	7.56%	5.89%	6.51%	5.89%	7.56%	11.44%	12.34%	21.00%	Selected trend for each service based off recent actuals
C	FY 2019-20 Estimated Utilization	34,076,057	13,951,278	7,061,833	8,200,728	327,031	807,442	730,091	422,595	Row A *(1+ Row B)
D	FY 2020-21 Estimated Utilization	36,652,207	14,773,008	7,521,558	8,683,751	351,755	899,813	820,184	511,340	Row C *(1+ Row B)
E	FY 2021-22 Estimated Utilization	39,423,114	15,643,138	8,011,211	9,195,224	378,348	1,002,752	921,395	618,721	Row D *(1+ Row B)

Table 4.1 Reduction to Anesthesia Rates				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	Claims Priced at 100% of the Medicare Rate	$29,887,662	$30,575,078	FY 2019-20 R-13 Provider Rate Adjustments
B	Claims Priced at FY 2015-16 Medicaid Rates	$39,343,578	$40,248,480	FY 2019-20 R-13 Provider Rate Adjustments
C	Incremental Difference	($9,455,916)	($9,673,402)	Row A - Row B
D	Previously Approved Reduction to 120% of Medicare Rates	($3,478,384)	($3,478,384)	Amount appropriated in SB 19-207
E	**Estimated Impact of Reduction to 100% of Medicare Rates**	**($5,977,532)**	**($6,195,018)**	**Row C - Row D**

Table 5.1 Using 80-100% of Medicare Rates for Behavioral Health fee-for-service Services				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	Claims Priced at FY 2017-18 Medicaid Rate	$5,148,590	$5,258,304	Actuarial analysis, trended forward by projected caseload growth
B	Claims Adjusted to 80 - 100% of the Medicare Rate	$4,825,769	$4,928,604	Actuarial analysis, trended forward by projected caseload growth
C	Incremental Difference	($322,821)	($329,700)	Row B - Row A
D	Expenditure for Current Year Claims, Adjusted for Implementation Date and Cash Flow	($309,370)	($315,962)	Row C x 11.5/12
E	Expenditure for Prior Year Claims	$0	($12,890)	Previous Year Row D x 0.5/12
F	**Total Impact**	**($309,370)**	**($328,853)**	**Row D + Row E**

Table 5.2 Using 80-100% of Medicare Rates for RCCF Services				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	Claims Priced at FY 2017-18 Medicaid Rate	$7,998,018	$8,168,453	Actuarial analysis, trended forward by projected caseload growth
B	Claims Adjusted to 80 - 100% of the Medicare Rate	$9,976,809	$10,189,411	Actuarial analysis, trended forward by projected caseload growth
C	Incremental Difference	$1,978,791	$2,020,958	Row B - Row A
D	Expenditure for Current Year Claims, Adjusted for Implementation Date and Cash Flow	$1,896,341	$1,936,752	Row C x 11.5/12
E	Expenditure for Prior Year Claims	$0	$79,014	Previous Year Row D x 0.5/12
F	**Total Impact**	**$1,896,341**	**$2,015,766**	**Row D + Row E**

Table 5.3 Using 80-100% of Medicare Rates for DME Services				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	Claims Priced at FY 2017-18 Medicaid Rate (Under 80, Over 100 Rates Only)	$806,804	$824,022	Actuarial analysis, trended forward by projected caseload growth
B	Claims Adjusted to 80 - 100% of the Medicare Rate	$755,419	$771,541	Actuarial analysis, trended forward by projected caseload growth
C	Incremental Difference	($51,385)	($52,481)	Row B - Row A
D	Expenditure for Current Year Claims, Adjusted for Implementation Date and Cash Flow	($49,244)	($50,295)	Row C x 11.5/12
E	Expenditure for Prior Year Claims	$0	($2,052)	Previous Year Row D x 0.5/12
F	**Total Impact**	**($49,244)**	**($52,346)**	**Row D + Row E**

Table 6.1 In-Home Dialysis Rate Change				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculation**
A	FY 2019-20 Rate	$201.54	$201.54	FY 2018-19 Rate inflated by 1% to get to FY 2019-20 Rate
B	Conversion factor	42.86%	42.86%	Reduction of rate to pay for 3 units per week.
C	**New Converted Per Unit Rate**	**$86.37**	**$86.37**	**Row A x Row B**

Table 6.2 In-Home Dialysis Estimated Savings				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculation**
A	Rate before applied conversion factor	$201.54	$201.54	Table 6.1 Row A
B	FY 2018-19 In-Home Dialysis Units	7,718	7,718	In-Home Dialysis Units the Department paid for in FY 2018-19
C	Estimated Trend Factor	2.29%	2.29%	Average percent change in units over the last three fiscal years.
D	In-Home Dialysis Units[(1)]	8,071	8,256	Row B x (1 + 2 x Row C)
E	Expenditure Prior to Conversion	$1,626,690	$1,663,927	Row A x Row D
F	New Rate After Applying Conversion Factor	$86.37	$86.37	Table 6.1 Row C
G	Estimated Expenditure After Applying Conversion Factor	$697,153	$713,112	Row D x Row F
H	**Savings**	**($929,537)**	**($950,816)**	**Row G - Row E**

(1) The 2.29% trend factor was applied twice to get the estimated in-home dialysis units for FY 2020-21. The same trend factor of 2.29% was then applied to the estimated units of 8,071 for FY 2020-21.

Table 7.1 Children's Habilitation Residential Program (CHRP) Waiver Regional Child Care Facility (RCCF) Rate Increase				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	Full implementation impact	$709,815	$709,815	Table 7.2 Row E
B	Adjustment Factor	75.00%	100.00%	10/1/2020 Implementation
C	**Final Estimated Impact**	**$532,361**	**$709,815**	**Row A * Row B**

Table 7.2 CHRP Waiver RCCF Rate Increase						
Row	**Support Level**	**Current Units**	**Estimated Increased Utilization**	**Current Rate**	**Proposed Rate**	**Estimated Impact**
A	Support Level 3	263	973	$128.86	$559.95	$419,451
B	Support Level 4	120	444	$152.22	$589.00	$193,930
C	Support Level 5	51	189	$168.17	$620.00	$85,396
D	Support Level 6	6	22	$198.29	$700.00	$11,038
E	**Total**	**440**	**1628**	**N/A**	**N/A**	**$709,815**

Table 8.1 Alternative Care Facility (ACF) Rate Increase				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
A	Current Rate	$65.55	$65.55	Per Day
B	Esimated Utilization	266.81	266.81	Days per Utilizer
C	Estimated Utilizers	4,395	4,395	Number of Utilizers
D	Estimated Expenditure Under Current Rate	$76,865,893	$76,865,893	Row A * Row B * Row C
E	Proposed New Rate	$69.75	$69.75	Proposed Rate
F	Estimated Expenditure Under New Rate	$81,790,235	$81,790,235	Row E * Row B * Row C
G	Estimated Impact of New Rate	$4,924,342	$4,924,342	Row F - Row D
H	Implementation Adjustment	75.00%	100.00%	Implemented 10/1/2020
I	**Estimated Impact**	**$3,693,257**	**$4,924,342**	**Row G x Row H**

Table 9.1 Adult Day Rate Increase				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
EBD & CMHS Adult Day Basic				
A	Current Rate	$31.63	$31.63	Per Day
B	Esimated Utilization	429,492	429492.4	Days per Utilizer
C	Estimated Expenditure Under Current Rate	$13,586,627	$13,586,627	Row A * Row B
D	Proposed New Rate	$37.16	$37.16	Proposed Rate
E	Estimated Expenditure Under New Rate	$15,959,938	$15,959,938	Row D * Row B
F	Estimated Impact of New Rate	$2,373,311	$2,373,311	Row E - Row C
G	Implementation Adjustment	75.00%	100.00%	Implemented 10/1/2020
H	**Estimated Impact**	**$1,779,983**	**$2,373,311**	**Row F x Row G**
BI Adult Day Basic				
I	Current Rate	$78.08	$78.08	Per Day
J	Esimated Utilization	4,941	4940.5	Days per Utilizer
K	Estimated Expenditure Under Current Rate	$385,758	$385,758	Row I * Row J
L	Proposed New Rate	$98.98	$98.98	Proposed Rate
M	Estimated Expenditure Under New Rate	$489,011	$489,011	Row L * Row J
N	Estimated Impact of New Rate	$103,253	$103,253	Row M - Row K
O	Implementation Adjustment	75.00%	100.00%	Implemented 10/1/2020
P	**Estimated Impact**	**$77,440**	**$103,253**	**Row N x Row O**
EBD, CMHS, SCI Adult Day Specialized				
Q	Current Rate	$43.28	$43.28	Per Day
R	Esimated Utilization	225,485	225485	Days per Utilizer
S	Estimated Expenditure Under Current Rate	$9,758,041	$9,758,041	Row Q * Row R
T	Proposed New Rate	$52.66	$52.66	Proposed Rate
U	Estimated Expenditure Under New Rate	$11,874,040	$11,874,040	Row T * Row R
V	Estimated Impact of New Rate	$2,115,999	$2,115,999	Row U - Row S
W	Implementation Adjustment	75.00%	100.00%	Implemented 10/1/2020
X	**Estimated Impact**	**$1,586,999**	**$2,115,999**	**Row V x Row W**
Y	**Total Estimated Impact**	**$3,444,422**	**$4,592,563**	**Sum of Rows H , P , X**

Table 10.1 Family Planning Rate Increase				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes/Calculations**
99203: New Patient Visit Level 3 with Family Planning Modifier				
A	Current Rate	$83.47	$83.47	Per Visit
B	Proposed New Rate	$120.20	$120.20	Proposed Rate
C	Proposed Rate Increase	$36.73	$36.73	Row B - Row A
D	Estimated Utilization	2,630	2,630	MMIS Claims Data
E	Estimated Impact of Proposed Rate	$96,600	$96,600	Row C x Row D
F	Implementation Adjustment	95.83%	100.00%	Implemented 7/1/2020
G	**Estimated Impact**	**$92,575**	**$96,600**	**Row E x Row F**
99205: New Patient Visit Level 5 with Family Planning Modifier				
H	Current Rate	$183.72	$183.72	Per Visit
I	Proposed New Rate	$228.18	$228.18	Proposed Rate
J	Proposed Rate Increase	$44.46	$44.46	Row B - Row A
K	Estimated Utilization	106	106	MMIS Claims Data
L	Estimated Impact of Proposed Rate	$4,713	$4,713	Row J x Row K
M	Implementation Adjustment	95.83%	100.00%	Implemented 7/1/2020
N	**Estimated Impact**	**$4,517**	**$4,713**	**Row L x Row M**
O	**Total Estimated Impact**	**$97,092**	**$101,313**	**Row G + Row N**

Table 11.1: FY 2020-21 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds[(1)]	Reappropriated Funds	Federal Funds
	(1) Executive Director's Office					
A	(D) Eligibility Determination and Clients	$88,984,286	$12,590,592	$21,423,565	$0	$54,970,129
B	**Impact of 0.29% Rate Increase**	**$258,944**	**$36,638**	**$62,343**	**$0**	**$159,963**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $14,865; Local Funds: $47,478						
	(2) Medical Services Premiums	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Reappropriated Funds**	**Federal Funds**
C	Acute Care	$2,939,982,756	$856,193,441	$188,614,261	$0	$2,752,782,381
D	Community Based Long Term Care	$1,141,299,089	$558,005,848	$8,835,708	$0	$660,089,756
E	Service Management	$44,082,295	$15,224,038	$1,918,057	$0	$165,525,278
F	**Total Medical Services Premiums**	**$4,125,364,140**	**$1,429,423,327**	**$199,368,026**	**$0**	**$3,578,397,415**
G	**Impact of 0.29% Rate Increase**	**$12,004,810**	**$4,148,813**	**$578,654**	**$0**	**$7,277,343**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $512,797; Breast and Cervical Cancer Prevention and Treatment Fund: $1,422; Adult Dental Cash Fund: $64,434						
	(3) Behavioral Health Community Programs	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Reappropriated Funds**	**Federal Funds**
H	Behavioral Health Fee-for-Service	$9,441,206	$2,136,122	$580,984	$0	$7,284,442
I	**Impact of 0.29% Rate Increase**	**$27,474**	**$6,216**	**$1,691**	**$0**	**$19,567**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $1,691						
Row	**(4) Office of Community Living**	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Reappropriated Funds**	**Federal Funds**
J	Adult Comprehensive Services	$467,714,344	$233,857,171	$1	$0	$253,345,270
K	**Impact of 0.29% Rate Increase**	**$1,361,049**	**$680,525**	**$0**	**$0**	**$680,524**
L	Adult Supported Living Services	$83,240,195	$44,661,269	$700,194	$0	$41,035,294
M	**Impact of 0.29% Rate Increase**	**$242,229**	**$129,964**	**$2,038**	**$0**	**$110,227**
N	Children's Extensive Support Services	$25,117,450	$12,558,726	$0	$0	$13,605,286
O	**Impact of 0.29% Rate Increase**	**$73,092**	**$36,546**	**$0**	**$0**	**$36,546**
P	Case Management	$39,925,313	$20,805,374	$142,936	$0	$20,558,420
Q	**Impact of 0.29% Rate Increase**	**$116,183**	**$60,544**	**$416**	**$0**	**$55,223**
R	Children's Habitation/Rehabilitation Program	$5,012,157	$2,506,078	$0	$0	$2,714,919
S	**Impact of 0.29% Rate Increase**	**$14,585**	**$7,292**	**$0**	**$0**	**$7,293**
T	Family Support Services	$6,580,714	$6,580,714	$0	$0	$0
U	**Impact of 0.29% Rate Increase**	**$19,150**	**$19,150**	**$0**	**$0**	**$0**
V	Preventive Dental Hygiene	$59,858	$59,858	$0	$0	$0
W	**Impact of 0.29% Rate Increase**	**$174**	**$174**	**$0**	**$0**	**$0**
X	Eligibility Determination and Waitlist Management	$2,895,733	$2,876,586	$0	$0	$20,743
Y	**Impact of 0.29% Rate Increase**	**$8,427**	**$8,371**	**$0**	**$0**	**$56**
Z	**Total Impact**	**$14,126,117**	**$5,134,233**	**$645,142**	**$0**	**$8,346,742**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $2,454						

Table 11.2: FY 2021-22 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)

Row	Long Bill Group	Total Funds	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds
	(1) Executive Director's Office					
A	(D) Eligibility Determination and Clients	$91,431,354	$12,590,592	$21,423,565	$0	$56,481,808
B	**Impact of 0.29% Rate Increase**	**$266,065**	**$37,646**	**$64,057**	**$0**	**$164,362**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $15,273; Local Funds: $48,784						
	(2) Medical Services Premiums	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
C	Acute Care	$3,330,833,175	$970,018,450.38	$213,689,225.83	$0	$2,828,483,897
D	Community Based Long Term Care	$1,270,408,548	$621,130,260.03	$9,835,247.28	$0	$678,242,224
E	Service Management	$49,069,105	$16,946,257.01	$2,135,036.76	$0	$170,077,224
F	**Total Medical Services Premiums**	**$4,650,310,828**	**$1,608,094,967**	**$225,659,510**	**$0**	**$3,676,803,344**
G	**Impact of 0.29% Rate Increase**	**$13,532,405**	**$4,667,534**	**$654,982**	**$0**	**$8,209,889**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $580,439; Breast and Cervical Cancer Prevention and Treatment Fund: $1,610; Adult Dental Cash Fund: $72,934						
	(3) Behavioral Health Community Programs	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
H	Behavioral Health Fee-for-Service	$10,509,242	$2,377,771	$646,707	$0	$7,484,764
I	**Impact of 0.29% Rate Increase**	**$30,582**	**$6,919**	**$1,882**	**$0**	**$21,781**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $1,882						
Row	**(4) Office of Community Living**	**Total Funds**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**
J	Adult Comprehensive Services	$520,624,529	$260,312,264	$1	$0	$260,312,264
K	**Impact of 0.29% Rate Increase**	**$1,515,017**	**$757,508**	**$0**	**$0**	**$757,509**
L	Adult Supported Living Services	$92,656,742	$49,713,575	$779,403	$0	$42,163,765
M	**Impact of 0.29% Rate Increase**	**$269,631**	**$144,666**	**$2,268**	**$0**	**$122,697**
N	Children's Extensive Support Services	$27,958,862	$13,979,431	$0	$0	$13,979,431
O	**Impact of 0.29% Rate Increase**	**$81,360**	**$40,680**	**$0**	**$0**	**$40,680**
P	Case Management	$44,441,864	$23,158,982	$159,105	$0	$21,123,777
Q	**Impact of 0.29% Rate Increase**	**$129,326**	**$67,393**	**$463**	**$0**	**$61,470**
R	Children's Habitation/Rehabilitation Program	$5,579,158	$2,789,578	$0	$0	$2,789,579
S	**Impact of 0.29% Rate Increase**	**$16,235**	**$8,117**	**$0**	**$0**	**$8,118**
T	Family Support Services	$7,325,157	$7,325,157	$0	$0	$0
U	**Impact of 0.29% Rate Increase**	**$21,316**	**$21,316**	**$0**	**$0**	**$0**
V	Preventive Dental Hygiene	$66,629	$66,629	$0	$0	$0
W	**Impact of 0.29% Rate Increase**	**$194**	**$194**	**$0**	**$0**	**$0**
X	Eligibility Determination and Waitlist Management	$3,223,313	$3,202,000	$0	$0	$21,313
Y	**Impact of 0.29% Rate Increase**	**$9,380**	**$9,318**	**$0**	**$0**	**$62**
Z	**Total Impact**	**$15,871,511**	**$5,761,291**	**$723,652**	**$0**	**$9,386,568**
(1) Amount of cash fund by cash fund: Healthcare Affordability & Sustainability Fee: $2,731						

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Table 12.1 FY 2020-21 Impact of Eliminating Automatic 3% Rate Growth for Nursing Facilities							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Expenditure with 3% Growth For FY 2020-21 Nursing Facility Rates	$775,993,882	$387,996,941	$0	$0	$387,996,941	Table 12.3 Row I
B	Estimated Expenditure with 0% Growth For FY 2020-21 Nursing Facility Rates	$754,990,133	$377,495,067	$0	$0	$377,495,067	Table 12.4 Row I
C	Estiumated Expenditure with 0.29% Growth for FY 2020-21 Nursing Facility Rates	$757,026,055	$378,513,028	$0	$0	$378,513,028	Table 12.5 Row I
D	Estimated Savings from removal of 3% Growth trend	($21,003,749)	($10,501,875)	$0	$0	($10,501,875)	Row B - Row A
E	Estimated Increase in Expenditure from 0.29% Growth Trend	$2,035,922	$1,017,961	$0	$0	$1,017,961	Row C - Row B
F	**Net Savings in FY 2020-21 from removal of 3% Growth Trend and 0.29% Provider Rate Increase**	**($18,967,827)**	**($9,483,914)**	**$0**	**$0**	**($9,483,914)**	**Row D + Row E**

Table 12.2 FY 2021-22 Impact of Eliminating Automatic 3% Rate Growth for Nursing Facilities							
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Expenditure with 3% Growth For FY 2021-22 Nursing Facility Rates	$806,895,113	$403,447,557	$0	$0	$403,447,557	Table 12.3 Row I
B	Estimated Expenditure with 0% Growth For FY 2021-22 Nursing Facility Rates	$761,866,305	$380,933,153	$0	$0	$380,933,153	Table 12.4 Row I
C	Estiumated Expenditure with 0.29% Growth for FY 2021-22 Nursing Facility Rates	$763,920,759	$381,960,380	$0	$0	$381,960,380	Table 12.5 Row I
D	Estimated Savings from removal of 3% Growth trend	($45,028,808)	($22,514,404)	$0	$0	($22,514,404)	Row B - Row A
E	Estimated Increase in Expenditure from 0.29% Growth Trend	$2,054,454	$1,027,227	$0	$0	$1,027,227	Row C - Row B
F	**Net Savings in FY 2021-22 from removal of 3% Growth Trend and 0.29% Provider Rate Increase**	**($42,974,354)**	**($21,487,177)**	**$0**	**$0**	**($21,487,177)**	**Row D + Row E**

R-10 Provider Rate Adjustments
Appendix A: Calculations and Assumptions

Table 12.3 - Nursing Facility Expenditure Projections with 3% Annual Rate Increase					
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Description**
A	Estimated Medicaid Reimbursement (Per Day)	$197.86	$203.80	$209.91	Based on Department's February 15, 2019 forecast
B	Estimate of Patient Days	3,786,158	3,820,621	3,855,397	Based on Department's February 15, 2019 forecast
C	Total Estimated Costs for Days of Service	$749,129,256	$778,642,542	$809,286,384	Row A * Row B
D	Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.55%	92.55%	92.55%	Based on Department's February 15, 2019 forecast
E	Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$693,319,126	$720,633,673	$748,994,548	Row C * Row D
F	Estimated Expenditure for Prior Fiscal Year Dates of Service	$53,380,371	$55,810,130	$58,350,486	Based on Department's February 15, 2019 forecast
G	**Total Estimated Nursing Facility Service Expenditure**	**$746,699,497**	**$776,443,803**	**$807,345,034**	**Row E + Row F**
H	Total Estimated Nursing Facility Bottom Line Impacts	($162,057)	($449,921)	($449,921)	Based on Department's February 15, 2019 forecast
I	**Total Estimated Nursing Facility Service Expenditure Adjusted for Bottom Line Impacts**	**$746,537,440**	**$775,993,882**	**$806,895,113**	**Row G + Row H**

Table 12.4 - Nursing Facility Expenditure Projections with 0% Annual Rate Increase					
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Description**
A	Estimated Medicaid Reimbursement (Per Day)	$197.86	$197.86	$197.86	Eliminating automatic growth rate in FY 2020-21 and FY 2021-22
B	Estimate of Patient Days (without Hospital Back Up)	3,786,158	3,820,621	3,855,397	Based on Department's February 15, 2019 forecast
C	Total Estimated Costs for Days of Service	$749,129,256	$755,948,054	$762,828,850	Row A * Row B
F	Estimated Expenditure for Prior Fiscal Year Dates of Service	$53,380,371	$55,810,130	$56,318,125	Based on Department's February 15, 2019 forecast
G	**Total Estimated Nursing Facility Service Expenditure**	**$746,699,497**	**$755,440,054**	**$762,316,226**	**Row E + Row F**
H	Total Estimated Nursing Facility Bottom Line Impacts	($162,057)	($449,921)	($449,921)	Based on Department's February 15, 2019 forecast
I	**Total Estimated Nursing Facility Service Expenditure Adjusted for Bottom Line Impacts**	**$746,537,440**	**$754,990,133**	**$761,866,305**	**Row G + Row H**

Table 12.5 - Nursing Facility Expenditure Projections with 0.25% Annual Rate Increase					
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Description**
A	Estimated Medicaid Reimbursement (Per Day)	$197.86	$198.44	$198.44	Assuming a 0.25% growth in the per diem rate from FY 2019-20 to FY 2020-21.
B	Estimate of Patient Days (without Hospital Back Up)	3,786,158	3,820,621	3,855,397	Based on Department's February 15, 2019 forecast
C	Total Estimated Costs for Days of Service	$749,129,256	$758,147,862	$765,048,682	Row A * Row B
D	Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.55%	92.55%	92.55%	Based on Department's February 15, 2019 forecast
E	Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$693,319,126	$701,665,846	$708,052,555	Row C * Row D
F	Estimated Expenditure for Prior Fiscal Year Dates of Service	$53,380,371	$55,810,130	$56,318,125	Based on Department's February 15, 2019 forecast
G	**Total Estimated Nursing Facility Service Expenditure**	**$746,699,497**	**$757,475,976**	**$764,370,680**	**Row E + Row F**
H	Total Estimated Nursing Facility Bottom Line Impacts	($162,057)	($449,921)	($449,921)	Based on Department's February 15, 2019 forecast
I	**Total Estimated Nursing Facility Service Expenditure Adjusted for Bottom Line Impacts**	**$746,537,440**	**$757,026,055**	**$763,920,759**	**Row G + Row H**

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-11 Patient Placement and Benefit Implementation- SUD

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	**Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$734,412,064**	**$0**	**$904,215,757**	**($85,566,035)**	**$1,368,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$205,523,747	$0	$238,160,716	($16,622,834)	$451,440
	CF	$40,467,516	$0	$51,904,500	($5,519,687)	$232,560
	RF	$150,000	$0	$150,000	$0	$0
	FF	$488,270,801	$0	$614,000,541	($63,423,514)	$684,000

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$1,368,000**	**$1,368,000**
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,015,380	$0	$4,503,802	$451,440	$451,440
	CF	$2,615,231	$0	$2,547,721	$232,560	$232,560
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$684,000	$684,000
	Total	**$712,830,202**	**$0**	**$886,698,271**	**($86,934,035)**	**$0**
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Capitation Payments	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$199,508,367	$0	$233,656,914	($17,074,274)	$0
	CF	$37,852,285	$0	$49,356,779	($5,752,247)	$0
	RF	$0	$0	$0	$0	$0
	FF	$475,469,550	$0	$603,684,578	($64,107,514)	$0

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-11
Request Detail: Patient Placement and Benefit Implementation – Substance Use Disorder

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$80,000**	**($85,566,035)**	**$1,368,000**
FTE	0	0	0
General Fund	$26,400	($16,622,834)	$451,440
Cash Funds	$13,600	($5,519,687)	$232,560
Reappropriated Funds	$0	$0	$0
Federal Funds	$40,000	($63,423,514)	$684,000

Summary of Request:

The Department requests $80,000 total funds, including $26,400 General Fund and $13,600 cash funds in FY 2019-20; a reduction of $85,566,035 total funds, including reductions of $16,622,834 General Fund and $5,519,687 cash funds in FY 2020-21; and an increase of $1,368,000 total funds, including $451,440 General Fund and $232,560 cash funds in FY 2021-22 and ongoing. The Department's requested change to cash funds comes from the Healthcare Affordability and Sustainability Fee cash fund. The Department requests a funding adjustment related to the expansion of the substance use disorder (SUD) benefit through HB 18-1136, "Substance Use Disorder Treatment." The adjustment reflects new information regarding the pace at which treatment providers will likely begin offering SUD treatment services. The Department projects lower estimated costs of the new residential and inpatient services benefit than the amount assumed in the fiscal note for HB 18-1136. The request also includes funding to provision SUD providers with an evidence-based tool to determine the appropriate treatment placement for clients. This request represents a decrease of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

In 2018, the General Assembly passed HB 18-1136 requiring the Department to extend behavioral health care services to include residential and inpatient SUD treatment, pending approval of federal financial participation through an 1115 waiver.[1] The Department is in the process of securing the waiver and plans to implement the service changes by July 1st, 2020, as assumed in the fiscal note for the bill.

The fiscal note for HB 18-1136 included $173,868,069 in funding starting in FY 2020-21 to pay for the additional substance use disorder services. This was based on a report from the Colorado Health Institute, funded by the Department to fulfill requirements in HB 17-1351, which estimated the cost of the expanded benefit based on the assumption that 17,000 enrollees would utilize the new treatment options each year.[2]

Problem or Opportunity:

Patient Placement Tool

In order to receive federal approval through an 1115 waiver to implement the inpatient and residential substance use disorder benefit, the Department must submit an implementation plan that outlines how providers would utilize evidence-based, SUD-specific patient placement criteria, per guidance from the Centers for Medicare and Medicaid Services (CMS). These criteria must ensure that:

- "Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM (American Society of Addiction Medicine) Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines."
- "Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings."

If the Department does not require its providers to use a unified decision support system, each Medicaid provider would be required to develop their own system that can justify their patient placement decisions under the ASAM criteria or another nationally recognized evidence-based clinical treatment guidelines. If the utilization management is not adequate, the Department may have difficulties in gaining approval for the 1115 waiver. In addition, without a consistent tool, there is the potential for over or under utilization of inpatient and residential services, resulting in poorer health outcomes.

Cost Adjustment for Substance Use Disorder Benefit

Using contractor funding appropriated through HB 18-1136, the Department's actuary modeled expected costs for the new residential and inpatient substance use disorder benefit. The actuary also analyzed how the expanded benefit would impact the per-member per-month rates paid to the Department's Regional Accountable Entities (RAEs) for behavioral health services. Based on preliminary analysis, the Department

[1] https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

[2] https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf

anticipates that the cost of the benefit will be significantly less than projected for the fiscal impact of HB 18-1136 in the first year of implementation. This is due in large part to a lower estimated number of benefit utilizers. The Department originally estimated that it would provide residential or inpatient treatments to an additional 17,000 members with implementation of HB 18-1136, based on an average historical uptake rate of 11%. New estimates from the Colorado Health Institute (CHI) indicate that provider capacity limitations may restrict services in the first year to less than half of the anticipated utilization. Thus, the Department has the opportunity to adjust the estimated cost of the benefits to reflect more accurate information.

Proposed Solution:

The Department requests $80,000 total funds, including $26,400 General Fund, in FY 2019-20 and a reduction of $85,566,035 total funds, including $16,622,834 General Fund in FY 2020-21 and ongoing to fund a patient placement tool and an adjustment to reduce the estimated cost of the SUD treatment benefit.

Patient Placement Tool

The Department requests $80,000 total funds, including $26,400 General Fund in FY 2019-20, and $1,368,000 total funds, including $451,440 General Fund in FY 2020-21 and ongoing to contract with a provider of a SUD patient placement referral tool through a competitive bidding process. With this funding, the Department expects access to a tool which can map patients to the correct level of care based on the ASAM criteria, any required help in implementing the tool, including trainings and system modifications, licenses for up to 2,500 users (users being health care provider employees), and IT support.

There are currently three patient placement tools on the market, all of which use the ASAM criteria to map patients to the least intensive but safe level of care. The ASAM criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions. Guidance from CMS on the 1115 waiver references ASAM criteria as acceptable assessment criteria to base the implementation plan requirements on.

Implementing the tool would help the Department reach its goal in the Department's FY 2019-20 Performance Plan to improve the delivery of member programs and health outcomes by ensuring members receive the most appropriate, evidence-based treatment. The tool would also help the Department reach its goal to control Medicaid costs by ensuring the right people receive the right services. The success of the tool at achieving these goals would be reviewed through the report the Department is required by statute to submit to the General Assembly on January 15, 2022.

Alternatively, the Department could require each provider to create their own system of ASAM criteria compliance, which would lead to inconsistent treatment decisions across providers and the potential for improper utilization of the new residential substance use disorder benefit. If this request is not approved, it could also jeopardize the Department's ability to gain CMS approval of its 1115 waiver.

Cost Adjustment for Substance Use Disorder Benefit

The Department requests a reduction of $86,934,035 total funds, including $17,074,274 General Fund, in FY 2020-21, to reflect the most recent cost projections for the expanded substance use disorder benefit. The

estimate used for the fiscal note for HB 18-1136 did not account for any ramp-up in implementation. While the Department has made efforts to build provider capacity since the passage of the bill, it is unlikely that full provider capacity would immediately exist upon the launch of the benefit. Instead, the Department expects that provider capacity will grow over time. As a result, the capitation rates paid to the Regional Accountable Entities for behavioral health are expected to be lower than the original budget. Therefore, the Department requests to reduce the overall budget for the SUD benefit in FY 2020-21 only to account for lower than budgeted expenditures.

Anticipated Outcomes:

Patient Placement Tool

The Department anticipates that requiring providers to use a tool that will consistently and efficiently map patients to the appropriate ASAM Level of Care would lead to better health outcomes and may lead to long term cost savings. Two quasi-experimental studies on the effectiveness of such tools are described below.

In 2014, the Norwegian Directorate of Health and Drug and Alcohol Addiction funded a 10-site, 261-person, cohort study of the effectiveness of the ASAM criteria software. Subjects were assessed using the ASAM software but naturally placed in a level of care and deemed to be under-matched (matched to a lower level of care than the ASAM recommendation), appropriately matched, or over-matched. After three months, the under-matched population saw no significant change in their Addiction Severity Index Score, where the appropriately matched and over-matched populations saw significant drops. Retention among the under-matched, appropriately matched, and over-matched populations was at 45%, 62%, and 70%, respectively, and readiness to step down to a lower level of care was at 46%, 61%, and 17%, respectively.[3]

In 2003, Harvard Medical School funded a similar cohort study that looked at 95 U.S. veterans who were naturally placed in residential rehabilitation. Controlling for pre-assessment chronicity, subjects who were under-matched based off of a specially designed computerized interview that mapped them to an ASAM Level of Care utilized nearly twice as many hospital bed-days over the subsequent year as subjects who were not under-matched.[4]

ASAM reports success in the areas where their mapping software is being used. “The pilot program in Massachusetts (N=3,600) found good level-of-care distributions, conformity with ASAM’s principles [to teach addiction medicine by expanding and strengthening our workforce and dispelling stigma, to standardize the delivery of addiction medicine so that more patients receive high-quality, evidence-based care, and to cover addiction medicine in a way that expands patient access to coordinated, comprehensive care], and

[3] Stallvik, M, Gastfriend, D, Nordahl, H. (2015). Matching patients with substance use disorder to optimal level of care with the ASAM criteria software. Journal of Substance Use, 20:6, 389-398.

[4] Sharon, E., Krebs, C., Turner, W., Desai, N., Binus, G., Penk, W., Gastfriend, D. (2003). Predictive validity of the ASAM patient placement criteria for hospital utilization. Journal of Addictive Diseases, 22:sup1, 79-93.

provider/patient acceptance. Successful large system pilots have expanded public sector use in Massachusetts, Los Angeles, and California's prison system."[5]

This research and information from other states suggest that with the implementation of an ASAM criteria tool for SUD assessment throughout the state, Colorado SUD providers would consistently match patients to appropriate levels of care and thereby improve treatment outcomes and more effectively manage the cost of inpatient/residential care. The tool would also support parity compliance efforts.

Cost Adjustment for Substance Use Disorder Benefit

The Department anticipates that the costs for inpatient and residential services will be significantly less than initially projected in HB 18-1136 and that the rates paid to the Regional Accountable Entities (RAEs) will reflect the lower costs. This is a technical adjustment and not a change in the benefit design or service delivery.

Assumptions and Calculations:

Patient Placement Tool

The Department assumes that the system would be implemented on July 1st, 2020, when the Department will begin covering residential services. Before the system goes live, the Department must pay set up and training costs.

The Department received preliminary cost information from a vendor to estimate costs of implementing the tool. The Department estimates it would cost $50,000 to set up the tool. This includes developing a system that is dedicated only to Colorado and its provider agencies, creating a unique client identifier algorithm to match a state system, and providing for reporting access so that the State, as well as the providers, may have access to any of the questions and answers within the tools. This system allows each provider to access their own client records, and records may only be shared through an integrated consent process compliant with federal regulations. The State would have access to all data. The dedicated system can be expanded as the initiative moves forward with additional users and programs, with no additional set up costs for the site.

The Department estimates training costs based on the training used for providers using patient placement software in Arizona. The Department assumed four in-person trainings in the proper use of the ASAM criteria and unlimited webinar trainings, as well as six in-person trainings in the proper use of the software and two follow-up webinar trainings.

Once the system is implemented, the Department would pay for the software subscriptions for providers and system support costs.

[5] "ASAM ELearning." ASAM ELearning: The Success of ASAM's CONTINUUM – Large System Adventures in Innovation (1 CME). Accessed June 10, 2019. https://elearning.asam.org/products/the-success-of-asams-continuum-large-system-adventures-in-innovation-1-cme.

The Department assumes that it would need the same number of users, 2,500, as Arizona which, as of March 2019, has 1,598,692 Medicaid enrollees compared to Colorado's 1,208,335 enrollees, and a capitated managed care behavioral health system similar to Colorado's. The Department estimates it would cost $420 per user per year for the software license, where a user is defined as an employee of a provider who has access to the software. Under those assumptions, service costs per year post implementation would be $1,050,000.

The Department estimates it would cost $18,000 per year post implementation for tier three IT support. This level of support is conducted through a designated point person and addresses system-wide issues. The Department assumes it would need direct user IT support as well, for an estimated $120 per user per year, or a total cost of $300,000 per year.

Cost Adjustment for Substance Use Disorder Benefit

Based on the updated CHI analysis, the Department assumes the expanded benefit will cost $86,934,035 less than the funding appropriated through HB 18-1136 in FY 2020-21. The Department assumes provider capacity for the benefit will increase by FY 2021-22, and therefore the Department will need the full amount of funding appropriated in HB 18-1136 starting in that year.

Supplemental, 1331 Supplemental or Budget Amendment Criteria:

This request requires supplemental funding in FY 2019-20 for the patient placement tool and qualifies as such by meeting the criteria of an unforeseen contingency. Appropriations for HB 18-1136 did not include funding for the costs associated with the requirement listed in the 1115 waiver that "Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines."[6]

It is a priority to successfully implement HB 18-1136. In order to implement the bill, the Department must receive an 1115 waiver to receive a federal match on the services and thus the providers must implement a patient placement system. Without supplemental appropriations, the Department would not be able to implement the software concurrent with the new SUD benefit on July 1, 2020.

[6] Centers for Medicare & Medicaid Services, Section 1115 Substance Use Disorder (SUD) Demonstration: Implementation Plan.

R-11 Patient Placement and Benefit Implementation – Substance Use Disorder
Appendix A: Calculations and Assumptions

Table 1.1: FY 2019-20, Patient Placement and Benefit Implementation – Substance Use Disorder, Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$80,000	0.0	$26,400	$13,600	$0	$40,000	50%	Table 2.1 Row C
C	**Total Request**	**$80,000**	**0.0**	**$26,400**	**$13,600**	**$0**	**$40,000**	**50%**	**Row A**

Table 1.2: FY 2020-21, Patient Placement and Benefit Implementation – Substance Use Disorder, Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$1,368,000	0.0	$451,440	$232,560	$0	$684,000	50%	Table 2.2 Row B
B	(3) Behavioral Health Community Programs, Behavioral Health Capitation Payments	($86,934,035)	0.0	($17,074,274)	($5,752,247)	$0	($64,107,514)	74%	Table 2.2 Row D
C	**Total Request**	**($85,566,035)**	**0.0**	**($16,622,834)**	**($5,519,687)**	**$0**	**($63,423,514)**	**74%**	**Row A + Row B**

Table 1.3: FY 2021-22 and Ongoing, Patient Placement and Benefit Implementation – Substance Use Disorder, Summary by Line Item									
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$1,368,000	0.0	$451,440	$232,560	$0	$684,000	50%	Table 2.3 Row B
B	(3) Behavioral Health Community Programs, Behavioral Health Capitation Payments	$0	0.0	$0	$0	$0	$0		Table 2.3 Row D
C	**Total Request**	**$1,368,000**	**0.0**	**$451,440**	**$232,560**	**$0**	**$684,000**	**50%**	**Row A + Row B**

Table 2.1: FY 2019-20, Patient Placement and Benefit Implementation – Substance Use Disorder, Summary by Initiative									
Row	**Description**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
SUD Patient Placement Tool									
A	Implementation	$50,000	0.0	$16,500	$8,500	$0	$25,000	50%	Table 3, Row I
B	User Training	$30,000	0.0	$9,900	$5,100	$0	$15,000	50%	Sum of Table 3, Rows G and H
C	**Total Request for SUD Patient Placement Tool**	**$80,000**	**0.0**	**$26,400**	**$13,600**	**$0**	**$40,000**	**50%**	**Row A + Row B**

Table 2.2: FY 2020-21, Patient Placement and Benefit Implementation – Substance Use Disorder, Summary by Initiative									
Row	**Description**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
SUD Patient Placement Tool									
A	Licensing and Technical Support	$1,368,000	0.0	$451,440	$232,560	$0	$684,000	50%	Table 3, Row J
B	**Total Request for SUD Patient Placement Tool**	**$1,368,000**	**0.0**	**$451,440**	**$232,560**	**$0**	**$684,000**	**50%**	**Row A**
Cost Adjustment for SUD Benefit									
C	Capitation Rate Adjustment	($86,934,035)	0.0	($17,074,274)	($5,752,247)	$0	($64,107,514)	74%	Assume a 50% reduction in costs for the residential and inpatient benefit; see narrative
D	**Total Request for Cost Adjustment for SUD Benefit**	**($86,934,035)**	**0.0**	**($17,074,274)**	**($5,752,247)**	**$0**	**($64,107,514)**	**74%**	**Row C**
E	**Total Estiamte**	**($85,566,035)**	**0.0**	**($16,622,834)**	**($5,519,687)**	**$0**	**($63,423,514)**	**74%**	**Row B + Row D**

Table 2.3: FY 2021-22 and Ongoing, Patient Placement and Benefit Implementation – Substance Use Disorder, Summary by Initiative									
Row	**Description**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
Cost Adjustment for SUD Benefit									
A	Licensing and Technical Support	$1,368,000	0.0	$451,440	$232,560	$0	$684,000	50%	Table 3, Row J
B	**Total Estiamte**	**$1,368,000**	**0.0**	**$451,440**	**$232,560**	**$0**	**$684,000**	**50%**	**Row A**
Cost Adjustment for SUD Benefit									
C	Capitation Rate Adjustment	$0	0.0	$0	$0	$0	$0		Assume no change in FY 2021-22 and ongoing
D	**Total Request for Cost Adjustment for SUD Benefit**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**		**Row C**
E	**Total Estiamte**	**$1,368,000**	**0.0**	**$451,440**	**$232,560**	**$0**	**$684,000**	**50%**	**Row B + Row D**

R-11 Patient Placement and Benefit Implementation – Substance Use Disorder
Appendix A: Calculations and Assumptions

Table 3: SUD Patient Placement Program Costs				
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**Notes**
A	Service Cost Per User Per Year	$420	$420	$840 per user per year, 50% for over 2000 users
B	Direct IT Support Cost Per User Per Year	$0	$120	$120 per user per year. Estimated vis ASAM proposal
C	**Cost Per User Per Year**	**$420**	**$540**	**Row A + Row B**
D	Estimated Users Per Year	0	2,500	Implementation Date: July 1st 2020 2,500 Users in Arizona
E	**Estimated Utilization Dependent Costs Per Year**	**$0**	**$1,350,000**	**Row C x Row D**
F	System Wide IT Support	$0	$18,000	Ongoing IT support through a designated point person. Estimated via ASAM proposal
G	Estimated Training Costs (ASAM Criteria Training)	$10,000	$0	ASAM Proposal: Covers 4 in-person trainings, each for 40 people and Webinar access
H	Estimated Training Costs (Continuum Software Training)	$20,000	$0	ASAM Proposal: Covers 6 in-person trainings and 2 follow-up webinar trainings.
I	Estimated Other Set Up Costs	$50,000	$0	ASAM Proposal: Includes creating dedicated system for Colorado in first 8-12 weeks
J	**Estimated Total Costs**	**$80,000**	**$1,368,000**	**Sum Rows E through I**

Schedule 13

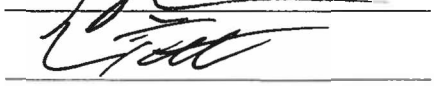
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-12 Work Number Verification

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($22,577,733)**	**($46,239,666)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($3,791,252)	($7,739,065)
	CF	$983,543,298	$0	$984,608,781	($1,436,052)	($2,923,121)
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($17,350,429)	($35,577,480)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (D) Eligibility Determinations and Client Services, (1) Eligibility Determinations and Client Services - Work Number Verification	**Total**	**$0**	**$0**	**$0**	**$1,531,649**	**$3,305,114**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$505,040	$1,089,815
	CF	$0	$0	$0	$252,569	$545,013
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$774,040	$1,670,286
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($24,109,382)**	**($49,544,780)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($4,296,292)	($8,828,880)
	CF	$983,543,298	$0	$984,608,781	($1,688,621)	($3,468,134)
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($18,124,469)	($37,247,766)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-12
Request Detail: Work Number Verification

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**($22,577,733)**	**($46,239,666)**
FTE	0.0	0.0	0.0
General Fund	$0	($3,791,252)	($7,739,065)
Cash Funds	$0	($1,436,052)	($2,923,122)
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	($17,350,429)	($35,577,480)

Summary of Request:

The Department requests a decrease of $22,577,733 total funds, including a decrease of $3,791,252 General Fund in FY 2020-21, and a decrease of $46,239,666 total funds, including a decrease of $7,739,065 General Fund in FY 2021-22, in order to implement a robust income verification process for Medicaid and CHP+ eligibility determinations based on real-time verifications. The Department's requested change to cash funds includes the Healthcare Affordability and Sustainability Fee cash fund. The Department is requesting to procure a contract with a vendor to obtain work number verification data and anticipates costs avoided from a reduction in Medicaid caseload. The Department would begin utilizing this data in the second half of FY 2020-21 and the savings would be ongoing, with FY 2021-22 seeing the full-year impact of the real-time income verification process. This request represents a decrease of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

The Department determines eligibility for Medicaid and Child Health Plan Plus (CHP+) members based on information about the member and the member's immediate family. The primary eligibility determinants are total gross household income compared to the Federal Poverty Level (FPL) and the household composition. To be determined eligible for Medicaid or CHP+, a member must meet the eligibility requirements of one of the eligibility categories as defined by the Department, following the guidelines set in the Social Security Act and Colorado state statute. Currently income is self-attested by individual members when they are initially determined or re-determined eligible for Medicaid or CHP+ with a requirement of post-eligibility verification through a valid electronic data source.

An individual is not required to provide documentation of income unless the self-attestation of income cannot be verified electronically, or the information verified electronically does not clear the reasonable compatibility process. Reasonable compatibility is a method of comparing applicants' self-attested income against income information from additional sources, such as information provided by the Colorado Department of Labor and Employment (CDLE) through the Income and Eligibility Verification System (IEVS) interface, as allowed by federal regulation[1]. Most employers in Colorado are required to report the wages of their employees to CDLE, and the IEVS interface is used to retrieve wage data from CDLE to verify wage information reported by their employer.

Reasonable compatibility is established if the income reported through IEVS is at or below the income limit for the program or if the individual attests to income below the applicable income standard, and the data source indicates income above the applicable standard, and the difference between the two is less than 10%. If income information provided by a member is determined to be not reasonably compatible with income obtained through IEVS, a notice about the discrepancy is sent to the member. The member will have a reasonable opportunity period to provide a reasonable explanation of the discrepancy or updated income verification. The Department is implementing a reasonable opportunity period of 30 days, effective at the beginning of FY 2020-21. If the discrepancy is not resolved during the reasonable opportunity period, the member's eligibility will be redetermined using the IEVS income and they may be terminated due to being over income. The purpose of the IEVS interface and the reasonable compatibility process is to correctly verify if the income eligibility requirements for Medicaid and CHP+ are met. In FY 2017-18, 236,474 members were sent a discrepancy notice from the reasonable compatibility process. Of those, 74,157 were subsequently disenrolled following their reasonable opportunity period.

Problem or Opportunity:

The income verification process does not operate in real time. Employers are only required to report their employment data to CDLE quarterly; therefore, the updates that the Colorado Benefits Management System (CBMS) receives from the IEVS interface affect the Medicaid caseload after these quarterly updates are received and the member's reasonable opportunity period has ended. This means that there is at least a four-

[1] 42 CFR § 435.952(C)

month period during which certain individuals are enrolled in Medicaid who are later found to be ineligible, as their income is over the allowable threshold. Due to the current delayed income verification process, the Department is paying for services incurred by members who are later determined to be ineligible.

In addition, the current reasonable compatibility process creates additional workload for eligibility workers and confusion for members. Eligibility workers must update cases that are reported to them after an income discrepancy notice has been issued with either the explanation of the discrepancy or the new income verification. Members who receive notices experience a great deal of confusion about what it means for them and what to do next. Implementing an income verification upon the initial application or redetermination would significantly minimize the amount of work needed to follow up on IEVS verifications and would result in a streamlined process for members.

Proposed Solution:

The Department requests a net decrease of $22,577,733 total funds, including a net decrease of $3,791,252 General Fund. This request represents a decrease of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation. The Department also requests a net decrease of $46,239,666 total funds, including a net decrease of $7,739,065 General Fund in FY 2021-22 and future years in order to implement a real-time income verification process for eligibility determinations. The requested savings would come from preventing members who are later determined to be over the income threshold for Medicaid or CHP+ from being enrolled in the first place.

To implement the real-time verification process, the Department would contract with a vendor that can provide income verification data in real-time as the member is being determined eligible for medical assistance through CBMS. The Department would be able to access two different hubs of employer-reported data – one hub is maintained by the Centers for Medicare and Medicaid Services (CMS), which the Department can access at zero cost. The second hub contains a more complete dataset of employment records and would be available to the Department at a cost.

The CMS hub only contains information requested of the vendor by CMS. CMS requests the data with various fields that serve as filters to narrow down the data to be relevant to its purposes. If there is information about an employer that does not match CMS' filters, that record will not be included in the CMS data hub. For example, CMS requires Federal Employment Identification Number (FEIN) to be collected in their database hub. This dataset may not have FEIN for every employer record included in the dataset, as the dataset existed before CMS required this field. Any employment record in the complete database operated by the vendor that does not include FEIN will not be in the data hub operated by CMS, and the Department would need to pay the vendor to obtain real-time income information regarding any member who works for that employer. There are some employment records that do not exist even in this more robust dataset, such as for smaller, rural employers. The Department would need to continue to use CDLE data from the IEVS interface for those employers.

The Department proposes using the two databases together, along with the current IEVS interface, to properly identify eligibility in a "waterfall" approach. The Department would configure CBMS to search member employment records through the CMS data hub first; any employment records that do not match to that database would be searched against the vendor's dataset. If the employment record does not exist in either the CMS data hub or the vendor's dataset, the Department would use the current IEVS income verification process to verify income after the member is determined eligible. This waterfall approach would ensure the Department verifies income in the least costly, most efficient manner for each member.

The Department estimates that the overall effect of these real-time income determinations would be to reduce the number of members who are later determined to be ineligible for Medicaid. The Department estimates that these members are on Medicaid or CHP+ for at least four months before they are disenrolled through the reasonable compatibility process. Real-time income verification would dampen the Medicaid caseload as these members would never be determined eligible for Medicaid in the first place. The Department estimates the costs avoided as a result of these members not enrolling in Medicaid to be $24,109,382 total funds in FY 2020-21 and $49,544,780 total funds in FY 2021-22.

If this request is not approved the reasonable compatibility process would continue to have a significant built-in delay, with members enrolling into Medicaid and CHP+ only to be later determined ineligible.

Anticipated Outcomes:

The Department anticipates the work number verification system would put downward pressure on caseload growth, particularly for the MAGI Parents and Adults eligibility categories, which are income-sensitive populations. It would prevent Medicaid and CHP+ members from enrolling who are later found to be ineligible due to income and save money for the State. In addition, the work number verification system would reduce the administrative burden on county workers who are required to resolve all of the discrepancies through the current reasonable compatibility process and simplify the eligibility determination process for members. These outcomes align with the Department's Performance Plan long-range goals of enhancing the community experience of individuals and families, reducing the cost of health care in Colorado, and operational excellence.

Assumptions and Calculations:

The Department estimates that this request would lead to a net savings of $22,577,733 in FY 2020-21 and a net savings of $46,239,666 in FY 2021-22 and onward. The net savings for both fiscal years is based on the combined estimate impact of the cost of contracting with a vendor to access the work number verification dataset and the savings to the Department from a reduction in caseload due to preventing certain members from enrolling in Medicaid and CHP+.

The Department would pay the vendor directly each time the eligibility system checks the complete, paid database to verify a member's income. Because the vendors collect wage information from only larger employers, the Department anticipates that the IEVS interface would still assist the Department with eligibility determinations; however, the volume of IEVS interface determinations is expected to decrease.

To arrive at the estimated costs, the Department used the number of newly determined cases and the number of re-determined cases for most recent months to get an approximate monthly average of the number of cases that would be checked against the work number verification system for Medicaid and CHP+ determinations. This monthly average is then applied to the share of cases that would be checked against the complete dataset held by the vendor, rather than the free CMS hub, to get the estimated number of cases that the Department would need to pay for in any given month. The share of cases in the complete dataset is based on the percentage of applicants matched to employer records within the Supplemental Nutrition Assistance Program (SNAP), which currently has a similar work number verification contract with a vendor. The Department assumes that this will be comparable to the percentage of Medicaid applicants who would be matched to employer records in the dataset. The Department assumes that the number of cases determined each month would grow proportionally to caseload growth and applies the caseload growth percentage to average affected monthly cases for FY 2021-22.

The Department received an estimated cost from a vendor of the cost per verification in the dataset. The total estimated paid verifications are then multiplied by this verification cost to obtain the total cost to the Department to use the work number verification dataset. The vendor-estimated rate increased from FY 2019-20 to FY 2020-21, and the Department assumes the rate will grow by the same percentage between FY 2020-21 and FY 2021-22 and has built that growth into the estimate.

The Department is assuming that all the necessary preparatory work would be completed before January 1, 2021, and real-time income verification process would begin on that day. Thus, the total cost for FY 2020-21 is divided in half to match the implementation timeline. The Department assumes the preparatory work would include building an interface between CBMS and the vendor database and CMS hub, which can be accomplished through existing CBMS pool hours, procuring the contract, and modifying the State Plan and Department rules to incorporate real-time income verification.

The Department estimates the cost savings by first determining the number of members whose Medicaid span was terminated because of the IEVS interface in FY 2017-18. These members were identified as members who received an IEVS discrepancy notice and no longer had an active Medicaid span after their reasonable opportunity period. The Department trended this forward by projected caseload growth to estimate the number of members who would be disenrolled due to the reasonable compatibility process in FY 2020-21 and FY 2021-22. The Department identified the expenditure these members incurred during their reasonable opportunity period using claims data from the Medicaid Management Information System (MMIS) to calculate a per member per month (PMPM) cost for impacted members. This PMPM is then multiplied by four months, which is the minimum estimated time they would otherwise be enrolled on Medicaid, and the estimated number of affected members to obtain the estimated costs avoided from preventing these members from enrolling in the first place.

All calculations are detailed in the Appendix.

Table 1.1 FY 2020-21 Work Number Verification Request Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total Request**	**($22,577,733)**	**0.0**	**($3,791,252)**	**($1,436,052)**	**$0**	**($17,350,429)**	**Row B + Row C**
B	Verification	$1,531,649	0.0	$505,040	$252,569	$0	$774,040	Table 2.1, Row A
C	(2) Medical Services Premiums	($24,109,382)	0.0	($4,296,292)	($1,688,621)	$0	($18,124,469)	Table 2.1, Row B

Table 1.2 FY 2021-22 Work Number Verification Request Summary by Line Item								
Row	**Item**	**Total Funds**	**FTE**	**General Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	**Total Request**	**($46,239,666)**	**0.0**	**($7,739,065)**	**($2,923,122)**	**$0**	**($35,577,480)**	**Row B + Row C**
B	Verification	$3,305,114	0.0	$1,089,815	$545,013	$0	$1,670,286	Table 2.2, Row A
C	(2) Medical Services Premiums	($49,544,780)	0.0	($8,828,880)	($3,468,135)	$0	($37,247,766)	Table 2.2, Row B

Table 2.1 FY 2020-21 Summary By Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Comments**
	Work Number Verification								
A	Contractor Cost for Verifications	$1,531,649	0.0	$505,040	$252,569	$0	$774,040	50.54%	Table 3.2, Row G
B	Costs Avoided from Lower Caseload	($24,109,382)	0.0	($4,296,292)	($1,688,621)	$0	($18,124,469)	75.18%	Table 3.1, Row J
C	**Total Impact in FY 2020-21**	**($22,577,733)**	**0.0**	**($3,791,252)**	**($1,436,052)**	**$0**	**($17,350,429)**	**76.85%**	**Row A + Row B**

Table 2.2 FY 2021-22 and Ongoing Summary By Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Comments**
	Work Number Verification								
A	Contractor Cost for Verifications	$3,305,114	0.0	$1,089,815	$545,013	$0	$1,670,286	50.54%	Table 3.2, Row G
B	Costs Avoided from Lower Caseload	($49,544,780)	0.0	($8,828,880)	($3,468,135)	$0	($37,247,766)	75.18%	Table 3.1, Row J
C	**Total Impact in FY 2021-22**	**($46,239,666)**	**0.0**	**($7,739,065)**	**($2,923,122)**	**$0**	**($35,577,480)**	**76.94%**	**Row A + Row B**

Table 3.1 Estimated Costs Avoided From Real Time Income Verification				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	Estimated Annual Number of Clients Terminated Through IEVS[(1)]	74,157	74,894	Identified as the Number of Clients whose Medicaid Spans were Terminated after receiving a letter from IEVS
B	Caseload Growth Factor	0.99%	2.75%	February Caseload Projections
C	Estimated Total Annual Number of Clients Terminated Through IEVS	74,894	76,954	Row A*(1+Row B)
D	Estimated PMPM Costs of IEVS Clients	$292.65	$292.65	Calculated as the Sum of Claims of clients in Row A divided by Row C divided by 12
E	Cost of Claims Over 4 Month Affected Period	$87,670,480	$90,081,418	Row D * Row C * 4 Months
F	Percent of Employers in Dataset	55.00%	55.00%	Vendor Estimate
G	**Costs Avoided**	**($48,218,764)**	**($49,544,780)**	**Row E * Row F * (-1)**
H	Implementation Date Adjustment	50.00%	100.00%	Assuming Start date January 1, 2021
I	**Total Costs Avoided**	**($24,109,382)**	**($49,544,780)**	**Row I* Row H**

[(1)]Income Eligibility Verification System (IEVS)

Table 3.2 Estimated Cost of Vendor Contract				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	Estimated Verifications- Medicaid	36,520	37,524	Table 3.3 Row G
B	Estimated Verification Rate	$6.66	$6.99	Vendor Estimate
C	Rate Adjustment	5.01%	5.01%	Vendor Estimate; Assuming the same growth rate for both years
D	Cost Per Verification	$6.99	$7.34	Row B * (1+Row C)
E	**FY 2020-21 Estimated Cost**	**$3,063,298**	**$3,305,114**	**Row A * Row D * 12**
F	Implementation Date Adjustment	50.00%	100.00%	Assuming Start date January 1, 2021
G	**Total Cost of Vendor Contract**	**$1,531,649**	**$3,305,114**	**Row E * Row F**

Tabel 3.3 Estimated Average Monthly Cases to be Verified				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	Newly Determined Cases	35,057	35,057	Average of Previous 4 months
B	Redetermined Cases	138,948	138,948	Average of Previous 4 months
C	Monthly Medicaid Cases	174,005	174,005	Row A + Row B
D	Caseload Growth	0.99%	2.75%	S-1 Caseload Forecast
E	**Total Monthly Medicaid Cases**	**174,005**	**178,790**	**Row D * (1 + Row D)**
F	Percent of Employers in Dataset	55.00%	55.00%	Vendor estimate
G	Paid Service Share of Cases	38.16%	38.16%	Estimated number covered by the free service
H	**Total Affected Medicaid Cases**	**36,520**	**37,524**	**Row E * Row F * Row G**

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-13 Long-Term Care Utilization Management

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$22,864,305**	**$0**	**$22,630,967**	**$1,746,531**	**$1,746,531**
	FTE	0.0	0.0	0.0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	$5,808,855	$0	$7,030,521	$431,632	$431,632
	CF	$1,587,101	$0	$1,587,101	$5,002	$5,002
	RF	$0	$0	$0	$0	$0
	FF	$15,468,349	$0	$14,013,345	$1,309,897	$1,309,897

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$22,864,305**	**$0**	**$22,630,967**	**$1,746,531**	**$1,746,531**
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,808,855	$0	$7,030,521	$431,632	$431,632
	CF	$1,587,101	$0	$1,587,101	$5,002	$5,002
	RF	$0	$0	$0	$0	$0
	FF	$15,468,349	$0	$14,013,345	$1,309,897	$1,309,897

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-13
Long Term Care Utilization Management

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$1,746,531**	**$1,746,531**
FTE	0.0	0.0	0.0
General Fund	$0	$431,632	$431,632
Cash Funds	$0	$5,002	$5,002
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$1,309,897	$1,309,897

Summary of Request:

The Department requests $1,746,531 total funds including $431,632 General Fund, $5,002 cash funds and $1,309,897 federal funds in FY 2020-21and ongoing for enhancing the scope of work of its Long-Term Care Utilization Management (LTC UM) contract. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund. The enhanced scope would direct utilization management activities of the In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) populations. This request represents less than 0.5% of the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

The Department currently contracts with separate Quality Improvement Organizations (QIO) for its standard Utilization Management contract (UM) and its Long-Term Care Utilization Management contract (LTC UM). A QIO is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to individuals. Additionally, an entity designated as a QIO is part of the QIO program,[1] one of the largest federal programs dedicated to improving health quality for Medicaid and Medicare beneficiaries and an integral part of the National Quality Strategy of the U.S. Department of Health and Human Services (HHS) for providing better care and better health at lower cost.[2] The mission of the QIO program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicaid and Medicare beneficiaries.[3]

The Department's current LTC UM contract is comprised of multiple activities to review and evaluate program enrollment and service delivery options provided through Home and Community Based Services (HCBS) waiver programs. HCBS programs provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. Enrollments in these programs need to be examined and reviewed to comply with key regulatory requirements from the Centers for Medicare and Medicaid Services (CMS).

The activities performed in the LTC UM contract include:

1. Brain Injury Supportive Living Program and Transitional Living Program Acuity Assessments
2. Critical Incident Reporting and Monitoring
3. Post Eligibility Treatment of Income Incurred Medical Expenses Review
4. Intermediate Care Facility Continued Stay Reviews
5. Hospital Back-Up Continued Stay Reviews
6. Case Management Agency Performance and Quality Reviews
7. Quality Improvement Strategy and Review

Older adults and people with disabilities accounted for 12.79% of the Department's overall caseload in FY 2017-18. Their total cost of care, including medical and long-term services and supports, represented 42.9% of the Department's total expenditure of Medical Services Premiums in FY 2017-18. To ensure high quality services for this population, the Department must continually work to improve the authorization and oversight of the life-saving long term services and supports that are at the core of the service package utilized

[1] https://qioprogram.org/sites/default/files/QIN-QIO_Fact_Sheet_Aug2018_FINAL_508.pdf

[2] The National Quality Strategy (NQS) was first published in March 2011 as the National Strategy for Quality Improvement in Health Care and is led by the Agency for Healthcare Research and Quality (AHRQ) on behalf of the HHS; https://www.ahrq.gov

[3] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html

by older adults and members with disabilities. Additionally, this process of oversight must include processes to ensure the health, safety, and welfare of all individuals in services.

The LTC UM activities performed by the QIO provide critical program oversight by ensuring member services are authorized in full compliance with required rules and regulations. Additional objectives of the LTC UM contract are improving the quality of the work of the Department with its contracted agencies, as well as identifying and preventing fraud.

Both IHSS and CDASS form part of the Department's commitment to providing service-delivery options that empower members and their families to direct and manage the long-term care services and supports they need to live at home. IHSS allows the member, with the support of a home care agency, to direct and manage the attendants that provide their personal care, homemaker and health maintenance services. Through IHSS, the member is empowered to select, train and manage attendants of choice to best fit their unique needs. The member may also delegate these responsibilities to an authorized representative. IHSS is available in the following HCBS programs: Children's Home and Community Based Services (CHCBS) waiver, Elderly, Blind, and Disabled (EBD) waiver, and Spinal Cord Injury (SCI) waiver.

CDASS allows people with disabilities to manage their attendant care to an even greater degree than IHSS. In CDASS, the member receives a funding allocation[4] from the Department and comprehensive training from a case management agency to develop and manage their Attendant Support Management Plan (ASMP)[5]. The member is then able to hire, train, supervise, manage, and if necessary, fire their attendants. The member may also have an authorized representative direct the services on the member's behalf. In CDASS, the member, or an authorized representative, exclusively controls attendant care by making the attendant-care decisions and taking responsibility for them. CDASS provides the member with greater flexibility in managing their daily routine and the opportunity to take greater control of their life.

Problem or Opportunity:

The Department lacks a thorough utilization review strategy for specific high-growth populations within HCBS programs. Expenditures attributed to IHSS populations grew by approximately 35.6% from FY 2017-18 to FY 2018-19 while CDASS expenditures grew at approximately 6.54% over the same period. The existing review activities from Over Cost Containment (OCC) reviews encompass a sampling of plans within these populations; however, the OCC activities focus on identifying potential violations of federal cost neutrality requirements and provide insufficient oversight of the oftentimes complex cases of consumer-directed service options.

[4] The funds determined by the case manager and made available by the Department to members receiving CDASS and administered by the Fiscal Management Services (FMS) authorized for attendant support services and administrative fees paid to the FMS.

[5] The documented plan for members to manage their care as determined in Department rule 10 CCR 2505-10 § 8.510.4 which is reviewed and approved by the case manager.

Determinations of service authorization in IHSS and CDASS are made by case management agency representatives who frequently lack clinical expertise and whose decisions are not subject to oversight or accountability measures. Lack of clinical expertise and accountability increases the risk of a case manager inappropriately authorizing these services. Without additional resources directed to LTC UM, the Department is unable to direct its vendor, a certified QIO entity, to evaluate the IHSS and CDASS determinations for appropriateness and medical necessity of services.

Proposed Solution:

The Department requests $1,746,531 total funds including $431,632 General Fund, $5,002 cash funds and $1,309,897 federal funds in FY 2020-21 and ongoing to implement additional LTC UM activities. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund.

The Department currently utilizes a UM vendor for appropriate authorization of skilled care services under Long Term Home Health. CDASS and IHSS allow for an attendant to perform the delivery of skilled care services through health maintenance activities. Implementing UM review for CDASS and IHSS would allow the Department to have consistency in the service authorization for skilled care services regardless of the service delivery model.

A robust and thorough UM program with QIO oversight of IHSS and CDASS would ensure case managers are authorizing the clinically appropriate services for members who choose to receive their health maintenance services through a self-directed option. While implementation of this request would likely result in savings on medical costs, the Department is not including explicit savings in this request and will account for demonstrated savings in future years through the normal budget process.

If this request is not approved, the Department would continue to have no reliable way to ensure that service plans are consistent with best practices.

Anticipated Outcomes:

Approval of this request would provide the Department funding to implement additional activities within its LTC UM contract.

The risk of inappropriate authorization of services would be mitigated by the oversight provided by the QIO contracted as the Department's UM vendor. The QIO would begin UM activities by receiving the initial Prior Authorization Review (PAR) submitted by the case manager and then prospectively reviewing the list of the proposed services, funding allocation and other relevant information for the member's proposed service-delivery plan. The UM vendor would review health maintenance service to ensure the appropriateness and medical necessity of the authorized services according to evidence-based criteria and regulations. The Department could then direct concurrent and retrospective reviews of each case as necessary.

Approval of this request would allow the Department, using an LTC UM vendor, to ensure appropriate authorization of Health Maintenance Activities through IHSS and CDASS service delivery options.

The Department would monitor the success of the additional UM activities by comparing service allocations from prior to implementation to service allocations after implementation. This work can be accomplished within existing Department resources and data. The Department would also require the vendor to provide detailed reporting on how allocations were reduced or increased from the initial assessment. Case managers would be responsible for ensuring that, as authorized services change, that members are having their needs met in the community.

Assumptions and Calculations:

Detailed assumptions and calculations are provided in Appendix A.

Table 1 shows a summary by line item for this request.

Table 2 shows a summary by initiative for this request.

Table 3 shows the detailed deliverables of the additional activities encompassing IHSS and CDASS that comprise a contract maximum. The Department established the expected contract maximum rate for these services utilizing the following industry-wide factors; employee classifications and salaries, facility expenses, capital expenses, and administrative costs.

Table 1.1 - Summary By Line Item FY 2020-21								
Row	**Description**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[(1)]**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$1,746,531	0.0	$431,632	$5,002	$0	$1,309,897	Table 2.1, Row C
B	**Total Request**	**$1,746,531**	**0.0**	**$431,632**	**$5,002**	**$0**	**$1,309,897**	**Row A**

[(1)]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund

Table 1.2 - Summary By Line Item FY 2021-22 and Ongoing								
Row	**FY 2020-21**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[(1)]**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$1,746,531	0.0	$431,632	$5,002	$0	$1,309,897	Table 2.2, Row C
B	**Total Request**	**$1,746,531**	**0.0**	**$431,632**	**$5,002**	**$0.00**	**$1,309,897**	**Row A**

[(1)]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund

Table 2.1 - Summary by Initiative FY 2020-21									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
Long Term Care Utilization Management Contract									
Cost of Additional Activities									
A	Consumer-Directed Attendant Support Services (CDASS) Utilization Reviews	$253,841	0.0	$62,191	$1,270	$0	$190,380	75.00%	Table 3, Row F
B	In-Home Support Services (IHSS) Utilization Reviews	$1,492,690	0.0	$369,441	$3,732	$0	$1,119,517	75.00%	Table 3, Row L
C	**Total Request**	**$1,746,531**	**0.0**	**$431,632**	**$5,002**	**$0**	**$1,309,897**	**75.00%**	**Row A + Row B**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund

Table 2.2 - Summary by Initiative FY 2021-22 and Ongoing									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
Long Term Care Utilization Management Contract									
Cost of Additional Activities									
A	Consumer-Directed Attendant Support Services (CDASS) Utilization Reviews	$253,841	0.0	$62,191	$1,270	$0	$190,380	75.00%	Table 3, Row F
B	In-Home Support Services (IHSS) Utilization Reviews	$1,492,690	0.0	$369,441	$3,732	$0	$1,119,517	75.00%	Table 3, Row L
C	**Total Request**	**$1,746,531**	**0.0**	**$431,632**	**$5,002**	**$0**	**$1,309,897**	**75.00%**	**Row A + Row B**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund

Table 3 - Long Term Care Utilization Management Contract
Proposed Additional Activities
FY 2020-21 and Ongoing

Row	Deliverables	Quantity	Final Price	Total Price	Category	Enhanced Match (75%)	CFR	FMAP	Total Funds	Federal Funds
A	Each CDASS PAR Reviewed	3,977	$54.03	$214,876.43	CDASS	Yes	42 CFR §475.102	75%	$214,876.00	$161,157.00
B	CDASS PAR Review Monthly Report	12	$1,156.24	$13,874.85	CDASS	Yes	42 CFR §475.102	75%	$13,875.00	$10,406.00
C	CDASS PAR Review Quarterly Trend Analysis	4	$2,189.33	$8,757.30	CDASS	Yes	42 CFR §475.102	75%	$8,757.00	$6,568.00
D	CDASS PAR Review Annual Report	1	$4,688.82	$4,688.82	CDASS	Yes	42 CFR §475.102	75%	$4,689.00	$3,517.00
E	CDASS PAR Review Weekly Meeting	52	$223.91	$11,643.58	CDASS	Yes	42 CFR §475.102	75%	$11,644.00	$8,733.00
F	**Subtotal - CDASS Activities**	**NA**	**NA**	**NA**	**CDASS**	**Yes**	**42 CFR §475.102**	**75%**	**$253,841.00**	**$190,381.00**
G	Each IHSS PAR Reviewed	26,906	$54.03	$1,453,725.25	IHSS	Yes	42 CFR §475.102	75%	$1,453,725.00	$1,090,294.00
H	IHSS PAR Review Quarterly Trend Analysis	4	$2,189.33	$8,757.30	IHSS	Yes	42 CFR §475.102	75%	$8,757.00	$6,568.00
I	IHSS PAR Review Monthly Report	12	$1,156.24	$13,874.85	IHSS	Yes	42 CFR §475.102	75%	$13,875.00	$10,406.00
J	IHSS Annual Report	1	$4,688.82	$4,688.82	IHSS	Yes	42 CFR §475.102	75%	$4,689.00	$3,517.00
K	IHSS Weekly Meeting	52	$223.91	$11,643.58	IHSS	Yes	42 CFR §475.102	75%	$11,644.00	$8,733.00
L	**Subtotal - IHSS Activities**	**NA**	**NA**	**NA**	**IHSS**	**Yes**	**42 CFR §475.102**	**75%**	**$1,492,690.00**	**$1,119,518.00**
M	**Total Proposed Additional Activities (Row F + Row L)**								**$1,746,531.00**	**$1,309,899.00**

Acronym Legend
CDASS - Consumer-Directed Attendant Support Services
IHSS - In Home Support Services
PAR - Prior Authorization Review

Schedule 13

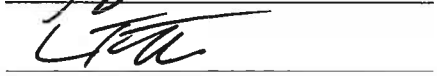
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-14 Enhanced Care and Condition Management

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$71,525,490**	**$0**	**$70,874,137**	**$433,636**	**$390,324**
	FTE	500.0	0.0	504.1	1.0	1.0
	GF	$23,679,257	$0	$23,776,718	$143,099	$128,806
	CF	$7,175,758	$0	$7,324,251	$73,715	$66,354
	RF	$2,820,754	$0	$2,708,037	$0	$0
	FF	$37,849,721	$0	$37,065,131	$216,822	$195,164

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$93,645**	**$97,394**
	FTE	500.0	0.0	504.1	1.0	1.0
	GF	$13,478,948	$0	$14,470,561	$30,903	$32,140
	CF	$3,571,232	$0	$3,714,633	$15,918	$16,556
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$46,824	$48,698
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$10,042**	**$10,042**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$3,314	$3,314
	CF	$421,237	$0	$525,947	$1,707	$1,707
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$5,021	$5,021

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$142**	**$147**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$47	$48
	CF	$5,301	$0	$5,495	$24	$25
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$71	$74
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$4,168**	**$4,334**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$1,375	$1,430
	CF	$159,398	$0	$166,329	$708	$737
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$2,085	$2,167
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$4,168**	**$4,334**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$1,375	$1,430
	CF	$159,398	$0	$166,329	$708	$737
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$2,085	$2,167
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$5,653**	**$950**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$1,014,866	$0	$939,016	$1,865	$313
	CF	$243,961	$0	$197,797	$961	$161
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$2,827	$476
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$315,818**	**$273,123**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	GF	$6,015,380	$0	$4,503,802	$104,220	$90,131
	CF	$2,615,231	$0	$2,547,721	$53,689	$46,431
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$157,909	$136,561

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-14
Request Detail: Enhanced Care and Condition Management

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$433,636**	**$390,324**
FTE	0.0	1.0	1.0
General Fund	$0	$143,099	$128,806
Cash Funds	$0	$73,715	$66,354
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$216,822	$195,164

Summary of Request:

The Department requests $433,636 total funds, including $143,099 General Fund, $73,715 cash funds, $216,822 federal funds, and 1.0 FTE in FY 2020-21; and $390,324 total funds, including $128,806 General Fund, $66,354 cash funds, $195,164 federal funds, and 1.0 FTE in FY 2021-22 and ongoing to provide dedicated Department resources for improving clinical care and condition management for the Department's highest risk and highest cost members. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund. The resources requested would allow the Department to dedicate effort on assisting Regional Accountable Entities (RAEs) with improved case management of their highest risk, highest cost members. The Department anticipates that this minimal investment would galvanize current clinical care and condition management efforts across the state and would reduce utilization for the targeted population. This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

Through Phase II of the Accountable Care Collaborative (ACC) and SB 18-266 "Controlling Medicaid Costs," the Department has generated broad delivery system reform that has provided a solid platform to support and expand efforts to improve the targeted focus on affordability aligned with the "Polis-Primavera Roadmap to Saving Coloradans Money on Health Care."[1] The Department has achieved broad savings through the integration of physical and behavioral health under the RAEs as well as mandatory enrollment in the ACC, and is now focusing efforts on high-cost, complex populations to further control costs.

To this end, beginning in FY 2018-19, the Department conducted a clinical and data-driven analysis of the Medicaid population and a review of the RAEs' existing care management and coordination efforts to develop a statewide approach to addressing the health care needs of the state's highest-cost members. This analysis provides the RAEs with targeted populations to allow evidence-informed allocation of care coordination resources. The analysis narrowed in on an impactable population with over $25,000 in annual per member expenditure. This population is composed of 37,067 members with an overall spend on medical services of $2,461,520,979 in CY 2018. It includes neonates, children and adults with complex medical conditions, members with disabilities, children in foster care, and members age 65 and older. With this information, RAEs have created plans specific to their region to improve the cost and quality of care for this targeted population. Using existing resources, the Department has developed cost trend and quality outcome metrics and is leveraging staff oversight to support and monitor the performance of the RAEs in reducing costs for this population. Preliminary outcomes are included in the 2019 SB 18-266 legislative report.

In FY 2018-19, the Department conducted an analysis of the prevalence, comorbidity, and cost of the top chronic conditions present in the Medicaid population. The top chronic conditions by total spend are chronic pain, anxiety/depression, hypertension, diabetes, substance use disorder (SUD), cardiovascular disease and chronic obstructive pulmonary disease. The conditions with the highest cost of single diagnosis presentation are chronic pain, anxiety and depression; representing 110,635 members with over $1,088,820,494 in annual medical services expenditures. While 8,476 members of this group already have average per capita costs of over $25,000; 102,159 members have under $25,000 in annual per member expenditure with a total annual spend of $425,224,073. If not managed, the Department's analysis suggests that these chronic conditions have strong disease progression correlation with comorbidities of SUD, hypertension and diabetes. The presence of comorbidities increases costs significantly over the long term and impacts life quality. The Department is working with the RAEs to understand existing programs and capabilities to prevent the progression and improve the outcomes for these conditions.

Problem or Opportunity:

The Department has taken significant steps with the integration of physical and behavioral health and mandatory enrollment in the ACC to improve health outcomes and bend the cost curve of medical care downward. On this strong platform, the Department now has the opportunity to refine and focus the program

[1] https://www.colorado.gov/governor/news/gov-polis-unveils-roadmap-lowering-health-care-costs

on targeted, high-risk and high-cost populations that present the greatest opportunity for additional savings on medical care. Given that less than 5% of the Department's clients are responsible for over 50% of the Department's spending on medical services, the Department anticipates that its targeted efforts for this population, and minimal additional investment in care and condition management for this population, would produce disproportionally large savings to the Department's spending on medical care. Utilizing the new resources available through SB 18-266 "Controlling Medicaid Costs," the Department has the opportunity to leverage the flexible design of the RAEs to target their efforts on these populations with the highest impactable medical spending.

Through the work of the ACC Cost Collaborative (the Department's convened cost and best practices forum with the RAEs), a gap was identified in the ability of RAEs to provide chronic condition management programs on a regional basis. It was determined that programs for certain conditions would have better cost and quality outcomes if a centralized offering of the programs were implemented. Conditions with statewide prevalence and a need for continuity in offering across the population were identified for a centralized program and include chronic pain, anxiety, and depression. The Department now has an opportunity to follow up on the work of the ACC Cost Collaborative and begin implementing centralized programs that assist members with these chronic conditions to better manage these conditions and navigate clinical options available to them.

Proposed Solution:

The Department requests $433,636 total funds, including $143,099 General Fund, $73,715 cash funds, $216,822 federal funds, and 1.0 FTE in FY 2020-21; and $390,324 total funds, including $128,806 General Fund, $66,354 cash funds, $195,164 federal funds, and 1.0 FTE in FY 2021-22, and ongoing, to improve clinical care and chronic condition management for the Department's highest-risk, highest-cost members. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund.

The request includes 1.0 FTE to serve as the Enhanced Care Management Program Manager to coordinate the ongoing efforts of the Department and the RAEs to improve care and condition management for the highest-risk, highest-cost members. The Department's request also includes $315,818 total funds in FY 2020-21 and $273,123 total funds in FY 2021-22 and ongoing for contractor costs to provide members with interactive, user-friendly software that gives members on-demand, clinically-based guidance and techniques for managing chronic pain, anxiety, and depression.

The requested FTE would be responsible for coordinating and expanding Department initiatives to provide better care and condition management for the state's highest-risk, highest-cost populations. The position would harmonize the work of existing Department staff and set up the dedicated infrastructure needed to propel forward the Department's efforts at curbing medical spending for high-risk, high-cost members. The position would closely coordinate with RAEs, the Department of Human Services, regional hospitals, and other providers to develop and implement initiatives for better-coordinated care in the targeted populations. The position would serve as a centralized point of contact at the Department for the RAEs by coordinating intensive and individualized services for complex members. The FTE would work closely with RAEs to

provide analytic and clinical insight into regionally attributed members, and assist RAEs with the production of regional-specific plans to help control cost and quality of care for targeted members. This position would evaluate data-driven and clinical analyses for highly complex populations to better synchronize member care across multiple providers, ensure appropriate services are utilized and duplicative or unnecessary care is avoided.

The requested contractor funding beginning in FY 2020-21 is to hire a contractor that would coordinate closely with the requested FTE and regional RAE programs to address the management of chronic pain, anxiety, and depression among members. This contractor would provide interactive, web, and mobile software that gives users evidence-based guidance and techniques to managing these chronic conditions. Examples of what this software would include are:

- mobile applications that provide step-by-step anxiety and mood management techniques based on well-established cognitive behavioral therapy and mindfulness practices;
- peer-led programs enabled by the software that teach members strategies for dealing with chronic pain and managing opioid use; and
- customizable, daily tracking features that allow members to track their sleep, mood, or pain symptoms to promote increased awareness and reinforce positive changes.

If this request is not approved, then the Department would miss an opportunity to further focus and enhance cost control efforts achieved through the integration of physical and behavioral health as well as mandatory enrollment in the ACC. While these ongoing initiatives provide strong foundations for curbing the cost of medical care among the Department's members, without a consistent and centralized focus on complex high-cost populations, uncontrolled health care costs would continue to rise. If this request is not approved, the Department would also miss the opportunity to empower members with clinically-proven, user-friendly software that assists members in managing chronic conditions and reduces the overall cost of care delivery.

This request directly contributes to the Department's efforts at Medicaid Cost Control, one of the five pillars in the Department's FY 2019-20 Performance Plan. The current health care environment in Colorado is characterized by steadily increasing per member costs, rising hospital costs, and expensive specialty prescription drugs that consume a disproportionately large share of pharmacy costs. In response to these rising costs, the Department has included the Medicaid Cost Control pillar in its performance plan to ensure the right services are provided to the right people, at the right price. A key initiative in this effort is RAE Modernization, which this request contributes to by providing RAEs with the support and resources needed to act on clinical and data-driven insights about their highest-risk and highest-cost members. This modern approach to care and condition management allows the Department and RAEs to counter rising health care costs through reduced utilization of services and preventing chronic conditions from worsening.

Anticipated Outcomes:

The Department anticipates that improved clinical care management of targeted high-cost members costing over $25,000 annually and improved condition management of members with targeted chronic conditions

costing less than $25,000 annually would result in improved health outcomes and lower utilization of high-cost medical services, such as emergency departments and inpatient hospital settings. This would be achieved through the work of the requested FTE to expand Department oversight of cost and care management by the RAEs to prevent unneeded escalation of cases to more expensive care settings and delays in services causing both decreased quality of care and increase in costs. Members in the targeted population are frequently the highest users of potentially preventable emergency department visits and hospital stays. The Department anticipates that a concentrated focus on improved care coordination for these members would redirect their care to lower-cost care options outside of expensive acute care settings. While implementation of this request will likely result in savings on medical costs, the Department is not including explicit savings in this request and will account for demonstrated savings in future years through the normal budget process.

The National Governors Association authored an October 2017 report called "Building Complex Care Programs: A Road Map for States."[2] The report reviewed complex care management initiatives implemented across multiple state Medicaid programs. While there is variation across these different initiatives, the report concludes that such complex care programs have successfully demonstrated reductions in potentially preventable emergency department visits and the number and length of inpatient stays. For example, Alaska implemented a complex care program with significant improvement in care cost and quality demonstrating an estimated return on investment of 2.21 percent. The Department anticipates that saving will be generated by refocusing RAEs efforts to manage high-cost and high-risk members, and by making minimal investment in care management for the high-cost target population.

The Department assumes that the provision of clinically-proven, user-friendly software to members for managing chronic pain, anxiety, and depression would result in decreased utilization of more expensive care settings such as outpatient psychotherapy and help to prevent these conditions from developing in to costly acute care needs such as emergency department visits and inpatient hospital stays. For example, an October 2017 research article published in the Annals of Clinical Research Trials, "Real-World Outcomes Associated with a Digital Self-Care Health Platform,"[3] studied the effectiveness of a commercially-available software product similar to the software being requested by the Department. The study looked at a commercially-insured adult population exhibiting some degree of depression and found that users experienced a reduction in symptom severity with an effect size comparable to that of traditional psychotherapy. While the study did not specifically look at the Medicaid population, the Department expects that similar software would also have favorable clinical impacts on Medicaid members seeking care for depression.

Additionally, the Journal of Medical Economics published a November 2018 study called "Quantifying the Economic Impact of a Digital Self-Care Behavioral Health Platform on Missouri Medicaid Expenditures."[4] The study looked at the return on investment of a statewide initiative in Missouri to provide members with software that assists members with managing their behavioral health conditions, similar to the software being

---

[2] https://classic.nga.org/files/live/sites/NGA/files/pdf/2017/ComplexCare_RoadMap_12.17_Health.pdf

[3] https://scientonline.org/open-access/real-world-outcomes-associated-with-a-digital-self-care-behavioral-health-platform.pdf

[4] https://www.tandfonline.com/doi/abs/10.1080/13696998.2018.1510834?journalCode=ijme20

requested by the Department. The study indicated a return on investment of between 142 percent and 695 percent. While the estimated range of return on investment is imprecise, the study clearly found a positive return on investment via reduced total cost of care. The Department anticipates that investment in comparable, clinically-proven software would also produce a positive return on investment among Colorado Medicaid members suffering from chronic behavioral health conditions.

On the continuum of evidence, the two software studies cited above come with significant caveats. Both studies are peer-reviewed and published in academic journals; however, there are potential conflicts of interest involved with each. Both studies looked at a commercial software product called "myStrength", and both studies were funded in full or in part by the company that produces this software. Additionally, one or more authors of both studies held executive positions at, consulted for, and/or owned stock in this company at the time of publication. Despite these relationships, the Department assumes valid research methods were used to pass peer review, and that the essential conclusions of favorable clinical outcomes and positive return on investment for the software are valid.

Assumptions and Calculations:

The Department has made a number of assumptions in calculating this request as described below. See Appendix A for more detailed calculations.

FTE Costs

The Department requests 1.0 FTE at the Program Management II classification level to serve as the Program Manager for the Department's efforts to coordinate enhanced care and condition management with the RAEs. The Department assumes the FTE would begin work on July 1, 2020 and become an ongoing, permanent position. The Department assumes that new employees in FY 2020-21 would be paid on a bi-weekly pay schedule. Personal Services costs for a full-time position funded with General Fund would be pro-rated to 0.9615 FTE, or 25 out of 26 pay periods, as the 26th pay period is expected to be paid in July of the next fiscal year. The Department assumes this FTE would be eligible for the standard federal match rate of 50% for Medicaid administrative activities. The Department assumes the state share of funding for the position, and the contractor costs below, would come from the state General Fund, but would be offset by Healthcare Affordability and Sustainability (HAS) Fee Cash Funds at a rate proportional to the number of members in the Medicaid expansion population of 34%.

Contractor Costs

The Department requests $315,818 total funds in FY 2020-21 and $273,123 total funds in FY 2021-22 to hire a contractor to provide clinically-proven software to targeted members for management of chronic pain, anxiety, and depression. The Department assumes the contractor would begin work on July 1, 2020, and continue work ongoing to provide evidence-based care management software to members. The Department has based the cost on an initial review of existing products and has assumed an initial implementation cost of $50,000 and an ongoing licensing cost of $2.50 per member per year. The Department assumes licenses would be needed for all members in the target population as shown in detail in tables 4.1 and 4.2 of

Appendix A. The Department assumes the contractor costs would be eligible for the standard federal match rate of 50% for Medicaid administrative activities.

R-14 Enhanced Care and Condition Management
Appendix A: Calculations and Assumptions

Table 1.1: FY 2020-21 Enhanced Care and Condition Management Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$93,645	1.0	$30,903	$15,918	$0	$46,824	Table 3, Salary, PERA, and Medicare
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$10,042	0.0	$3,314	$1,707	$0	$5,021	Table 3, Health-Life-Dental
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$142	0.0	$47	$24	$0	$71	Table 3, STD
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$4,168	0.0	$1,375	$708	$0	$2,085	Table 3, AED
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,168	0.0	$1,375	$708	$0	$2,085	Table 3, SAED
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$5,653	0.0	$1,865	$961	$0	$2,827	Table 3, Operating Expenses
G	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$315,818	0.0	$104,220	$53,689	$0	$157,909	Table 2.1, Row E
I	**Total Request**	**$433,636**	**1.0**	**$143,099**	**$73,715**	**$0**	**$216,822**	**Sum of Rows A through G**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund

Table 1.2: FY 2021-22 and Ongoing Enhanced Care and Condition Management Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds1**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$97,394	1.0	$32,140	$16,556	$0	$48,698	Table 3, Salary, PERA, and Medicare
B	(1) Executive Director's Office; (A) General Administration; Health, Life, and Dental	$10,042	0.0	$3,314	$1,707	$0	$5,021	Table 3, Health-Life-Dental
C	(1) Executive Director's Office; (A) General Administration; Short-term Disability	$147	0.0	$48	$25	$0	$74	Table 3, STD
D	(1) Executive Director's Office; (A) General Administration; S.B. 04-257 Amortization Equalization Disbursement	$4,334	0.0	$1,430	$737	$0	$2,167	Table 3, AED
E	(1) Executive Director's Office; (A) General Administration; S.B. 06-235 Supplemental Amortization Equalization Disbursement	$4,334	0.0	$1,430	$737	$0	$2,167	Table 3, SAED
F	(1) Executive Director's Office; (A) General Administration; Operating Expenses	$950	0.0	$313	$161	$0	$476	Table 3, Operating Expenses
G	(1) Executive Director's Office; (A) General Administration; General Professional Services and Special Projects	$273,123	0.0	$90,131	$46,431	$0	$136,561	Table 2.2, Rows E
I	**Total Request**	**$390,324**	**1.0**	**$128,806**	**$66,354**	**$0**	**$195,164**	**Sum of Rows A through G**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund

Table 2.1: FY 2020-21 Enhanced Care and Condition Management Summary by Initiative									
Row	**Description**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Overall FFP**	**Source**
Program Costs									
A	FTE Costs	$117,818	1.0	$38,879	$20,026	$0	$58,913	50%	Sum of Rows B through D
B	*FTE Salary, PERA, Medicare*	*$93,645*	*0.0*	*$30,903*	*$15,918*	*$0*	*$46,824*	*50%*	*Table 3, Personal Services*
C	*FTE AED, SAED, STD and HLD*	*$18,520*	*0.0*	*$6,111*	*$3,147*	*$0*	*$9,262*	*50%*	*Table 3, Personal Services*
D	*FTE Operating Expenses*	*$5,653*	*0.0*	*$1,865*	*$961*	*$0*	*$2,827*	*50%*	*Table 3, Operating Expenses*
E	Contractor Costs	$315,818	0.0	$104,220	$53,689	$0	$157,909	50%	Table 4.1, Row E
F	**Total Request**	**$433,636**	**1.0**	**$143,099**	**$73,715**	**$0**	**$216,822**	**50%**	**Sum of Rows A and E**

Table 2.2: FY 2021-22 and Ongoing Enhanced Care and Condition Management Summary by Initiative									
Row	**Description**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Overall FFP**	**Source**
Program Costs									
A	FTE Costs	$117,201	1.0	$38,675	$19,923	$0	$58,603	50%	Sum of Rows B through D
B	*FTE Salary, PERA, Medicare*	*$97,394*	*0.0*	*$32,140*	*$16,556*	*$0*	*$48,698*	*50%*	*Table 3, Personal Services*
C	*FTE AED, SAED, STD and HLD*	*$18,857*	*0.0*	*$6,222*	*$3,206*	*$0*	*$9,429*	*50%*	*Table 3, Personal Services*
D	*FTE Operating Expenses*	*$950*	*0.0*	*$313*	*$161*	*$0*	*$476*	*50%*	*Table 3, Operating Expenses*
E	Contractor Costs	$273,123	0.0	$90,131	$46,431	$0	$136,561	50%	Table 4.1, Row E
F	**Total Request**	**$390,324**	**1.0**	**$128,806**	**$66,354**	**$0**	**$195,164**	**50%**	**Sum of Rows A and E**

Table 3: FTE Calculations

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22 and Ongoing	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
Program Management II	$3,334	1.0	$83,351	1.0	$86,688
PERA			$9,085		$9,449
AED			$4,168		$4,334
SAED			$4,168		$4,334
Medicare			$1,209		$1,257
STD			$142		$147
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, 1.0 FTE		**1.0**	**$112,165**	**1.0**	**$116,251**
Subtotal Personal Services		1.0	**$112,165**	1.0	**$116,251**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	1.0	$500	1.0	$500
Telephone Expenses	$450	1.0	$450	1.0	$450
PC, One-Time	$1,230	1.0	$1,230	-	
Office Furniture, One-Time	$3,473	1.0	$3,473	-	
Subtotal Operating Expenses			**$5,653**		**$950**
TOTAL REQUEST		1.0	**$117,818**	1.0	**$117,201**
	General Fund:		*$38,879*		*$38,675*
	Cash Funds:		*$20,026*		*$19,923*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$58,913*		*$58,603*

Table 4.1: Estimated Contractor Costs				
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**Source**
A	Software Licensing Cost per User per Year	$2.50	$2.50	Department estimate
B	Number of Clients Using Software	106,327	109,249	Table 4.2, Row C
C	**Annual Licensing Cost**	**$265,818**	**$273,123**	**Row A x Row B**
D	Implementation Cost	$50,000	$0	Department estimate
E	**Total Cost**	**$315,818**	**$273,123**	**Sum of Rows C and D**

Table 4.2: Estimated Number of Clients in Target Population				
Row	**Description**	**FY 2020-21**	**FY 2021-22**	**Notes**
A	CY 2018 Number of Clients in Target Population	102,159	102,159	Claims data for individuals with target chronic conditions
B	Caseload Trend	4.08%	6.94%	February 15, 2019 caseload forecast
C	**Estimated Number of Clients in Target Population**	**106,327**	**109,249**	**Row A x Row B**

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-15 Medicaid Recovery & Third Party Liability Modernization

Dept. Approval By: _____

OSPB Approval By: _____

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,041,836,169**	**$0**	**$8,067,168,372**	**($12,301,943)**	**($32,473,223)**
	FTE	500.0	0.0	504.1	5.8	6.0
	GF	$2,319,338,108	$0	$2,329,173,946	($3,468,482)	($9,479,366)
	CF	$997,104,608	$0	$998,896,068	$2,074,120	$1,682,273
	RF	$91,709,248	$0	$91,596,531	$0	$0
	FF	$4,633,684,205	$0	$4,647,501,827	($10,907,581)	($24,676,130)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$465,897**	**$484,553**
	FTE	500.0	0.0	504.1	5.8	6.0
	GF	$13,478,948	$0	$14,470,561	$153,745	$159,902
	CF	$3,571,232	$0	$3,714,633	$79,203	$82,374
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$232,949	$242,277
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$60,252**	**$60,252**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$19,884	$19,884
	CF	$421,237	$0	$525,947	$10,242	$10,242
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$30,126	$30,126

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$706**	**$734**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$233	$241
	CF	$5,301	$0	$5,495	$120	$125
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$353	$368
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$20,735**	**$21,564**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$6,842	$7,115
	CF	$159,398	$0	$166,329	$3,525	$3,666
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$10,368	$10,783
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$20,735**	**$21,564**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$6,842	$7,115
	CF	$159,398	$0	$166,329	$3,525	$3,666
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$10,368	$10,783
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$33,918**	**$5,700**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$1,014,866	$0	$939,016	$11,192	$1,881
	CF	$243,961	$0	$197,797	$5,766	$970
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$16,960	$2,849
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$120,000**	**$120,000**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	GF	$6,015,380	$0	$4,503,802	$39,600	$39,600
	CF	$2,615,231	$0	$2,547,721	$20,400	$20,400
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$60,000	$60,000

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	**Total**	**$74,893,151**	**$0**	**$80,930,645**	**$375,000**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,972,677	$0	$11,030,317	$123,750	$0
	CF	$6,385,552	$0	$6,963,036	$63,750	$0
	RF	$12,204	$0	$12,204	$0	$0
	FF	$58,522,718	$0	$62,925,088	$187,500	$0
01. Executive Director's Office, (G) Recoveries and Recoupment Contract Costs, (1) Recoveries and Recoupment Contract Costs - Third-Party Liability Cost Avoidance Contract	**Total**	**$0**	**$0**	**$0**	**$16,337,967**	**$16,787,286**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$5,391,529	$5,539,804
	CF	$0	$0	$0	$2,777,454	$2,853,839
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$8,168,984	$8,393,643
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($29,737,153)**	**($49,974,876)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($9,222,099)	($15,254,908)
	CF	$983,543,298	$0	$984,608,781	($889,865)	($1,293,009)
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($19,625,189)	($33,426,959)

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-15
Request Detail: Medicaid Recovery and Third-Party Liability Modernization

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**($12,301,943)**	**($32,473,223)**
FTE	0.0	5.8	6.0
General Fund	$0	($3,468,482)	($9,479,366)
Cash Funds	$0	$2,074,120	$1,682,273
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	($10,907,581)	($24,676,130)

Summary of Request:

The Department requests a reduction of $12,301,943 total funds, including a reduction of $3,468,482 General Fund and an increase of 5.8 FTE in FY 2020-21 and a reduction of $32,473,223 total funds, including a reduction of $9,479,366 General Fund and an increase of 6.0 FTE in FY 2021-22 to: recover improper payments for medical services; enhance the process for cost avoidance of claims when a third party is liable; and, use artificial intelligence software to identify and recover improper payments. This includes additional staffing, funding for contracts and a legal case tracking system to increase efficiencies in Medicaid recoveries which would lead to increased recoveries of claims and decreased costs for medical services.

Current Program:

Tort and Casualty Recovery Operations

Federal[1] and state law[2] require that Medicaid is the payor of last resort and that members who also have other insurance follow the rules and requirements of the other insurance plan as a primary payor, meaning that any available sources of funds should be exhausted prior to Medicaid paying claims for services. Medicaid is responsible for any remaining balance after adjudication by the primary payor up to its allowed amount, including when the plan's annual deductible has not been met or for services not covered under the plan, but covered by Medicaid.

A tort and casualty case generally arises due to a settlement for personal injury claims due to auto accidents, slips and falls, medical malpractice, and other reasons. In the case of personal injury claims, the Department has an automatic statutory lien authorized by sections 25.5-4-301(4) through (6), C.R.S. against settlement monies for the amount paid by Medicaid related to the incident or accident. In FY 2018-19, the Department recovered $17.8 million from tort and casualty settlements.[3] These recoveries are processed by both the Department's third-party liability (TPL) vendor and two Department staff and are used to offset the of cost of medical services in the Department's budget. For the recoveries that are outsourced, the Department is contractually liable for a 10% contingency fee payment based upon the amounts recovered by the vendor. The Department currently uses a Microsoft Access database to track and maintain legal case files for tort and casualty recoveries.

Third-Party Liability (TPL) Cost Avoidance

Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other state and federal programs (unless specifically excluded by Federal statute). In general, if a state has determined that a potentially liable third party exists, it must attempt to ensure that the provider bills the third party first before sending the claim to Medicaid. This is known as "cost avoidance." Whenever a state has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party. This is known as "pay and chase."

States are required to cost-avoid claims, with a few specific exceptions which are identified in regulation. 42 CFR § 433.139(b)(1) outlines that if the agency has established the probable existence of TPL at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. This cost avoidance occurs through the reporting of commercial health coverage through a variety

[1] https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/tpl.pdf
[2] Section 25.5-4-300.4, C.R.S.
[3] https://www.colorado.gov/pacific/sites/default/files/13-%20HCPF%2C%202019%20FEB%2C%20S-1%20Exhibit%20L.pdf

of means, but also through data use agreements between the TPL vendor and carriers, health plans, and pharmacy benefit managers (PBMs).

Cost avoidance occurs when a claim is rejected by the Department's claims system due to presence of third-party payor information that is loaded in the system. The provider is directed to submit the claim to the primary payor before Medicaid will issue any payment. A national best practice in Medicaid is to contract with a vendor who can verify and send commercial eligibility data to the state. The Department's vendor estimates that between 10 and 13 percent of Medicaid members, a range of 132,829 to 172,678 members have TPL eligibility. Because the Department does not currently contract with a vendor to identify and send TPL information to the claims system, the Department primarily uses the pay and chase model and pays its vendor a contingency fee on recoveries, and only has approximately 75,000 TPL policies loaded into the claims system. These policies are not updated and maintained on a regular basis.

Identification and Collection of Overpayments

The Department currently has several processes in place to identify fraud, waste and abuse and identifies and recovers improper payments and overpayments. Section 25.5-4-301, C.R.S. outlines requirements for recoveries and overpayments, including provider audits and the provider appeals process. Department Program staff also identify and refer suspected cases of fraud, waste and abuse to Audits and Compliance staff who then further investigate and process referrals. Recoveries and overpayment processing can be a lengthy process requiring many steps to ensure that Colorado law is being followed, and the Department works closely with providers and attorneys throughout the process. After determining a credible allegation of fraud, the Department also refers cases to the Medicaid Fraud and Control Unit within the Attorney General's Office when fraud is suspected.

SB 13-137 "Improvements to Prevent Fraud in the Medicaid Program" directed the Department to implement fraud, waste and abuse detection, prevention and recovery solutions to improve program integrity.[4] The Department researched pre-payment analytics and in June 2013 the Department issued a Request for Information and held a vendor fair. The Department determined that implementation of any new system should be delayed due to the transition to the new Medicaid Management Information System (MMIS) claims system. The Department is currently implementing software known as ClaimsXten within its MMIS which will help reduce pay-and-chase recoveries and increase prepayment identification of inappropriate claims by establishing rules and claims edits to identify and deny improper claims. ClaimsXten will force providers to more accurately bill by preventing payment based on National Correct Coding Initiative (NCCI)[5] and medically unlikely edits. The system is currently undergoing testing and rule development and will be in production by July 2020.

In addition to prepayment reviews, program integrity analysts use the MMIS Surveillance and Utilization Review Subsystem (SURS) to identify leads of claims that were potentially paid improperly. The SURS is a

[4] Section 25.5-1-114.5, C.R.S.

[5] https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/

set of automated reports based on Centers for Medicare and Medicaid Services (CMS) specifications currently generated in the Department's data system, the Business Intelligence and Data Management (BIDM) system monthly. Staff use these reports to help identify providers that may be billing in an aberrant manner. For example, payments made to a provider for an unusually large number of services for an uncommon type of procedure over a relatively short period of time could indicate fraudulent behavior on that provider's part and, therefore, warrant additional review or investigation of the provider's practices A demonstration of these reports and how to access them was part of the CMS certification of the new system. Additionally, in July 2019, the Department contracted with the current BIDM system vendor, IBM Watson Health, to perform a Fraud, Waste, and Abuse (FWA) Vulnerability Assessment.

The Department also has 12 staff who identify new leads and review and respond to referrals to process recoveries of overpayments and each staff collects $800,000 on average each fiscal year. Although larger amounts of improper payments are identified, the process can be slow due to the lengthy legal process required for recoveries. The Department also has two recovery contracts. One contractor is a federally required Recovery Audit Contract (RAC) contractor[6] that detects and collects overpayments through review of claims. Issues identified by the contractor also leads to policy changes to prevent future improper payments. The other contractor is with a vendor to review, identify and recover improper payments in its Home and Community-based Services (HCBS) waiver programs.

Problem or Opportunity:

Without additional resources, the Department is not able to increase oversight and modernize its processes for decreasing medical costs due to improper payments in three areas: tort and casualty recoveries, identification of third-party insurance and identification of fraud, waste and abuse.

Tort and Casualty Recovery Operations

Due to the volume and complexity of tort and casualty cases, often requiring extensive contact with attorneys and follow up, internal recovery staff and the TPL vendor are not able to keep up with the volume to work all cases, therefore preventing additional recovery of claims. Many individuals in Colorado with catastrophic injuries are enrolled in Medicaid at some point, therefore the opportunity for additional recoveries is large. Additionally, because the Department pays a 10% contingency fee to its TPL vendor for the tort and casualty recoveries they process, the Department prefers to keep the larger settlement cases in-house; however, the Department does not have enough resources for these activities which leads to increased contingency fees paid to the vendor. Due to the lack of resources, the State is unable to recover funds that should have been paid by third parties.

Additionally, the Microsoft Access database used to track legal case files is highly inefficient, does not provide the level of functionality such as reporting and notifications needed to stay on top of case changes, is not supported by the Governor's Office of Information Technology (OIT), which results in inefficient manual processes. Case management systems should be able to generate reminders, identify stale cases,

[6] https://www.colorado.gov/pacific/hcpf/recovery-audit-contractor-rac-program

generate and send correspondence, as well as store and retrieve documents. Such a system would allow the caseworker to access all aspects of the case in one place without having to search in multiple areas. The Department needs a better system to track and report on legal case files to make the process more efficient. Although the Department's TPL vendor offers an off-the-shelf system that would allow more efficient tracking of the cases, the Department cannot license it without additional funding. Moreover, working out of the same system with the TPL vendor is a best practice in the industry and would decrease the time currently spent on identifying duplicate cases between the Department and the vendor.

Third-Party Liability (TPL) Cost Avoidance

Although federal and state law require that third parties provide eligibility data to states, the Department does not have the resources to proactively receive verified data from all third parties. TPL information is only updated in limited circumstances and the file does not identify TPL data for all its members. This prevents the Department from avoiding costs that should be paid for by third parties. Further, the current solution requires significant resources to process TPL recoveries, therefore limiting actions that can be taken by the Department and thus increasing costs for medical services when other parties should have been liable. In some cases, such as when services are provided out of network for the commercial plan, the third-party recovery cannot be obtained. The Department's contract with its TPL vendor includes providing some commercial health plan eligibility data following recovery of a claim but could be amended to include the provision of commercial eligibility data on the entire scope of Medicaid's enrollment population, therefore increasing avoided costs and increasing compliance with federal law.

Identification and Collection of Overpayments

Even with all the efforts underway, the Department does not have enough resources dedicated to identification and collection of improper payments and the lack of staffing prevents the Department from identifying and recovering additional overpayments as a result of fraud, waste and abuse that exist. Further, a lack of dedicated staffing prevents the Department from implementing additional vendor contracts which would lead to increased identification and collection of overpayments. The Department currently has one contract manager for its RAC contract and through its experience with recovery contracts a dedicated contract manager is required to ensure the vendor follows state specific rules and procedures in order to ensure provider rules and regulations are followed throughout the process. Although contracts could be implemented for more sophisticated prepayment claims review software using artificial intelligence or increased scope of work for recovery contractors, including vendors who would access all payer claims database (APCD) data to identify improper billing practices across all payers, without additional staff the Department does not have the resources to implement and oversee these contracts. Lack of additional resources prevents the Department from reducing costs for medical services.

Proposed Solution:

The Department requests a reduction of $12,301,943 total funds, including a reduction of $3,468,482 General Fund and an increase of 5.8 FTE in FY 2020-21 and a reduction of $32,473,223 total funds, including a reduction of $9,479,366 General Fund and an increase of 6.0 FTE in FY 2021-22 to modernize its operations related improper payments for medical services. The request includes administrative resources for staff and

vendor contracts in order to increase oversight and modernize its processes for decreasing medical costs due to improper payments in three areas: tort and casualty recoveries; identification of third-party insurance; and, identification and collection of overpayments. The request supports the Department's performance goals of Medicaid cost control and operational excellence. If this request is not approved the Department would lose an opportunity to control costs, leading to higher costs in the Medicaid program and less funding available for other State priorities.

Tort and Casualty Recovery Operations
The Department requests three FTE to process additional tort and casualty recoveries to increase the amount of resources focused on this work. This would lead to increased recoveries and reduce the amount of contingency fees being paid to the vendor. The Department also requests funding for a legal case management tracking system to improve the process. With the correct tools, caseworkers can process more cases, which would generate greater recoveries, improve processing times, and improve response times to personal injury attorneys and members.

Third-Party Liability (TPL) Cost Avoidance
The Department requests funding for a contract with a TPL vendor to provide a verified eligibility data interface into its claims system monthly which would lead to cost avoidance of claims and moving much of the recoveries to costs avoided. The request includes the annual cost for the contract as well as costs for system programming to allow it to receive and process the monthly file, and an estimate of avoided costs which would reduce the State's liability for medical services.

Identification and Collection of Overpayments
The Department requests funding for two FTE to process recoveries of improper payments and one FTE to serve as a contract manager to oversee a recovery of overpayment vendor contract which would lead to increased recoveries which decrease medical costs in the Department's budget. The vendor would use software that includes artificial intelligence and All-Payer Claims Database (APCD) data in order to identify and recover improper payments and refer fraud as it is found. The request also includes funding for the vendor contract and one- time cost for system changes to develop an interface of claims data to the vendor.

A detailed description of all FTE can be found in Appendix A.

Anticipated Outcomes:

Tort and Casualty Recovery Operations
The Department anticipates the outcome of the tort and casualty proposal would be a reduction of contingency fees paid to the vendor, increased recoveries, greater timeliness of case processing, and improved stakeholder and member experience. Recoveries for each caseworker are currently tracked and with three additional FTE the Department would be able to quantify the increased recoveries by tracking the performance of each FTE.

By using the TPL vendor's case management system, the Department would see better coordination on cases as all case information between the vendor and the Department would be in one place. The Department would

also gain access to reporting tools and could measure the efficiencies gained by working out of a case management system. For example, the system would have the capability to measure timeliness of case processing. There would be an implementation period to load the Department's letter templates and other programming changes to allow the Department to work out of the case management system. The success of this could be measured by tracking recoveries year over year.

Third-Party Liability (TPL) Cost Avoidance

The Department anticipates the implementation of the cost avoidance proposal to pay for verified TPL segments would provide greater compliance with federal law requiring cost avoidance of claims when TPL is known. The second anticipated outcome would be greater cost savings as cost avoidance is more efficient than recovering monies through a pay and chase methodology. Also as noted above, there are instances in pay and chase where the Department cannot legally recover monies from the primary payor. One example is when the member seeks treatment outside the plan's network. A commercial plan with a closed network has no liability in terms of honoring claims outside the terms of the health plan policy. With verified TPL in the system, the Department does not bear the cost of the claim and the cost avoidance process encourages the member to seek treatment according to the provisions in the health plan policy.

The Department intends to measure the performance of this solution using the reporting capabilities that it has developed based upon claims that are rejected by the claims system and the edit used for this purpose. The Department would be able to review data pre- and post-solution to gauge performance of the newly added TPL segments. The Department would also be able to examine the trend of pay and chase recoveries by comparing such recoveries relative to pre-solution recoveries to gauge the success of moving to greater cost avoidance of claims.

Identification and Collection of Overpayments

Increased staffing and contracting with a recovery of overpayment vendor would lead to increased identification and recovery of improper payments leading to reduced costs to the Medicaid program. Current FTE and contractors working in overpayments average $8 million identified overpayments with $800,000 recovered each year on average per person. The Department would track performance of the new FTE and vendor based on the number of overpayments identified and those identified and recovered. Because of the lengthy and complicated legal process, the Department would use both identification and actual recoveries in each year as metrics being tracked for performance.

Assumptions and Calculations:

Detailed calculations and a timeline can be found in Appendix B. Administrative costs would be eligible for 50 percent Federal Financial Participation (FFP) and would be requested in the federally required Public Assistance Cost Allocation Plan (PACAP). The system costs would be eligible for 75 percent enhanced FFP by submitting an Advanced Planning Document (APD) for federal approval of enhanced funding. If federal approval is not received, the Department would utilize the budget process to request any changes in funding. The Department assumes the state share of administrative costs would be allocated between General Fund

and Healthcare Affordability and Sustainability Fee Cash Fund based on caseload and that enough cash funds are available.

Tort and Casualty Recovery Operations
Detailed FTE descriptions can be found in Appendix A. The estimate assumes the FTE would be hired in July 2020 and fully trained to process recoveries by November 2020. The Department assumes that the additional recovery specialists would process at least $2 million in recoveries each fiscal year based on performance of current FTE. The estimate assumes that $1.5 million of those recoveries are currently being processed by the current TPL vendor, and there would be an associated reduction to contingency fees paid. The Department estimates the FTE would bring in an additional $500,000 in recoveries which are not currently being processed, therefore increasing overall recoveries by $500,000 total funds per FTE. Any additional savings would be adjusted through the budget process. Estimates for FY 2020-21 have been adjusted for a November 2020 implementation date.

The annual cost for the legal case tracking system is based on an estimate provided by the current TPL vendor and could be purchased through a contract amendment of the current contract.

Third-Party Liability (TPL) Cost Avoidance
The Department assumes the contract would not require competitive solicitation and an amendment to the current TPL vendor contract would be effective July 1, 2020. The contract estimate is based on an estimate provided by the current TPL vendor who contracts with many states for this same scope of work. The vendor would charge $20.50 per verified TPL segment. A segment represents an enrollment or termination of a policy. For example, a person might have coverage for medical and Pharmacy Benefit Manager (PBM) coverage; in this case, the person would have two segments, one each for medical and PBM coverage beginning at the start of the plan year, and two segments, one each for medical and PBM coverage ending at the end of the plan year, totaling four segments. The vendor charges separately for verification of medical and PBM coverage as these dates and coverages can be different. The estimate assumes each member with verified TPL would have an average of six segments per year, to account for changes mid-year in addition to the expected four per member with verified TPL.

The Department assumes that some, but not all recoveries would shift from pay and chase to costs avoided due to the contract. This is because federal regulations[7] require certain types of claims to be paid regardless of TPL identified, so there would always be certain claims that would need to be recovered through pay and chase. Additionally, due to retroactive Medicaid eligibility, which can go back 90 days prior to application date, and due to other factors, there would always be claims that would need to be recovered after the fact and would not be avoided up front. Due to the lack of information about which claims would be recovered versus avoided, and the fact that the net impact to the budget is the same other than a timing issue, the

[7] https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec433-139.pdf

Department has not estimated any changes in recoveries or contingency fees in this estimate and would utilize the budget process to update any changes to the forecast as the contract is implemented.

To estimate avoided costs, the Department assumes 10% of members have TPL that would be verified by the contractor. Based on experience in Colorado and in other states, the current TPL vendor estimates that 13% of members have other insurance, however the estimate assumes 10% in an effort not to overestimate avoided costs. Additionally, the Department assumes that the acute care costs would be the area of costs that would be avoided as these are the type of claims typically covered by TPL, such as pharmacy, hospital and physician services. To estimate avoided costs, the Department assumes 16.67% of per capita costs would be avoided because Medicaid generally has higher coverage requirements than commercial insurance so Medicaid would still pay certain claims for members and therefore would not avoid 100% of costs. Medicaid is also responsible for paying any deductibles for members with TPL until they have met their deductible and triggered the plan's financial responsibility. The estimate has been reduced to account for 75,000 members who already have some form of TPL loaded in the system.

The Department assumes that members across all populations would have verified TPL therefore has used the fund splits from its FY 2019-20 S-1 Medical Services Premiums forecast from Exhibit A for the estimate.

Identification and Collection of Overpayments

The Department assumes the vendor contract would include identification and processing of recoveries and the vendor would include dedicated clinical and legal resources to support the Department through the provider appeals process. The two FTE responsible for identification and processing overpayments would be hired by July 1, 2020 and be fully trained and begin to reduce costs by January 1, 2021. The contract manager would be hired July 1, 2020. The Department would follow state procurement rules for selecting a vendor for increased scope of work and the vendor would be selected by January 1, 2021. This could include selection of new vendor or through an amendment to an existing vendor contract. The Department estimates the vendor would need at least six months to build interfaces and state specific rules, therefore would not begin impacting costs until July 1, 2021. The Department assumes the vendor contract would be contingency fee based as required by section 25.5-4-301 C.R.S. therefore implementation costs would be absorbed by the contractor based on past experiences with contingency fee contractors.

The system changes would be completed by June 30, 2021.

Appendix A

FTE Details		
Title	**FTE**	**Duties**
Tort and Casualty Administrator	2.0	Position would provide additional internal resources to the Tort and Casualty Unit which recovers Medicaid dollars spent on behalf of clients when another party is liable for the costs. This requires recovering monies from an insurance carrier, mass tort settlement, vaccine injury fund, workers' compensation carrier, or through the criminal restitution process. Position communicates with personal injury attorneys, insurance adjusters to provide the Department's lien based upon medical assistance used related to the incident or accident. This work requires knowledge of tort law and the medical assistance act to successful articulate and defend the Department's interest. Position runs claims reports and analyses the reports to assess relatedness of medical claims and to calculate the amount of the Department's lien. The position represents the Department's claim in legal proceedings including participating in mediation or engaging the Attorney General's Office related to litigation or to escalate a case to protect the Department's recovery rights.
Tort and Casualty Lead	1.0	Position would have the same responsibilities described above but would be a work lead over the tort and casualty unit. The position would have responsibility for training the unit's FTE on the substance of the unit's work. The lead position would be responsible as well for workflow issues and ensuring that the unit has the tools that it requires to accomplish its duties including troubleshooting any issues with respect to the unit's information technology tools.
Total	**3.0**	**Sum of Tort and Casualty Recovery Operations Staffing**
Fraud Specialist	1.0	Position would identify and refer instances of suspected fraud committed by providers. This position would work with policy staff, data analysts and the referral specialist to identify instances of suspected fraud. The position would then be responsible for drafting the fraud referral summarizing the suspicious actions and the policy that the activity violates. Additionally, the position would coordinate and track all referrals sent to the appropriate law enforcement agency and provide assistance with any additional information the law enforcement agency may need.

Overpayment Specialist	1.0	Position would assist in the administration of overpayment recovery projects related to fraud, waste, and abuse. This position would assist the Department's Audits and Compliance Division with reviewing records and data to identify overpayments, draft and send overpayment recovery demand letters, assist in reviewing any appeals or informal reconsideration related to the demands, and help track the case status and amounts recovered. This position would also work to draft policy recommendation memos to address reducing fraud, waste, and abuse in the future.
Contract Manager	1.0	The position would manage a contract that identifies billing errors, fraud, waste and abuse within the Colorado All Payers Claims Database (CO APCD) that is maintained outside of the Department by the Center for Improving Value in Health Care (CIVHC). This position would be responsible for basic contract administration functions—including ensuring requests for proposals, contracts, and amendments are written according to state and federal requirements—and that contract deliverables are consistent with state and federal obligations. This position would collaborate with CIVHC to coordinate auditing of the CO APCD and with Medicaid policy staff to determine trends and policy gaps where possible Medicaid provider fraud, waste, and abuse exists and can be successfully deterred. Additionally, the position would oversee all audit functions of the vendor, including the development and implementation of audit plans and schedules, the issuance of adverse actions to Medicaid providers, referrals of possible cases of fraud, the recovery of overpayments, and formal appeals activities.
Total	**3.0**	**Sum of Identification and Collection of Overpayment Staffing**
Request Total	**6.0**	**Total FTE**

Table 1.1 FY 2020-21 R-15 Medicaid Recovery and Third Party Liability Modernization Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$465,897	5.8	$153,745	$79,203	$0	$232,949	Table 2.1 (Row B + Row M)
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$60,252	0.0	$19,884	$10,242	$0	$30,126	Table 6.1 Row B + Table 7.1 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$706	0.0	$233	$120	$0	$353	Table 6.1 Row C + Table 7.1 Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$20,735	0.0	$6,842	$3,525	$0	$10,368	Table 6.1 Row D + Table 7.1 Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$20,735	0.0	$6,842	$3,525	$0	$10,368	Table 6.1 Row E + Table 7.1 Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$33,918	0.0	$11,192	$5,766	$0	$16,960	Table 6.1 Row F + Table 7.1 Row F
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$120,000	0.0	$39,600	$20,400	$0	$60,000	Table 2.1 Row E
H	NEW LINE ITEM: (1) Executive Director's Office, (G) Recoveries and Recoupment Contract Costs, Third-Party Liability Cost Avoidance Contract	$16,337,967	0.0	$5,391,529	$2,777,454	$0	$8,168,984	Table 2.1 Row I
I	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$375,000	0.0	$123,750	$63,750	$0	$187,500	Table 2.1 (Row J + Row R)
J	(2) Medical Services Premiums	($29,737,153)	0.0	($9,222,099)	($889,865)	$0	($19,625,189)	Table 2.1 (Row F + Row G + Row K + Row P + Row Q + Row S)
K	**Total Request**	**($12,301,943)**	**5.8**	**($3,468,482)**	**$2,074,120**	**$0**	**($10,907,581)**	Sum of Rows A thru J

Table 1.2 FY 2021-22 R-15 Medicaid Recovery and Third Party Liability Modernization Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$484,553	6.0	$159,902	$82,374	$0	$242,277	Table 2.2 (Row B + Row M)
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$60,252	0.0	$19,884	$10,242	$0	$30,126	Table 6.2 Row B + Table 7.2 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$734	0.0	$241	$125	$0	$368	Table 6.2 Row C + Table 7.2 Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$21,564	0.0	$7,115	$3,666	$0	$10,783	Table 6.2 Row D + Table 7.2 Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$21,564	0.0	$7,115	$3,666	$0	$10,783	Table 6.2 Row E + Table 7.2 Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$5,700	0.0	$1,881	$970	$0	$2,849	Table 6.2 Row F + Table 7.2 Row F
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$120,000	0.0	$39,600	$20,400	$0	$60,000	Table 2.2 Row E
H	NEW LINE ITEM: (1) Executive Director's Office, (G) Recoveries and Recoupment Contract Costs, Third-Party Liability Cost Avoidance Contract	$16,787,286	0.0	$5,539,804	$2,853,839	$0	$8,393,643	Table 2.2 Row I
I	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$0	0.0	$0	$0	$0	$0	Table 2.2 (Row J + Row R)
J	(2) Medical Services Premiums	($49,974,876)	0.0	($15,254,908)	($1,293,009)	$0	($33,426,959)	Table 2.2 (Row F + Row G + Row K + Row P + Row Q + Row S)
K	**Total Request**	**($32,473,223)**	**6.0**	**($9,479,366)**	**$1,682,273**	**$0**	**($24,676,130)**	Sum of Rows A thru J

Table 1.3 FY 2022-23 R-15 Medicaid Recovery and Third Party Liability Modernization Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes/Calculations
A	(1) Executive Director's Office, (A) General Administration, Personal Services	$484,553	6.0	$159,902	$82,374	$0	$242,277	Table 2.3 (Row B + Row M)
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$60,252	0.0	$19,884	$10,242	$0	$30,126	Table 6.2 Row B + Table 7.2 Row B
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$734	0.0	$241	$125	$0	$368	Table 6.2 Row C + Table 7.2 Row C
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$21,564	0.0	$7,115	$3,666	$0	$10,783	Table 6.2 Row D + Table 7.2 Row D
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$21,564	0.0	$7,115	$3,666	$0	$10,783	Table 6.2 Row E + Table 7.2 Row E
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$5,700	0.0	$1,881	$970	$0	$2,849	Table 6.2 Row F + Table 7.2 Row F
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$120,000	0.0	$39,600	$20,400	$0	$60,000	Table 2.3 Row E
H	NEW LINE ITEM: (1) Executive Director's Office, (G) Recoveries and Recoupment Contract Costs, Third-Party Liability Cost Avoidance Contract	$17,248,905	0.0	$5,692,139	$2,932,314	$0	$8,624,452	Table 2.3 Row I
I	(1) Executive Director's Office, (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$0	0.0	$0	$0	$0	$0	Table 2.3 (Row J + Row R)
J	(2) Medical Services Premiums	($53,273,977)	0.0	($16,211,545)	($1,493,741)	$0	($35,568,691)	Table 2.3 (Row F + Row G + Row K + Row P + Row Q + Row S)
K	**Total Request**	**($35,310,705)**	**6.0**	**($10,283,668)**	**$1,560,016**	**$0**	**($26,587,053)**	Sum of Rows A thru J

Table 1.1 FY 2020-21 R-15 Medicaid Recovery and Third Party Liability Modernization Summary by Line Item

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	***Total Request-Tort and Casualty Recovery Operations***	**$111,689**	**2.9**	**($514,144)**	**$1,069,987**	**$0**	**($444,154)**	**NA**	Row B + Row C + Row D + Row E + Row F + Row G
B	FTE- Personal Services, PERA and Medicare	$224,298	2.9	$74,018	$38,131	$0	$112,149	50%	Table 6.1 Row A
C	FTE- HLD, STD, AED, SAED	$50,432	0.0	$16,642	$8,573	$0	$25,217	50%	Table 6.1 Row B through E
D	FTE- Operating Costs	$16,959	0.0	$5,596	$2,883	$0	$8,480	50%	Table 6.1 Row F
E	Legal Case Tracking System	$120,000	0.0	$39,600	$20,400	$0	$60,000	50%	Estimate
F	Increased Recoveries	$0	0.0	($500,000)	$1,000,000	$0	($500,000)	50%	Table 4.1 Row G
G	Reduced Contingency Fees	($300,000)	0.0	($150,000)	$0	$0	($150,000)	50%	Table 4.1 Row J
H	***Total Request- Third Party Liability (TPL) Cost Avoidance***	**($12,124,186)**	**0.0**	**($2,889,860)**	**$968,699**	**$0**	**($10,203,025)**	NA	Row I + Row J + Row K
I	Contract Cost	$16,337,967	0.0	$5,391,529	$2,777,454	$0	$8,168,984	50%	Table 3.1 Row F
J	Vendor data interface-interChange modifications	$175,000	0.0	$57,750	$29,750	$0	$87,500	75%	Table 5.1 Row A
K	Avoided Costs	($28,637,153)	0.0	($8,339,139)	($1,838,505)	$0	($18,459,509)	NA	Table 3.1 Row L, Fund Splits from Medical Services Premiums, Exhibit A
L	***Total Request- Identification and Collection of Overpayments***	**($289,446)**	**2.9**	**($64,478)**	**$35,434**	**$0**	**($260,402)**	Various	Row M + Row N + Row O + Row P + Row Q + Row R + Row S
M	FTE- Personal Services, PERA and Medicare	$241,599	2.9	$79,727	$41,072	$0	$120,800	50%	Table 7.1 Row A
N	FTE- HLD, STD, AED, SAED	$51,996	0.0	$17,159	$8,839	$0	$25,998	50%	Table 7.1 Row B through E
O	FTE- Operating Costs	$16,959	0.0	$5,596	$2,883	$0	$8,480	50%	Table 7.1 Row F
P	Increased Overpayment Collections- FTE	($800,000)	0.0	($232,960)	($51,360)	$0	($515,680)	various	Table 8.1 Row D, Fund Splits from Exhibit A, Medical Services Premiums
Q	Vendor Contract	$0	0.0	$0	$0	$0	$0	50%	Table 8.2 Row G, Contingency Fee based contract would begin 1/1/2021 with no vendor cost until 1/1/22
R	Vendor data interface-interChange modifications	$200,000	0.0	$66,000	$34,000	$0	$100,000	75%	Table 5.1 Row B
S	Increased Overpayment Collections- Contract	$0	0.0	$0	$0	$0	$0	various	Table 8.2 Row E
T	**Total Request**	**($12,301,943)**	**5.8**	**($3,468,482)**	**$2,074,120**	**$0**	**($10,907,581)**	NA	Row A + Row H + Row L

Table 2.2 FY 2021-22 R-15 Medicaid Recovery and Third Party Liability Modernization Summary by Initiative

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP	Notes/Calculations
A	***Total Request-Tort and Casualty Recovery Operations***	**($42,630)**	**3.0**	**($840,569)**	**$1,569,253**	**$0**	**($771,314)**	NA	Row B + Row C + Row D + Row E + Row F + Row G
B	FTE- Personal Services, PERA and Medicare	$233,279	3.0	$76,982	$39,657	$0	$116,640	50%	Table 6.2 Row A
C	FTE- HLD, STD, AED, SAED	$51,241	0.0	$16,908	$8,711	$0	$25,622	50%	Table 6.2 Row B through E
D	FTE- Operating Costs	$2,850	0.0	$941	$485	$0	$1,424	50%	Table 6.2 Row F
E	Legal Case Tracking System	$120,000	0.0	$39,600	$20,400	$0	$60,000	50%	Estimate
F	Increased Recoveries	$0	0.0	($750,000)	$1,500,000	$0	($750,000)	50%	Table 4.1 Row G
G	Reduced Contingency Fees	($450,000)	0.0	($225,000)	$0	$0	($225,000)	50%	Table 4.1 Row J
H	***Total Request- Third Party Liability (TPL) Cost Avoidance***	**($14,496,116)**	**0.0**	**($3,569,923)**	**$845,445**	**$0**	**($11,771,638)**	NA	Row I + Row J + Row K
I	Contract Cost	$16,787,286	0.0	$5,539,804	$2,853,839	$0	$8,393,643	50%	Table 3.1 Row F
J	Vendor data interface-interChange modifications	$0	0.0	$0	$0	$0	$0	75%	One-time cost in FY 2020-21
K	Avoided Costs	($31,283,402)	0.0	($9,109,727)	($2,008,394)	$0	($20,165,281)	NA	Table 3.1 Row L Fund Splits from Exhibit A, Medical Services Premiums
L	***Total Request- Identification and Collection of Overpayments***	**($17,934,477)**	**3.0**	**($5,068,874)**	**($732,425)**	**$0**	**($12,133,178)**	various	Row M + Row N + Row O + Row P + Row Q + Row R + Row S
M	FTE- Personal Services, PERA and Medicare	$251,274	3.0	$82,920	$42,717	$0	$125,637	50%	Table 7.2 Row A
N	FTE- HLD, STD, AED, SAED	$52,873	0.0	$17,447	$8,988	$0	$26,438	50%	Table 7.2 Row B through E
O	FTE- Operating Costs	$2,850	0.0	$940	$485	$0	$1,425	50%	Table 7.2 Row F
P	Increased Overpayment Collections- FTE	($1,600,000)	0.0	($465,920)	($102,720)	$0	($1,031,360)	50%	Table 8.1 Row D, Fund Splits from Exhibit A, Medical Services Premiums
Q	Vendor Contract	$3,653,007	0.0	$1,205,492	$621,011	$0	$1,826,504	50%	Table 8.2 Row G
R	Vendor data interface-interChange modifications	$0	0.0	$0	$0	$0	$0	75%	One-time cost in FY 2020-21
S	Increased Overpayment Collections- Contract	($20,294,481)	0.0	($5,909,753)	($1,302,906)	$0	($13,081,822)	various	Table 8.2 Row E
T	**Total Request**	**($32,473,223)**	**6.0**	**($9,479,366)**	**$1,682,273**	**$0**	**($24,676,130)**	NA	Row A + Row H + Row L

Table 2.3 FY 2022-23 R-15 Medicaid Recovery and Third Party Liability Modernization Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	***Total Request-Tort and Casualty Recovery Operations***	**($42,630)**	**3.0**	**($840,569)**	**$1,569,253**	**$0**	**($771,314)**	NA	Row B + Row C + Row D + Row E + Row F + Row G
B	FTE- Personal Services, PERA and Medicare	$233,279	3.0	$76,982	$39,657	$0	$116,640	50%	Table 6.2 Row A
C	FTE- HLD, STD, AED, SAED	$51,241	0.0	$16,908	$8,711	$0	$25,622	50%	Table 6.2 Row B through E
D	FTE- Operating Costs	$2,850	0.0	$941	$485	$0	$1,424	50%	Table 6.2 Row F
E	Legal Case Tracking System	$120,000	0.0	$39,600	$20,400	$0	$60,000	50%	Estimate
F	Increased Recoveries	$0	0.0	($750,000)	$1,500,000	$0	($750,000)	50%	Table 4.1 Row G
G	Reduced Contingency Fees	($450,000)	0.0	($225,000)	$0	$0	($225,000)	50%	Table 4.1 Row J
H	***Total Request- Third Party Liability (TPL) Cost Avoidance***	**($16,856,915)**	**0.0**	**($4,239,476)**	**$742,720**	**$0**	**($13,360,159)**	NA	Row I + Row J + Row K
I	Vendor Contract	$17,248,905	0.0	$5,692,139	$2,932,314	$0	$8,624,452	50%	Table 3.1 Row F
J	TPL Cost Avoidance- interChange Modifications	$0	0.0	$0	$0	$0	$0	75%	One time cost in FY 2020-21
K	Avoided Costs	($34,105,820)	0.0	($9,931,615)	($2,189,594)	$0	($21,984,611)	NA	Table 3.1 Row L Fund Splits from Exhibit A, Medical Services Premiums
L	***Total Request- Identification and Collection of Overpayments***	**($18,411,160)**	**3.0**	**($5,203,623)**	**($751,957)**	**$0**	**($12,455,580)**	various	Row M + Row N + Row O + Row P + Row Q + Row R + Row S
M	FTE- Personal Services, PERA and Medicare	$251,274	3.0	$82,920	$42,717	$0	$125,637	50%	Table 7.2 Row A
N	FTE- HLD, STD, AED, SAED	$52,873	0.0	$17,447	$8,988	$0	$26,438	50%	Table 7.2 Row B through E
O	FTE- Operating Costs	$2,850	0.0	$940	$485	$0	$1,425	50%	Table 7.2 Row F
P	Increased Overpayment Collections- FTE	($1,600,000)	0.0	($465,920)	($102,720)	$0	($1,031,360)	50%	Table 8.1 Row D, Fund Splits from Exhibit A, Medical Services Premiums
Q	Vendor Contract	$3,757,644	0.0	$1,240,023	$638,799	$0	$1,878,822	50%	Table 8.2 Row G
R	Vendor data interface- interChange modifications	$0	0.0	$0	$0	$0	$0	75%	One-time cost in FY 2020-21
S	Increased Overpayment Collections- Contract	($20,875,801)	0.0	($6,079,033)	($1,340,226)	$0	($13,456,542)	various	Table 8.2 Row E
T	**Total Request**	**($35,310,705)**	**6.0**	**($10,283,668)**	**$1,560,016**	**$0**	**($26,587,053)**	NA	Row A + Row H + Row L

Table 3.1- Third Party Liability Cost Avoidance					
Row	**Label**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Source/Calculation**
A	Estimated Population	1,328,293	1,364,821	1,402,354	FY 2019-20 S-1 Medical Services Premiums Exhibit B trended forward using FY 2019-20 to FY 2020-21 trend
B	Percentage of Members with Other Insurance	10%	10%	10%	Estimate from Contractor based on national data. Only includes private insurance and does not include Medicare.
C	Members with Other Insurance	132,829	136,482	140,235	Row A * Row B
D	Estimated TPL Segments Per Member Identified Per Year	6	6	6	Estimate - 3 major medical & 3 pharmacy, see narrative for more detail
E	Contract Cost Per Segment	$20.50	$20.50	$20.50	Estimate
F	**Estimated Contract Cost**	**$16,337,967**	**$16,787,286**	**$17,248,905**	Row C * Row D * Row E
G	Acute Care Per Capita	$2,971	$3,052	$3,136	FY 2019-20 S-1 Medical Services Premiums Exhibit F Trended forward
H	Estimated Percentage of Cost Avoided	-16.67%	-16.67%	-16.67%	Assumes not all costs would be avoided due to federal requirements for cost avoidance
I	Cost Avoided Per Capita	($495)	($509)	($523)	Row G * Row H
J	Members with identified TPL	75,000	75,000	75,000	Data from MMIS unverified TPL policies loaded January through December 2018
K	Members with TPL identified that is not currently identified	57,829	61,482	65,235	Row C - Row J
L	**Estimated Avoided Costs**	**($28,637,153)**	**($31,283,402)**	**($34,105,820)**	Row I * Row K
M	**Net Impact**	**($12,299,186)**	**($14,496,116)**	**($16,856,915)**	Row F + Row L

Table 5.1 System Costs					
Row	**Item**	**Hourly Rate**	**Hours**	**Total Cost**	**Source/Calculation**
A	System Development for Identification of Third-Party Insurance	$143.05	1,223.35	$175,000	Develop claims data interface to vendor and into MMIS
B	System Development for Identification of Overpayments	$143.05	1,398.11	$200,000	Develop claims data interface to vendor and into MMIS
C	**Total Request**	**$143.05**	**2,621.46**	**$375,000**	Row A + Row B

Table 4.1 Tort and Casualty Recoveries					
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Source/Calculation**
A	Estimated Recoveries per FTE	($2,000,000)	($2,000,000)	($2,000,000)	Range for current vendor: $1.75 - $2 million per caseworker. Larger cases would be worked internally.
B	Estimated Recoveries processed per contractor staff	($1,500,000)	($1,500,000)	($1,500,000)	Based on current vendor performance
C	Increased Recoveries per FTE	($500,000)	($500,000)	($500,000)	Estimate based on current performance
D	Number of FTE	3	3	3	Request
E	Partial Year Adjustment	66.67%	100.00%	100.00%	Staff hired 10/1/20 and trained by 11/1/20
F	Total Recoveries processed by new FTE	($4,000,000)	($6,000,000)	($6,000,000)	Row A * Row D * Row E
G	**Total New Recoveries**	**($1,000,000)**	**($1,500,000)**	**($1,500,000)**	Row C * Row D * Row E
H	Current Contractor Recoveries Replaced by FTE Recoveries	($3,000,000)	($4,500,000)	($4,500,000)	Row F - Row G
I	Vendor Contingency Fee	10%	10%	10%	Current Contract
J	**Reduced Contingency Fees**	**($300,000)**	**($450,000)**	**($450,000)**	Row H * Row I
K	**Net Impact**	**($1,300,000)**	**($1,950,000)**	**($1,950,000)**	Row G + Row J

Table 6.1 Tort and Casualty Recovery FTE Costs- FY 2020-21							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$224,298	2.9	$74,018	$38,131	$0	$112,149
B	Health, Life and Dental	$30,126	0.0	$9,942	$5,121	$0	$15,063
C	Short-term Disability	$340	0.0	$112	$58	$0	$170
D	SB 04-257 Amortization Equalization Disbursement	$9,983	0.0	$3,294	$1,697	$0	$4,992
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$9,983	0.0	$3,294	$1,697	$0	$4,992
F	Operating Expenses	$16,959	0.0	$5,596	$2,883	$0	$8,480
G	**Total**	**$291,689**	**2.9**	**$96,256**	**$49,587**	**$0**	**$145,846**

Table 6.2 Tort and Casualty Recovery FTE Costs- FY 2021-22							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$233,279	3.0	$76,982	$39,657	$0	$116,640
B	Health, Life and Dental	$30,126	0.0	$9,942	$5,121	$0	$15,063
C	Short-term Disability	$353	0.0	$116	$60	$0	$177
D	SB 04-257 Amortization Equalization Disbursement	$10,381	0.0	$3,425	$1,765	$0	$5,191
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$10,381	0.0	$3,425	$1,765	$0	$5,191
F	Operating Expenses	$2,850	0.0	$940	$485	$0	$1,425
G	**Total**	**$287,370**	**3.0**	**$94,830**	**$48,853**	**$0**	**$143,687**

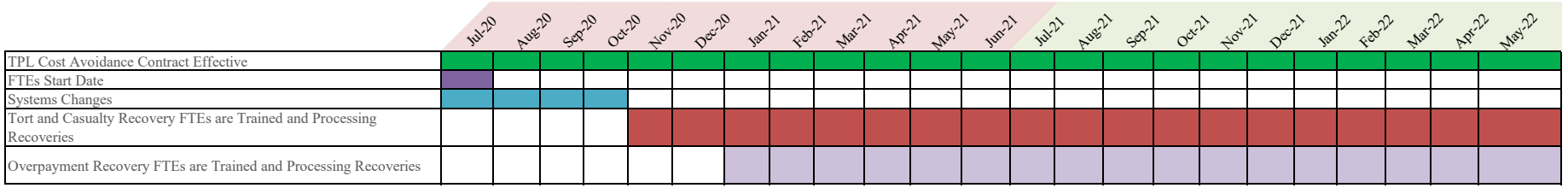
Table 7.1 Provider Overpayment FTE Costs- FY 2020-21							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$241,599	2.9	$79,727	$41,072	$0	$120,800
B	Health, Life and Dental	$30,126	0.0	$9,942	$5,121	$0	$15,063
C	Short-term Disability	$366	0.0	$121	$62	$0	$183
D	SB 04-257 Amortization Equalization Disbursement	$10,752	0.0	$3,548	$1,828	$0	$5,376
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$10,752	0.0	$3,548	$1,828	$0	$5,376
F	Operating Expenses	$16,959	0.0	$5,596	$2,883	$0	$8,480
G	**Total**	**$310,554**	**2.9**	**$102,482**	**$52,794**	**$0**	**$155,278**

Table 7.2 Provider Overpayment FTE Costs- FY 2021-22							
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
A	Personal Services	$251,274	3.0	$82,920	$42,717	$0	$125,637
B	Health, Life and Dental	$30,126	0.0	$9,942	$5,121	$0	$15,063
C	Short-term Disability	$381	0.0	$125	$65	$0	$191
D	SB 04-257 Amortization Equalization Disbursement	$11,183	0.0	$3,690	$1,901	$0	$5,592
E	SB 06-235 Supplemental Amortization Equalization Disbursement	$11,183	0.0	$3,690	$1,901	$0	$5,592
F	Operating Expenses	$2,850	0.0	$940	$485	$0	$1,425
G	**Total**	**$306,997**	**3.0**	**$101,307**	**$52,190**	**$0**	**$153,500**

Table 8.1 Increased Overpayment Collections for new FTE					
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Source/Calculation**
A	Estimated Recoveries per FTE	($800,000)	($800,000)	($800,000)	Estimate based on experience of current staff
B	Number of FTE	2	2	2	FTE- 2 recovery staff
C	Partial Year Adjustment	50.00%	100.00%	100.00%	Staff hired 7/1/20 and fully trained to impact recoveries by 1/1/21
D	**Estimated Increased Recoveries**	**($800,000)**	**($1,600,000)**	**($1,600,000)**	Row A * Row B * Row C

Table 8.2- Increased Overpayment Collections from Claims Data Review Contract					
Row	**Item**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Source/Calculation**
A	Estimated Acute Care Expenditure	$3,945,869,738	4,058,896,208	4,175,160,237	FY 2019-20 S-1 Medical Services Premiums Exhibit B, trended forward using FY 2019-20 to FY 2020-21 trend
B	Percentage of Overpayments that would be collected	0.50%	0.50%	0.50%	Estimate from Contractor based on national data (3-5 % at low end)
C	Estimated Increased Collection of Overpayments	($19,729,349)	($20,294,481)	($20,875,801)	Row A * Row B * (-1)
D	Partial Year Adjustment	0%	100%	100%	Contract would be effective 1/1/2020 with interfaces and processes for overpayment collections beginning 7/1/2021
E	**Adjusted Increased Overpayments Collected**	**$0**	**($20,294,481)**	**($20,875,801)**	Row C * Row D * Row E
F	Vendor Contract Percent	N/A	18%	18%	Department Estimate
G	**Estimated Vendor Contract Amount**	**$0**	**$3,653,007**	**$3,757,644**	Row E * Row F
H	**Net Impact**	**$0**	**($16,641,474)**	**($17,118,157)**	Row E + Row G

PROJECT TIMELINE
FY 2020-21 MEDICAID RECOVERY AND THIRD-PARTY LIABILITY MODERNIZATION



Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-16 Case Management & State-only Programs Modernization

Dept. Approval By: _____

OSPB Approval By: _____

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,646,643,001**	**$0**	**$8,669,613,696**	**$402,372**	**$397,497**
	FTE	500.0	0.0	504.1	3.8	4.0
	GF	$2,653,308,930	$0	$2,667,461,180	($69,366)	($100,135)
	CF	$996,642,695	$0	$995,214,528	$0	$0
	RF	$91,547,044	$0	$91,434,327	$0	$0
	FF	$4,905,144,332	$0	$4,915,503,661	$471,738	$497,632

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$318,991**	**$331,765**
	FTE	500.0	0.0	504.1	3.8	4.0
	GF	$13,478,948	$0	$14,470,561	$236,139	$245,596
	CF	$3,571,232	$0	$3,714,633	$0	$0
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$82,852	$86,169
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$31,708**	**$31,708**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$23,781	$23,781
	CF	$421,237	$0	$525,947	$0	$0
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$7,927	$7,927

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	**Total**	**$66,598**	**$0**	**$72,132**	**$543**	**$562**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$24,002	$0	$26,864	$402	$416
	CF	$5,301	$0	$5,495	$0	$0
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$141	$146
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	**Total**	**$1,984,802**	**$0**	**$2,182,512**	**$14,259**	**$14,831**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$722,807	$0	$812,689	$10,556	$10,979
	CF	$159,398	$0	$166,329	$0	$0
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$3,703	$3,852
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,984,802**	**$0**	**$2,182,512**	**$14,259**	**$14,831**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$722,807	$0	$812,689	$10,556	$10,979
	CF	$159,398	$0	$166,329	$0	$0
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$3,703	$3,852
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	**Total**	**$2,506,384**	**$0**	**$2,273,794**	**$22,612**	**$3,800**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,014,866	$0	$939,016	$16,959	$2,850
	CF	$243,961	$0	$197,797	$0	$0
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$5,653	$950
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	**Total**	**$22,864,305**	**$0**	**$22,630,967**	**($1,837,500)**	**($1,837,500)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$5,808,855	$0	$7,030,521	($918,750)	($918,750)
	CF	$1,587,101	$0	$1,587,101	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$15,468,349	$0	$14,013,345	($918,750)	($918,750)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($44,112,352)**	**($45,890,080)**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	GF	$2,285,686,174	$0	$2,294,366,911	($22,056,176)	($22,945,040)
	CF	$983,543,298	$0	$984,608,781	$0	$0
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($22,056,176)	($22,945,040)
	Total	**$503,255,278**	**$0**	**$502,793,147**	**($502,793,147)**	**($503,389,410)**
	FTE	0.0	0.0	0.0	0.0	0.0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Adult Comprehensive Services	GF	$248,117,256	$0	$250,596,573	($250,596,573)	($250,894,705)
	CF	$3,510,383	$0	$800,001	($800,001)	($800,001)
	RF	$0	$0	$0	$0	$0
	FF	$251,627,639	$0	$251,396,573	($251,396,573)	($251,694,704)
	Total	**$86,732,157**	**$0**	**$86,971,925**	**($86,971,925)**	**($86,971,925)**
	FTE	0.0	0.0	0.0	0.0	0.0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Adult Supported Living Services	GF	$45,959,837	$0	$46,082,518	($46,082,518)	($46,082,518)
	CF	$2,676,085	$0	$2,676,689	($2,676,689)	($2,676,689)
	RF	$0	$0	$0	$0	$0
	FF	$38,096,235	$0	$38,212,718	($38,212,718)	($38,212,718)
	Total	**$27,062,419**	**$0**	**$27,080,575**	**($27,080,575)**	**($27,080,575)**
	FTE	0.0	0.0	0.0	0.0	0.0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Children's Extensive Support Services	GF	$13,531,210	$0	$13,540,287	($13,540,287)	($13,540,287)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$13,531,209	$0	$13,540,288	($13,540,288)	($13,540,288)
	Total	**$45,206,293**	**$0**	**$45,243,320**	**($45,243,320)**	**($45,243,320)**
	FTE	0.0	0.0	0.0	0.0	0.0
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Case Management	GF	$23,571,393	$0	$23,590,677	($23,590,677)	($23,590,677)
	CF	$150,346	$0	$150,471	($150,471)	($150,471)
	RF	$0	$0	$0	$0	$0
	FF	$21,484,554	$0	$21,502,172	($21,502,172)	($21,502,172)

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$7,811,600**	**$0**	**$7,817,740**	**($7,817,740)**	**($7,817,740)**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Family Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,196,645	$0	$7,202,785	($7,202,785)	($7,202,785)
	CF	$614,955	$0	$614,955	($614,955)	($614,955)
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
	Total	**$3,197,573**	**$0**	**$3,200,203**	**($3,200,203)**	**($3,200,203)**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Eligibility Determination and Waiting List Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,197,573	$0	$3,200,203	($3,200,203)	($3,200,203)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0
	Total	**$5,152,220**	**$0**	**$5,155,578**	**($5,155,578)**	**($5,155,578)**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Program Costs - Children's Habilitation Residential Program	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,576,110	$0	$2,577,789	($2,577,789)	($2,577,789)
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,576,110	$0	$2,577,789	($2,577,789)	($2,577,789)
	Total	**$0**	**$0**	**$0**	**$611,865,306**	**$612,461,569**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (B) Medicaid Programs - Home and Community based Services for People with IDD	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$304,609,815	$304,907,947
	CF	$0	$0	$0	$1,528,123	$1,528,123
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$305,727,368	$306,025,499
	Total	**$0**	**$0**	**$0**	**$91,916,420**	**$93,694,148**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (B) Medicaid Programs - Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$46,921,092	$47,782,979
	CF	$0	$0	$0	$150,471	$150,471
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$44,844,857	$45,760,698

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$0**	**$0**	**$0**	**$20,430,614**	**$20,430,614**
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (C) State-Only Programs - State-Only Programs for People with IDD	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$17,867,092	$17,867,092
	CF	$0	$0	$0	$2,563,522	$2,563,522
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$0	$0

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-16
Request Detail: Case Management and State-Only Programs Modernization

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$402,372**	**$397,497**
FTE	0.0	3.8	4.0
General Fund	$0	($69,366)	($100,135)
Cash Funds	$0	$0	$0
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$471,738	$497,632

Summary of Request:

The Department requests an increase of $402,372 total funds, including a reduction of $69,366 General Fund, an increase of $471,738 federal funds, and 3.8 FTE in FY 2020-21, and an increase of $397,497 total funds, including a reduction of $100,135 General Fund, an increase of $497,632 federal funds, and 4.0 FTE in FY 2021-22. This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation. The Department seeks to implement the following initiatives that would increase programmatic oversight and management, increase funding transparency, and address audit findings:

1. 2.0 FTE for the management and oversight of the State-Only programs for persons with intellectual and developmental disabilities (IDD).
2. 2.0 FTE as administrative resources to implement and oversee case management redesign.
3. Adjust funding for federal funds available for intellectual and developmental disability eligibility determinations.
4. Collapse funding for Community Centered Boards (CCBs) and Single-Entry Points (SEP) into one appropriation, collapse all the State-Only programs into a new line item, and collapse all the Home and Community Based Services (HCBS) appropriation lines into a new line item.

Current Program:

There are currently 49 Case Management Agencies (CMAs), which include 24 Single Entry Points (SEPs), 20 Community Centered Boards (CCBs), and 5 private agencies that provide case management and administrative functions such as intake, functional eligibility determinations, and appeals for the over 70,000 members who need long term services and supports. These services are designed to keep members with disabilities living and engaging in their communities and out of costly, more restrictive nursing facilities or other institutions. Currently, SEPs provide these services for the majority of members needing long term services and supports, while the CCBs provide these services to members who have intellectual and developmental disabilities (IDD). Private CMAs provide services only for the Children's Home and Community Based Service waiver. CCBs provide additional services including intellectual and developmental disability functional eligibility determinations, administration and oversight of select State-Only programs, as well as being tasked with providing safeguards to prevent conflicts of interest between administration of case management and direct services. Currently, the Department pays for CCBs' and SEPs' administrative and case management functions from multiple appropriations. Paying from multiple appropriations requires the Department to create internal background documentation to keep track of funds, which increases the administrative burden and is not fully transparent.

State-Only Programs

The State-Only funded programs, including the State Supported Living Services (State SLS) program, Family Support Services Program (FSSP), and Omnibus Budget Reconciliation Act-Specialized Services (OBRA-SS) program, provide non-residential services to adults and children with intellectual and developmental disabilities (IDD) in need of support and who often do not necessarily qualify for Medicaid. Since some individuals receiving these services do not qualify or have difficulty maintaining eligibility for Medicaid waiver programs, the Department serves this population using only General Fund appropriations. The State SLS program provides support and services including behavioral health, day habilitation, homemaker, transportation, and supported employment services. FSSP provides services to families with expenses beyond those normally experienced by other families because they have a child with an intellectual or developmental disability or developmental delay. The OBRA-SS program provides services to individuals with mental illness or IDD, who reside in a nursing facility and need additional services specific to their mental illness or IDD, not provided by the nursing facility. The Department contracts with CCBs to provide case management and services within contractual maximums for these programs. These state-only programs are funded through four separate appropriation lines.

Determination of Intellectual and Developmental Disability

The Department pays for determinations of intellectual and developmental disability performed by CCBs using only General Fund dollars and does not receive a match. These determinations are required for an individual who is seeking Medicaid services and are used to determine whether a member is eligible for the HCBS waiver programs targeted to individuals with intellectual and developmental disabilities.

Case Management Redesign

Federal case management regulations at 42 CFR 431.301(1)(vi) requires case management and direct services under an HCBS waiver program be provided by separate agencies. In 2017, the General Assembly passed HB 17-1343 to align with federal regulations which required individuals enrolled in an HCBS waiver program specific for people with intellectual and developmental disability receive conflict-free case management (CFCM). HB 17-1343 required the Department to develop new qualifications for Case Management Agency (CMA) and case managers along with developing a third-party to assist individuals in the choice of CMA. Additionally, the Department received 1.0 FTE to oversee the implementation of, and ensure compliance with, CFCM regulations.

To implement the federal and state rules requiring separation of case management from service provision, the Department has held over 30 stakeholder engagement meetings with members, their families, advocates, and case management agencies to include Community-Centered Boards (CCBs), and Single Entry Points (SEPs). Through those engagements, it was clear that redesigning case management would require additional efforts beyond separating case management from service provision. There were other elements of the case management system that stakeholders wanted improved, such as simplified access to services, offering member choice, and creating the structure to ensure quality oversight. To achieve this, the Department has embarked on a process to not only implement CFCM but also to address other stakeholder concerns by redesigning how long term care case management is provided.

As part of this process, and in compliance with HB 17-1343, the Department is working with CMAs regarding their transition plans to a conflict free organization and received approval from the Medical Services Board (MSB) as well as Centers for Medicare and Medicaid Services (CMS) for new case management agency and case manager qualifications.

While redesigning the case management system, during FY 2018-19, the Colorado Office of the State Auditor (OSA) performed an audit[1] on the performance of the CCBs and issued findings to the Department related to the oversight and administration of Targeted Case Management (TCM) and the State SLS program that require programmatic and payment changes in order to come into compliance with the recommendations.

Problem or Opportunity:

The OSA audit identified a number of areas for the Department to increase oversight and accuracy of payments for services for people with disabilities in order to ensure at-risk populations are served appropriately and efficiently with all available funding. Additional resources are needed in order to implement audit findings and case management redesign in a timely and effective way.

[1] https://leg.colorado.gov/audits/community-centered-boards

Financial, Programmatic, and Quality Oversight of State-Only Programs

The OSA audit recommends the Department implement the following changes to the state-only programs: create a new data-driven funding allocation; put policies and systems in place to reduce program waiting lists; and establish a process to reallocate reverted funds. The OSA found the Department's funding allocation did not meet the needs of the communities it was serving by either providing too much or too little funding. Outdated funding allocations caused CCBs to revert funds despite individuals still being on waiting lists. Overall, the audit found there was a lack of oversight and regulation on the CCBs' management of the State SLS program. In an effort to address the findings, the Department has drafted programmatic rules which aim to provide oversight and management of all state-only programs. However, the Department does not believe that a rule change alone would fully address the recommendations issued by the audit.

Case Management Redesign

CFCM legislation created the opportunity for new CMAs to serve members in areas where CCBs are currently the only providers. In response to the new rules for case management, in which agencies may provide either services or case management to members, the Department is redesigning how it pays for case management. This includes drafting waiver amendments and engaging with stakeholders for necessary rule changes. As these changes occur, the Department will need to continue to coordinate with CMS, community advocates, CCBs, and new CMAs. This creates a large administrative workload which cannot be absorbed.

Additionally, during its performance audit of the CCBs, the OSA noted the Department's current case management payment methodology may incent quantity of service over quality of service. To address these findings, the Department is actively working through the process of creating a different payment methodology to align the payments between CCBs, SEPs, and CMAs. These payment changes, as well as programmatic changes as a part of case management redesign, are necessary to implement CFCM and the OSA audit recommendations; however, the Department does not currently have the resources to implement and have ongoing oversight of these important changes.

Federal Match for Intellectual and Developmental Disability Determinations

Currently, the Department does not receive a federal match for any intellectual and developmental disability determinations conducted by CCBs. These determinations are required for all members seeking to enroll in Home and Community-Based Services (HCBS) waiver programs and state-only programs operated by CCBs. The Department believes these determinations are eligible to receive a federal match, which would reduce the need for General Fund.

Appropriation Consolidation

As part of its efforts to redesign case management and to comply with federal regulation, the Department has started to take steps to implement new provider types. However, this introduces administrative and financial complexities for the payment of potential new CMAs joining the market. The Department pays for SEP and CCB contracts and case management from four different appropriations, of which the funding is only a portion of the total of those lines. The current appropriation structure would require the Department to administer contracts that touch multiple appropriations and would likely cause many accounting transfers

and adjustments. Adding to this complexity, the payment methodologies are not aligned as the CCBs are paid based on a 15-minute unit rate, while SEPs have fixed contract payments. To effectively implement CFCM legislation and Case Management Redesign, the Department needs increased flexibility within current CCBs and SEP appropriations to allow CMAs to serve any population.

Similar to the SEP and CCB contract and case management lines, the Department has state-only programs funded within four different appropriations. The funds within these appropriations are both Medicaid and non-Medicaid funds, and the distinction between the two is not clearly outlined in the Long Bill. Under the current appropriation, CCBs have fixed payment maximums for each program resulting in some CCBs having excess funds that must revert while others have waiting lists. Having four appropriations necessitates the Department to manually transfer funds, which requires documentation and drives administrative workloads. This results in a lack of funding transparency between Medicaid fund and non-Medicaid funds and increased administrative burden as the Department must create internal background documents for contract maximums and tracking dollars.

Additionally, the OSA performance audit found the Department was moving funds between programs and CCBs in an inefficient manner, which caused funds to revert and individuals to needlessly remain on waiting lists. The CCBs performance audit also found the Department's funding structure for CCBs lacked oversight and quality control. The Department is exploring different allocation and payment methods to address the audits findings. However, the Department is finding it difficult to implement and enforce oversight and quality controls under the current appropriation structure and within available resources.

Proposed Solution:

The Department requests an increase of $402,372 total funds, including a reduction of $69,366 General Fund, including $471,738 federal funds, and 3.8 FTE in FY 2020-21 and an increase $397,497 total funds, including a reduction of $100,135 General Fund, an increase of $497,632 federal funds and 4.0 FTE in FY 2021-22. The Department seeks to improve oversight and efficiency of administration with the following initiatives:

1. 2.0 FTE for the management and oversight of the state-only programs for persons with intellectual and developmental disabilities (IDD)
2. 2.0 FTE as administrative resources to implement and oversee case management redesign.
3. Adjust funding for federal funds available for intellectual and developmental disability and delay determinations.
4. Collapse the funding for Community Centered Boards (CCB) and Single-Entry Points (SEP) into one appropriation, collapse all the state-only programs into a new line item, and collapse all the HCBS appropriation lines into a new line item

The FTE would provide oversight and management of the state-only programs, as well as FTE to align with OSA recommendations and implement Case Management Redesign.

Financial, Programmatic and Quality Oversight of State-Only Programs

The Department requests two FTE for management and oversight of the three state-only programs. These FTE would address the OSA audit findings related to State SLS financial, programmatic, and quality oversight. One of the FTE would work on implementing management and administrative recommendations from the audit. This position would allow the Department to directly address recommendations 1A, 1B, and 1C related to developing a new allocation methodology, collecting necessary data, developing policies and procedures, minimizing the funds that are reverted each fiscal year, and conducting financial compliance reviews of the CCBs. The Department needs these additional staff to hold providers accountable through audits and ensure compliance with program rules. These resources would lead to improved usage of funds and the maximization of fiscal resources.

The other position would allow the Department to provide program-specific guidance and technical assistance to the CCBs, which would address OSA recommendations 2 and 3 related to performing case management functions appropriately for the State SLS program. Further, the work of this position would establish the standards and requirements that would allow the Department to have better oversight as required in OSA recommendation 4. The increase in oversight would align with the Department's goal of improving 'member health' by ensuring quality case management and services are provided to our members through the state-only programs.

If this request is not approved. the Department would not be able to maximize the amount of people served by the state-only programs. Additionally, the Department would also be at risk for future audit findings related to State SLS, OBRA-SS, and FSSP as requirements are established and training and technical assistance would not be available without these FTE.

Case Management Redesign

The Department requests two FTE to implement case management redesign. To comply with federal regulation of CFCM, the Department requires additional resources beyond what was appropriated in HB 17-1343. These resources would further develop, oversee the implementation of, and ensure compliance with, the Department's case management redesign. This includes stakeholder engagement, drafting rules and regulations, reviewing case management agencies applications, the development and writing of waiver amendments for submission to the CMS, as well as acting as point of contact for agencies on new requirements. These FTE would also address OSA recommendations 5A and 10 related to standardizing case management administration, and craft guidance on case management billing, administration and requirements to ensure members are receiving quality care. Without these FTE, the Department would not be able to provide technical guidance on case management redesign and may be subject to ongoing audit findings. These FTE resources align with the Department's goals of improving the delivery of programs for its members and allows members to more easily access the services they need.

If this request is not approved, the Department would be at risk for not complying with the legislative deadline for CFCM which would impact members who would not have complete access to CFCM.

Federal Match for Determinations of Intellectual and Developmental Disability

The Department requests a reduction of $367,759 General Fund as well as an increase in federal funds $367,759 in FY 2020-21 and requests a reduction of $394,736 General Fund as well as an increase in federal funds $394,736 in FY 2021-22, to obtain a federal match on eligible determinations. The request aligns with the Department's strategy of "Operational Excellence" and allow for implementation of efficient business practices. If this request is not approved the Department would continue to use only General Fund for this purpose.

Appropriation Consolidation

The Department requests to collapse the appropriations for CCBs and SEPs, the state-only programs and HCBS waivers programs into separate appropriations that are bottom-line funded. This action would not change legislative reporting or the total amount of funding appropriated but would increase the Department's flexibility to reallocate funds and simplify funding sources within contracts. Downstream effects would include moving the Department forward on Case Management Redesign by allowing the Department to enroll new CMAs more efficiently and allowing the Department to implement recommendations from the CCB OSA performance audit. Maximizing the number of people served by the state-only programs and allowing for increased choice for case management would positively impact members. Under the current appropriation format, the Department must assign funding to contracts from several different funding sources with different payment methodologies. The Department believes payment methodology challenges for new agencies could be addressed by combining the appropriations for CCBs and SEPs by aligning the funding source which would allow for flexibility in payment. For additional information regarding the line item reorganization please reference table 8.1 in appendix B.

The Department requests consolidating specific line appropriations in order to minimize burdensome administrative work caused by manually shifting or tracking funds. This request allows the Department to separate Medicaid funds from non-Medicaid funds in the Long Bill and ensure financial compliance. This aligns with the Department's goal of "Operational Excellence" by ensuring business operations are transparent and accurate.

If this request is not approved, the Department would have difficulty moving forward with case management redesign, legislative deadlines and OSA audit recommendations, and would have to continue to create complex internal background documents to keep track of the spending by the new CMAs. This alternative would be inefficient, time consuming, and prone to error.

Anticipated Outcomes:

Financial, Programmatic, and Quality Oversight of State-Only Programs

Approving the request for additional FTE resources for state-only programs would ensure the Department has sufficient resources to implement the OSA CCBs audit recommendations and would address the oversight and management issues the OSA audit identified. By providing these resources, the Department would be able to make meaningful changes to their fiscal management, contract oversight, programmatic quality, and

ensure individuals within the program are receiving services to meet their needs. Additionally, these changes would allow the Department to improve service delivery for all state-only programs managed by CCBs and avoid future audits.

Case Management Redesign
Approving the request for additional FTE for Case Management Redesign would ensure that the Department has sufficient resources for the transition and implementation of new CMAs. The additional resources would enable the Department to further develop, implement proposed Case Management Redesign initiatives, provide robust stakeholder engagement, meet legislative deadlines and implement OSA recommendations around payment reform.

Federal Match for Determinations of Intellectual and Developmental Disability
Receiving a federal match on intellectual and developmental disability determination activities would allow the Department to lessen the burden on the General Fund.

Appropriation Consolidation
Consolidation of funding for all administrative and case management activities performed by CCBs and SEPs would allow the Department greater flexibility to pay for comparable works as new CMAs enter the market and serve to simplify and streamline case management funding.

Additionally, the consolidation of state-only programs into one line item would allow the Department to address the OSA audit concerns by creating better management of current funds and easier transferability of funds between programs as necessary, most likely reducing reversions and allowing CCBs to serve the maximum number of people as possible.

Consolidation of funding for all HCBS waivers for persons with intellectual and developmental disabilities would create increased administrative efficiency within the Department.

Assumptions and Calculations:

Detailed calculations and a timeline can be found in Appendix B.

The Department assumes intellectual and developmental disability determination costs would be eligible for a 50 percent Federal Financial Participation (FFP) and would be requested in the federally required Public Assistance Cost Allocation Plan (PACAP). The Department assumes the state share of determination costs would be allocated from General Fund and that sufficient funds are available. The Department also assumes that it would submit the PACAP amendment in FY 2019-20, but the federal funds match would not be effective until July 1, 2020.

FTE Descriptions

Title	FTE	Duties
Financial Compliance Specialist	1.0	The position would perform financial oversight of the 20 Community Centered Boards (CCBs) and their operation of the State Supported Living Services Program (State SLS), Family Support Services Program (FSSP), and Omnibus Reconciliation Act of 1987 Specialized Services Program (OBRA-SS) that total over $20,000,000 annually. This position would conduct ongoing financial compliance reviews of the 20 CCBs and subcontracted providers, expenditure analysis, oversight and management of the allocation and payment methodologies, and management and redistribution of appropriated funds. Specifically, this position would be responsible for the development and implementation of all materials related to financial compliance reviews to include internal procedures, protocols, scope, templates and test files, risk assessment, schedule and assignment, tracking, sampling methodology, quality assurance, notification letters, findings and report templates, informal reconsiderations, appeals, and recoveries. This position would analyze expenditure data, track CCB spending, and redistribute funds as appropriate to minimize reversions and to serve as many members as possible within existing appropriations. Utilizing expenditure and case management data, this position would determine if changes to individual CCBs allocations, payment structure, and the methodology as necessary. This position would allow the Department of Health Care Policy & Financing (the Department) to come into full compliance with the November 2018 Office of the State Auditor (OSA) audit. While the OSA audit was directly related to the State SLS program, the Department is at risk for additional findings related to the OBRA-SS and FSSP programs and this position would work to minimize those risks. Additionally, this position would allow the Department to have ongoing, comprehensive financial oversight of the CCBs.
Financial Compliance Specialist	1.0	The position would manage the waiting list for State SLS and FSSP. These waiting lists are operated separately from those for Home and Community Based Services (HCBS) waiver programs. The position needs to be the expert in overseeing and authorizing enrollments for state-only programs, as well as oversight of CCBs for waiting list management. In addition, this position would be the subject matter expert (SME) for all case management activities for State SLS, FSSP, and OBRA-SS programs. This position would be the main contact for case management questions from CCBs. Likewise, this position would assist in the development and implementation of materials related to the programmatic and quality reviews to include

Title	FTE	Duties
		internal procedures, scope, test files and templates, scheduling and tracking, quality assurance, notification letters, finding and report templates, corrective action, and review closeout. This position would assist in conducting ongoing reviews of the CCBs' operation of the programs to include a review of service plan development, assessment, developmental disability determination, monitoring, and revision and reassessment to ensure compliance with contract requirements and regulations. Additionally, this position would conduct targeted and statewide technical assistance related to maintaining adequate case management documentation, corrective action, and compliance. This position would also make recommendations to leadership regarding any policy changes needed for the programs. Likewise, this position would minimize the risk for future audit findings related to OBRA-SS and FSSP as requirements are established and training and technical assistance is provided.
Case Management Redesign Project Manager	1.0	The position would provide project management and oversight for the transition to and implementation of Conflict-Free Case Management (CFCM). This work would include timeline development, monitoring of timeline/milestones regarding the work necessary to transition individuals from conflicted case management to CFCM. This position would be responsible for scheduling meetings, developing agendas, developing meeting summaries, and providing coordination between Office of Community Living (OCL), other Department of Health Care Policy & Financing (Department) staff, and outside entities as necessary. This position would manage the transition of approximately 8,100 individuals to CFCM. This would include coordinating with current case management agencies (CMAs), new CMAs, and direct service providers. In addition, HB 17-1343 requires 25% of individuals receive CFCM by June 30, 2021 and 100% by June 30, 2022. This position would be responsible for tracking the transitions and ensuring all agencies meet the regulatory and/or contractual timelines for their respective roles. This position would allow the Department to comply with federal regulation and state laws.

Title	FTE	Duties
Case Management Specialist	1.0	The position would be responsible for implementing case management redesign. This position would be responsible for researching and recommending changes to regulation necessary to implement CFCM and case management redesign. These regulatory changes are necessary to comply with HB 17-1343 requirements. This position must coordinate with other OCL staff for this process as well. This position would be responsible to recommend language necessary to amend the State Plan and waiver agreements for federal approval necessary to implement case management redesign. This position would be responsible for stakeholder engagement necessary for the work. This position would provide technical assistance for CMA qualifications and be coordinate with OCL staff to for approve/disapprove CMA applications. This position would coordinate with OCL staff and Department vendors for the transition to CFCM. This position would provide the necessary case management expertise to assist in the transition and coordinate with the project manager and other OCL staff to ensure all timelines and milestones are met. This position would coordinate with current staff to ensure all aspects of CFCM align with the overall case management redesign efforts. This position would conduct/provide technical assistance to agencies applying to be a CMA and assist with the application process as needed. This position would work with Department systems staff to ensure all systems meet the requirements necessary to implement case management redesign. This position would allow the Department to ensure compliance with federal regulation and state laws.

Table 1.1 Summary by Line Item FY 2020-21 Case Management and State-Only Programs Modernization								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office (A) General Administration, Personal Services	$318,991	3.8	$236,139	$0	$0	$82,852	FTE Calculator
B	(1) Executive Director's Office (A) General Administration, Health Life, and Dental	$31,708	0.0	$23,781	$0	$0	$7,927	FTE Calculator
C	(1) Executive Director's Office (A) General Administration, Short Term Disability	$543	0.0	$402	$0	$0	$141	FTE Calculator
D	(1) Executive Director's Office (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$14,259	0.0	$10,556	$0	$0	$3,703	FTE Calculator
E	(1) Executive Director's Office (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$14,259	0.0	$10,556	$0	$0	$3,703	FTE Calculator
F	(1) Executive Director's Office (A) General Administration, Operating Expenses	$22,612	0.0	$16,959	$0	$0	$5,653	FTE Calculator
G	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contracts	($1,837,500)	0.0	($918,750)	$0	$0	($918,750)	Table 5.1 Row M
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($44,112,352)	0.0	($22,056,176)	$0	$0	($22,056,176)	Table 5.1 Row N
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	($45,243,320)	0.0	($23,590,677)	($150,471)	$0	($21,502,172)	Table 4.1 Row N + Table 5.1 Row O
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	($3,200,203)	0.0	($3,200,203)	$0	$0	$0	Table 4.1 Row P + Table 5.1 Row P
K	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Case Management	$91,916,420	0.0	$46,921,092	$150,471	$0	$44,844,857	Table 3.1 Row I + Table 5.1 Row Q
L	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	($86,971,925)	0.0	($46,082,518)	($2,676,689)	$0	($38,212,718)	Table 4.1 Row M + Table 6.1 Row M
M	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	($7,817,740)	0.0	($7,202,785)	($614,955)	$0	$0	Table 4.1 Row O
N	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$20,430,614	0.0	$17,867,092	$2,563,522	$0	$0	Table 4.1 Row Q
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	($502,793,147)	0.0	($250,596,573)	($800,001)	$0	($251,396,573)	Table 6.1 Row N
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	($27,080,575)	0.0	($13,540,287)	$0	$0	($13,540,288)	Table 6.1 Row O
Q	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	($5,155,578)	0.0	($2,577,789)	$0	$0	($2,577,789)	Table 6.1 Row P
R	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$611,865,306	0.0	$304,609,815	$1,528,123	$0	$305,727,368	Table 6.1Row Q
S	**Total Request**	**$402,372**	**3.8**	**($69,366)**	**$0**	**$0**	**$471,738**	**Sum of Row A through Row R**

Table 1.2 Summary by Line Item FY 2021-22 Case Management and State-Only Programs Modernization								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office (A) General Administration, Personal Services	$331,765	4.0	$245,596	$0	$0	$86,169	FTE Calculator
B	(1) Executive Director's Office (A) General Administration, Health Life, and Dental	$31,708	0.0	$23,781	$0	$0	$7,927	FTE Calculator
C	(1) Executive Director's Office (A) General Administration, Short Term Disability	$562	0.0	$416	$0	$0	$146	FTE Calculator
D	(1) Executive Director's Office (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$14,831	0.0	$10,979	$0	$0	$3,852	FTE Calculator
E	(1) Executive Director's Office (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$14,831	0.0	$10,979	$0	$0	$3,852	FTE Calculator
F	(1) Executive Director's Office (A) General Administration, Operating Expenses	$3,800	0.0	$2,850	$0	$0	$950	FTE Calculator
G	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contracts	($1,837,500)	0.0	($918,750)	$0	$0	($918,750)	Table 5.2 Row M
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($45,890,080)	0.0	($22,945,040)	$0	$0	($22,945,040)	Table 5.2 Row N
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	($45,243,320)	0.0	($23,590,677)	($150,471)	$0	($21,502,172)	Table 4.2 Row N + Table 5.2 Row O
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	($3,200,203)	0.0	($3,200,203)	$0	$0	$0	Table 4.2 Row P + Table 5.2 Row P
K	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Case Management	$93,694,148	0.0	$47,782,979	$150,471	$0	$45,760,698	Table 3.2 Row I + Table 5.2 Row Q
L	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	($86,971,925)	0.0	($46,082,518)	($2,676,689)	$0	($38,212,718)	Table 4.2 Row M + Table 6.2 Row M
M	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	($7,817,740)	0.0	($7,202,785)	($614,955)	$0	$0	Table 4.2 Row O
N	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$20,430,614	0.0	$17,867,092	$2,563,522	$0	$0	Table 4.2 Row Q
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	($503,389,410)	0.0	($250,894,705)	($800,001)	$0	($251,694,704)	Table 6.2 Row N
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	($27,080,575)	0.0	($13,540,287)	$0	$0	($13,540,288)	Table 6.2 Row O
Q	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	($5,155,578)	0.0	($2,577,789)	$0	$0	($2,577,789)	Table 6.2 Row P
R	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$612,461,569	0.0	$304,907,947	$1,528,123	$0	$306,025,499	Table 6.2 Row Q
S	**Total Request**	**$397,497**	**4.0**	**($100,135)**	**$0**	**$0**	**$497,632**	**Sum of Row A through Row R**

Table 2.1 Summary by Initiative FY 2020-21 Case Management and State-Only Programs Modernization									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	***State General Fund Programs Quality Performance FTE***	**$194,413**	**1.9**	**$194,413**	**$0**	**$0**	**$0**	**0.00%**	**Row B + Row C**
B	State General Fund Programs Financial Compliance FTE	$105,895	1.0	$105,895	$0	$0	$0	0.00%	FTE Calculator
C	State General Fund Programs Quality Performance FTE	$88,518	1.0	$88,518	$0	$0	$0	0.00%	FTE Calculator
D	***Case Management Redesign FTE***	**$207,959**	**1.9**	**$103,980**	**$0**	**$0**	**$103,979**	**50.00%**	**Row E + Row F**
E	Case Management Redesign Project Management FTE	$119,441	1.0	$59,721	$0	$0	$59,720	50.00%	FTE Calculator
F	Case Management Redesign CM Specialist FTE	$88,518	1.0	$44,259	$0	$0	$44,259	50.00%	FTE Calculator
G	***Appropriation Adjustments***	**$0**	**0.0**	**($367,759)**	**$0**	**$0**	**$367,759**	**N/A**	**Row H + Row I**
H	Long Bill Consolidation [(1)]	$0	0.0	$0	$0	$0	$0	N/A	Table 4.1 Row R + Table 5.1 Row R + Table 6.1 Row R
I	Federal Match on IDD Determinations	$0	0.0	($367,759)	$0	$0	$367,759	50.00%	Table 3.1 Row I
J	**Total Request**	**$402,372**	**3.8**	**($69,366)**	**$0**	**$0**	**$471,738**	**N/A**	**Row A + Row D + Row G**
(1) See narrative for more detail									

Table 2.2 Summary by Initiative FY 2021-22 Case Management and State-Only Programs Modernization									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
A	***State General Fund Programs Quality Performance FTE***	**$191,705**	**2.0**	**$191,705**	**$0**	**$0**	**$0**	**0.00%**	**Row B + Row C**
B	State General Fund Programs Financial Compliance FTE	$104,889	1.0	$104,889	$0	$0	$0	0.00%	FTE Calculator
C	State General Fund Programs Quality Performance FTE	$86,816	1.0	$86,816	$0	$0	$0	0.00%	FTE Calculator
D	***Case Management Redesign FTE***	**$205,792**	**2.0**	**$102,896**	**$0**	**$0**	**$102,896**	**50.00%**	**Row E + Row F**
E	Case Management Redesign Project Management FTE	$118,976	1.0	$59,488	$0	$0	$59,488	50.00%	FTE Calculator
F	Case Management Redesign CM Specialist FTE	$86,816	1.0	$43,408	$0	$0	$43,408	50.00%	FTE Calculator
G	***Appropriation Adjustments***	**$0**	**0.0**	**($394,736)**	**$0**	**$0**	**$394,736**	**N/A**	**Row H + Row I**
H	Long Bill Consolidation [(1)]	$0	0.0	$0	$0	$0	$0	50.00%	Table 4.2 Row R + Table 5.2 Row R + Table 6.2 Row R
I	Federal Match on IDD Determinations	$0	0.0	($394,736)	$0	$0	$394,736	50.00%	Table 3.2 Row I
J	**Total Request**	**$397,497**	**4.0**	**($100,135)**	**$0**	**$0**	**$497,632**	**N/A**	**Row A + Row D + Row G**
(1) See narrative for more detail									

Table 3.1 FY 2020-21 Federal Match on Intellectual and Developmental Disabilities Determinations						
Current Appropriation						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
A	IDD Determination	$726,194	$726,194	$0	$0	0%
B	Delay Determination	$9,323	$9,323	$0	$0	0%
C	**Total**	**$735,517**	**$735,517**	**$0**	**$0**	**N/A**
Requested Appropriation						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
D	IDD Determination	$726,194	$363,097	$0	$363,097	50%
E	Delay Determination	$9,323	$4,661	$0	$4,662	50%
F	**Total**	**$735,517**	**$367,758**	**$0**	**$367,759**	**N/A**
Incremental Difference						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
G	IDD Determination	$0	($363,097)	$0	$363,097	50%
H	Delay Determination	$0	($4,662)	$0	$4,662	50%
I	**Total**	**$0**	**($367,759)**	**$0**	**$367,759**	**N/A**

Table 3.2 FY 2021-22 Federal Match on Intellectual and Developmental Disabilities Determinations						
Current Appropriation						
Row	**Element**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
A	IDD Determination	$779,408	$779,408	$0	$0	0%
B	Delay Determination	$10,063	$10,063	$0	$0	0%
C	**Total**	**$789,471**	**$789,471**	**$0**	**$0**	**N/A**
Requested Appropriation						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
D	IDD Determination	$779,408	$389,704	$0	$389,704	50%
E	Delay Determination	$10,063	$5,032	$0	$5,032	50%
F	**Total**	**$789,471**	**$394,736**	**$0**	**$394,736**	**N/A**
Incremental Difference						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
G	IDD Determination	$0	($389,704)	$0	$389,704	50%
H	Delay Determination	$0	($5,032)	$0	$5,032	50%
I	**Total**	**$0**	**($394,736)**	**$0**	**$394,736**	**N/A**

Table 4.1 FY 2020-21
Movement of State-Only Appropriated Funds by Line Item

Current Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source
A	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$10,135,919	$8,187,352	$1,948,567	$0	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
B	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Case Management	$2,156,935	$2,156,935	$0	$0	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
C	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	$7,817,740	$7,202,785	$614,955	$0	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
D	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Waitlist and Eligibility Management	$320,020	$320,020	$0	$0	Table 6.1 Appropriation Build Eligibility Determination and Waitlist
E	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$0	$0	$0	$0	Creating New Line
F	**Total**	**$20,430,614**	**$17,867,092**	**$2,563,522**	**$0**	**Sum of Row A through Row E**

Requested Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source
G	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$0	$0	$0	$0	Assume zero funding for Appropriation
H	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Case Management	$0	$0	$0	$0	Assume zero funding for Appropriation
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	$0	$0	$0	$0	Assume zero funding for Appropriation
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Waitlist and Eligibility Management	$0	$0	$0	$0	Assume zero funding for Appropriation
K	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$20,430,614	$17,867,092	$2,563,522	$0	Row F
L	**Total**	**$20,430,614**	**$17,867,092**	**$2,563,522**	**$0**	**Sum of Row G through Row K**

Incremental Difference

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source
M	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	($10,135,919)	($8,187,352)	($1,948,567)	$0	Row G - Row A
N	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Case Management	($2,156,935)	($2,156,935)	$0	$0	Row H - Row B
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	($7,817,740)	($7,202,785)	($614,955)	$0	Row I - Row C
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Waitlist and Eligibility Management	($320,020)	($320,020)	$0	$0	Row J - Row D
Q	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$20,430,614	$17,867,092	$2,563,522	$0	SUM Row A through Row D
R	**Difference**	**$0**	**$0**	**$0**	**$0**	**SUM of Row M through Row Q**

(1) IDD and FSSP Loan Program source of Cash Fund

Table 4.2 FY 2021-22
Movement of State-Only Appropriated Funds by Line Item

Current Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source
A	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$10,135,919	$8,187,352	$1,948,567	$0	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
B	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Case Management	$2,156,935	$2,156,935	$0	$0	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
C	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	$7,817,740	$7,202,785	$614,955	$0	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
D	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Waitlist and Eligibility Management	$320,020	$320,020	$0	$0	Table 6.1 Appropriation Build Eligibility Determination and Waitlist
E	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$0	$0	$0	$0	Creating New Line
F	**Total**	**$20,430,614**	**$17,867,092**	**$2,563,522**	**$0**	**Sum of Row A through Row E**

Requested Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source
G	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$0	$0	$0	$0	Assume zero funding for Appropriation
H	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Case Management	$0	$0	$0	$0	Assume zero funding for Appropriation
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	$0	$0	$0	$0	Assume zero funding for Appropriation
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Waitlist and Eligibility Management	$0	$0	$0	$0	Assume zero funding for Appropriation
K	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$20,430,614	$17,867,092	$2,563,522	$0	Row F
L	**Total**	**$20,430,614**	**$17,867,092**	**$2,563,522**	**$0**	**Sum of Row G through Row K**

Incremental Difference

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source
M	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	($10,135,919)	($8,187,352)	($1,948,567)	$0	Row G - Row A
N	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Case Management	($2,156,935)	($2,156,935)	$0	$0	Row H - Row B
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Family Support Services	($7,817,740)	($7,202,785)	($614,955)	$0	Row I - Row C
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Waitlist and Eligibility Management	($320,020)	($320,020)	$0	$0	Row J - Row D
Q	NEW LINE (4) Office of Community Living (C) State Only Programs State Only Programs for People with Intellectual and Developmental Disabilities	$20,430,614	$17,867,092	$2,563,522	$0	SUM Row A through Row D
R	**Difference**	**$0**	**$0**	**$0**	**$0**	**SUM of Row M through Row Q**

(1) IDD and FSSP Loan Program source of Cash Fund

Table 5.1 FY 2020-21
Movement of SEP and CCB Admin and Case Management Funds

Current Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	FFP	Source
A	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contracts	$1,837,500	$918,750	$0	$918,750	50%	Assumed portion of Appropriation
B	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$44,112,352	$22,056,176	$0	$22,056,176	50%	S-1 FY 19-20 Exhibit I2 Without SB 16-192 Re-Assessments
C	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	$43,086,385	$21,433,742	$150,471	$21,502,172	50%	R-5 FY 2020-21 Appropriation Build Without SB 16-192 Re-Assessments
D	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	$2,880,183	$2,880,183	$0	$0	0%	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
E	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Case Management	$0	$0	$0	$0	50%	Creating New Line
F	**Total**	**$91,916,420**	**$47,288,851**	**$150,471**	**$44,477,098**	**N/A**	**Sum of Row A through Row E**

Requested Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	FFP	Source
G	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contracts	$0	$0	$0	$0	50%	Assume zero funding for Appropriation
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$0	$0	$0	$0	50%	Assume zero funding for Appropriation
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	$0	$0	$0	$0	50%	Assume zero funding for Appropriation
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	$0	$0	$0	$0	0%	Assume zero funding for Appropriation
K	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Case Management	$91,916,420	$47,288,851	$150,471	$44,477,098	50%	Row F
L	**Total**	**$91,916,420**	**$47,288,851**	**$150,471**	**$44,477,098**	**N/A**	**Sum of Row G through Row K**

Incremental Difference

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	FFP	Source
M	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contracts	($1,837,500)	($918,750)	$0	($918,750)	50%	Row G - Row A
N	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($44,112,352)	($22,056,176)	$0	($22,056,176)	50%	Row H - Row B
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	($43,086,385)	($21,433,742)	($150,471)	($21,502,172)	50%	Row I - Row C
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	($2,880,183)	($2,880,183)	$0	$0	0%	Row J - Row D
Q	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Case Management	$91,916,420	$47,288,851	$150,471	$44,477,098	50%	SUM Row A through Row D
R	**Difference**	**$0**	**$0**	**$0**	**$0**	**N/A**	**Sum of Row M through Row Q**

(1) Healthcare Affordability and Sustainability Fee Cash Fund source of Cash Fund

Table 5.2 FY 2021-22
Movement of SEP and CCB Admin and Case Management Funds

Current Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	FFP	Source
A	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contract	$1,837,500	$918,750	$0	$918,750	50%	Same as previous FY
B	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$45,890,080	$22,945,040	$0	$22,945,040	50%	Using 4.03% Growth Rate
C	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	$43,086,385	$21,433,742	$150,471	$21,502,172	50%	R-5 FY 2020-21 Appropriation Build Without SB 16-192 Re-Assessments
D	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	$2,880,183	$2,880,183	$0	$0	0%	Table 6.1 Appropriation Build Eligibility Determination and Waitlist
E	NEW LINE (4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management Funding	$0	$0	$0	$0	50%	Creating New Line
F	**Total**	**$93,694,148**	**$48,177,715**	**$150,471**	**$45,365,962**	**N/A**	**Sum of Row A through Row E**

Requested Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	FFP	Source
G	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contract	$0	$0	$0	$0	50%	Assume zero funding for Appropriation
H	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	$0	$0	$0	$0	50%	Assume zero funding for Appropriation
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	$0	$0	$0	$0	50%	Assume zero funding for Appropriation
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	$0	$0	$0	$0	0%	Assume zero funding for Appropriation
K	NEW LINE (4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management Funding	$93,694,148	$48,177,715	$150,471	$45,365,962	50%	Row F
L	**Total**	**$93,694,148**	**$48,177,715**	**$150,471**	**$45,365,962**	**N/A**	**Sum of Row G through Row K**

Incremental Difference

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	FFP	Source
M	(1) Executive Director's Office (E) Utilization and Quality Review Contracts, Professional Services Contract	($1,837,500)	($918,750)	$0	($918,750)	50%	Row G - Row A
N	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($45,890,080)	($22,945,040)	$0	($22,945,040)	50%	Row H - Row B
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management	($43,086,385)	($21,433,742)	($150,471)	($21,502,172)	50%	Row I - Row C
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Eligibility Determination and Waitlist Management	($2,880,183)	($2,880,183)	$0	$0	0%	Row J - Row D
Q	NEW LINE (4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities (2) Program Costs, Case Management Funding	$93,694,148	$48,177,715	$150,471	$45,365,962	50%	SUM Row A through Row D
R	**Difference**	**$0**	**$0**	**$0**	**$0**	**N/A**	**Sum of Row M through Row Q**

(1) Healthcare Affordability and Sustainability Fee Cash Fund source of Cash Fund

Table 6.1 FY 2020-21
Movement of HCBS Programs for People with IDD by Line Item

Current Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source/Calculation
A	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$76,836,006	$37,895,166	$728,122	$38,212,718	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
B	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$502,793,147	$250,596,573	$800,001	$251,396,573	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
C	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	$27,080,575	$13,540,287	$0	$13,540,288	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
D	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	$5,155,578	$2,577,789	$0	$2,577,789	R-5 Table G.3 FY 2020-21 Office of Community Living Appropriation Build
E	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$0	$0	$0	$0	Creating New Line
F	**Total**	**$611,865,306**	**$304,609,815**	**$1,528,123**	**$305,727,368**	**Sum of Row A through Row E**

Requested Appropriation

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source/Calculation
G	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$0	$0	$0	$0	Assume zero funding for Appropriation
H	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$0	$0	$0	$0	Assume zero funding for Appropriation
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	$0	$0	$0	$0	Assume zero funding for Appropriation
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	$0	$0	$0	$0	Assume zero funding for Appropriation
K	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$611,865,306	$304,609,815	$1,528,123	$305,727,368	Row F
L	**Total**	**$611,865,306**	**$304,609,815**	**$1,528,123**	**$305,727,368**	**Sum of Row G through Row K**

Incremental Difference

Row	Item	Total Funds	General Fund	Cash Funds [1]	Federal Funds	Source/Calculation
M	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	($76,836,006)	($37,895,166)	($728,122)	($38,212,718)	Row G - Row A
N	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	($502,793,147)	($250,596,573)	($800,001)	($251,396,573)	Row H - Row B
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	($27,080,575)	($13,540,287)	$0	($13,540,288)	Row I - Row C
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	($5,155,578)	($2,577,789)	$0	($2,577,789)	Row J - Row D
Q	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$611,865,306	$304,609,815	$1,528,123	$305,727,368	SUM Row A through Row D
R	**Difference**	**$0**	**$0**	**$0**	**$0**	**Sum of Row M through Row Q**

(1) Healthcare Affordability and Sustainability Fee Cash Fund and IDD Case Fund source of Cash Fund

Table 6.2 FY 2021-22
Movement of HCBS Programs for People with IDD by Line Item

Current Appropriation						
Row	**Element**	**Total Funds**	**General Fund**	**Cash Funds [1]**	**Federal Funds**	**Source**
A	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$76,836,006	$37,895,166	$728,122	$38,212,718	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
B	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$503,389,410	$250,894,705	$800,001	$251,694,704	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
C	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	$27,080,575	$13,540,287	$0	$13,540,288	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
D	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	$5,155,578	$2,577,789	$0	$2,577,789	R-5 Table G.3 FY 2021-22 Office of Community Living Appropriation Build
E	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$0	$0	$0	$0	Creating New Line
F	**Total**	**$612,461,569**	**$304,907,947**	**$1,528,123**	**$306,025,499**	**Sum of Row A through Row E**
Requested Appropriation						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds [1]**	**Federal Funds**	**Source**
G	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	$0	$0	$0	$0	Assume zero funding for Appropriation
H	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	$0	$0	$0	$0	Assume zero funding for Appropriation
I	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	$0	$0	$0	$0	Assume zero funding for Appropriation
J	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	$0	$0	$0	$0	Assume zero funding for Appropriation
K	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$612,461,569	$304,907,947	$1,528,123	$306,025,499	Row F
L	**Total**	**$612,461,569**	**$304,907,947**	**$1,528,123**	**$306,025,499**	**Sum of Row G through Row K**
Incremental Difference						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds [1]**	**Federal Funds**	**Source**
M	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Supported Living Services	($76,836,006)	($37,895,166)	($728,122)	($38,212,718)	Row G - Row A
N	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Adult Comprehensive Services	($503,389,410)	($250,894,705)	($800,001)	($251,694,704)	Row H - Row B
O	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Extensive Support Services	($27,080,575)	($13,540,287)	$0	($13,540,288)	Row I - Row C
P	(4) Office of Community Living (A) Division of Intellectual and Developmental Disabilities, Children's Habilitation Residential Program	($5,155,578)	($2,577,789)	$0	($2,577,789)	Row J - Row D
Q	NEW LINE (4) Office of Community Living (B) Medicaid Programs for People with Intellectual and Developmental Disabilities Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities	$612,461,569	$304,907,947	$1,528,123	$306,025,499	SUM Row A through Row D
R	**Difference**	**$0**	**$0**	**$0**	**$0**	**Sum of Row M through Row Q**

(1) Healthcare Affordability and Sustainability Fee Cash Fund and IDD Case Fund source of Cash Fund

7.1 Current Long Bill Structure
(4) Office of Community Living
(A) Division of Intellectual and Developmental Disabilities
(1) Administrative Costs
Personal Services
Operation Expenses
Community and Contract Management System
Support Level Administration
(2) Program Costs [(1)]
Adult Comprehensive Services
Adult Supported Living Services
Children's Extensive Support Services
Children's Habilitation Residential Program
Case Management
Family Support Services
Preventive Dental Hygiene
Supported Employment Provider and Certification Reimbursement
Supported Employment Pilot Program
Eligibility Determination and Waiting List Management
(1) Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs – It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for Program Costs.

7.2 Proposed Long Bill Structure
(4) Office of Community Living
(A) Administrative Costs
Personal Services
Operational Expenses
Community and Contract Management Services
Support Level Administration
(B) Medicaid Programs [(1)]
Home and Community Based Services (HCBS) for People with Intellectual and Developmental Disabilities
Case Management
(C) State-Only Programs
State Only Programs for People with Intellectual and Developmental Disabilities
Preventive Dental Hygiene
Supported Employment Provider and Certification Reimbursement
Supported Employment Pilot Program
(1) Department of Health Care Policy and Financing, Office of Community Living, Medicaid Programs – It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total.

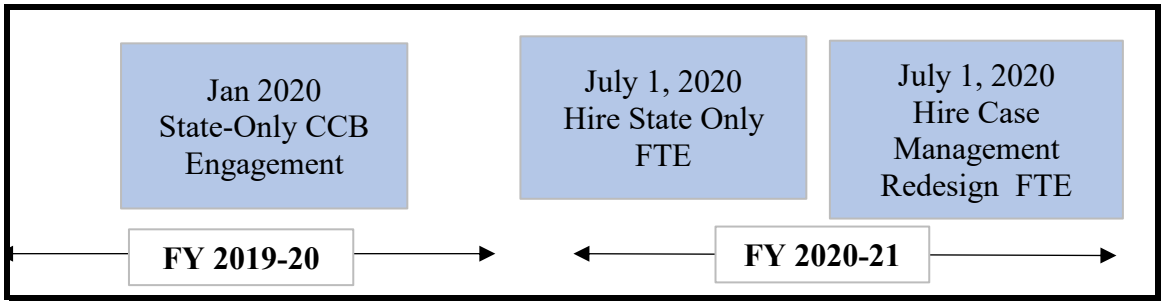

Jan 2020
State-Only CCB
Engagement
July 1, 2020
Hire State Only
FTE
July 1, 2020
Hire Case
Management
Redesign FTE
FY 2019-20
FY 2020-21

Table 9.1 Case Management Redesign FTE Calculations

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Monthly	FTE		FTE	$90,216
PROJECT MANAGER II	$7,518	1.0	$86,743	1.0	
PERA			$9,021		$9,382
AED			$4,337		$4,511
SAED			$4,337		$4,511
Medicare			$1,258		$1,308
STD			$165		$171
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, #.# FTE		**1.0**	**$113,788**	**1.0**	**$118,026**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR IV	$5,322	1.0	$61,405	1.0	$63,864
PERA			$6,386		$6,642
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$117		$121
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, #.# FTE		**1.0**	**$82,865**	**1.0**	**$85,866**
Subtotal Personal Services		1.9	**$196,653**	2.0	**$203,892**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	2.0	$1,000	2.0	$1,000
Telephone Expenses	$450	2.0	$900	2.0	$900
PC, One-Time	$1,230	2.0	$2,460	-	
Office Furniture, One-Time	$3,473	2.0	$6,946	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$11,306**		**$1,900**
TOTAL REQUEST		1.9	**$207,959**	2.0	**$205,792**
	General Fund:		*$103,980*		*$102,896*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$103,979*		*$102,896*

Table 9.2 State General Fund Programs Quality Performance FTE Calculations

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Monthly	FTE		FTE	$78,672
COMPLIANCE SPECIALIST IV	$6,556	1.0	$75,643	1.0	
PERA			$7,867		$8,182
AED			$3,782		$3,934
SAED			$3,782		$3,934
Medicare			$1,097		$1,141
STD			$144		$149
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, #.# FTE		**1.0**	**$100,242**	**1.0**	**$103,939**
Classification Title	Monthly	FTE		FTE	
ADMINISTRATOR IV	$5,322	1.0	$61,405	1.0	$63,864
PERA			$6,386		$6,642
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$117		$121
Health-Life-Dental			$7,927		$7,927
Subtotal Position 2, #.# FTE		**1.0**	**$82,865**	**1.0**	**$85,866**
Subtotal Personal Services		1.9	**$183,107**	2.0	**$189,805**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating Expenses	$500	2.0	$1,000	2.0	$1,000
Telephone Expenses	$450	2.0	$900	2.0	$900
PC, One-Time	$1,230	2.0	$2,460	-	
Office Furniture, One-Time	$3,473	2.0	$6,946	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$11,306**		**$1,900**
TOTAL REQUEST		1.9	**$194,413**	2.0	**$191,705**
	General Fund:		*$194,413*		*$191,705*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$0*		*$0*

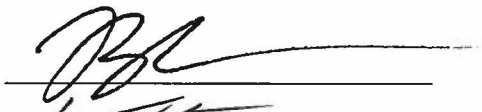
Schedule 13

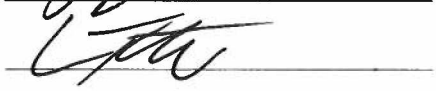
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-17 Program Capacity for Older Adults

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$72,807,933**	**$0**	**$75,987,618**	**$558,020**	**$163,494**
	FTE	500.0	0.0	504.1	0.9	1.0
	GF	$23,472,732	$0	$26,303,437	$184,146	$53,953
	CF	$6,147,628	$0	$6,363,631	$94,864	$27,795
	RF	$2,670,754	$0	$2,558,037	$0	$0
	FF	$40,516,819	$0	$40,762,513	$279,010	$81,746

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$68,988**	**$71,752**
	FTE	500.0	0.0	504.1	0.9	1.0
	GF	$13,478,948	$0	$14,470,561	$22,766	$23,678
	CF	$3,571,232	$0	$3,714,633	$11,728	$12,198
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$34,494	$35,876
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$10,042**	**$10,042**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$3,314	$3,314
	CF	$421,237	$0	$525,947	$1,707	$1,707
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$5,021	$5,021

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$104**	**$110**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$34	$36
	CF	$5,301	$0	$5,495	$18	$19
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$52	$55
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$3,070**	**$3,194**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$1,013	$1,054
	CF	$159,398	$0	$166,329	$522	$543
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$1,535	$1,597
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$3,070**	**$3,194**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	GF	$722,807	$0	$812,689	$1,013	$1,054
	CF	$159,398	$0	$166,329	$522	$543
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$1,535	$1,597
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$5,436**	**$951**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	GF	$1,014,866	$0	$939,016	$1,794	$314
	CF	$243,961	$0	$197,797	$924	$162
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$2,718	$475
	Total	**$22,864,305**	**$0**	**$22,630,967**	**$467,310**	**$74,251**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (E) Utilization and Quality Review Contracts, (1) Utilization and Quality Review Contracts - Professional Service Contracts	GF	$5,808,855	$0	$7,030,521	$154,212	$24,503
	CF	$1,587,101	$0	$1,587,101	$79,443	$12,623
	RF	$0	$0	$0	$0	$0
	FF	$15,468,349	$0	$14,013,345	$233,655	$37,125

Auxiliary Data			
Requires Legislation?	YES		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-17
Request Detail: Program Capacity for Older Adults

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$558,020**	**$163,494**
FTE	0.0	0.9	1.0
General Fund	$0	$184,146	$53,953
Cash Funds	$0	$94,864	$27,795
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$279,010	$81,746

Summary of Request:

The Department requests an increase of $558,020 in total funds, including an increase of $184,146 General Fund and 0.9 FTE in FY 2020-21; and, an increase of $163,494 total funds, including $53,953 in General Fund and 1.0 FTE in FY 2021-22 to make several changes to the Department's administration of Medicaid programs for older adults. The Department's requested funding includes the Healthcare Affordability and Sustainability Fee cash fund. This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation. This request includes two changes to the nursing facility program, including: technical changes to the current statute that pertains to nursing facility reimbursement, and resources to investigate a new reimbursement methodology for nursing facilities that places more focus on the quality of care provided and less focus on the daily costs to the nursing facility. The Department's request also includes resources to increase oversight of the Program of All-Inclusive Care for the Elderly (PACE) and its providers to ensure the provision of quality care, compliance, and the fiscal viability of PACE.

Current Program:

The Department administers the nursing facility and Program of All-Inclusive Care for the Elderly (PACE) benefits, which are primarily for older adults who need assistance with activities of daily living within the Medicaid program. In FY 2017-18, the Department spent approximately $684 million dollars on class 1 nursing facilities for approximately 10,100 full-time equivalent members and about $160 million dollars on PACE with close to 3,700 members enrolled. Nursing facility providers are paid a per diem rate for each member residing in the facility, while PACE organizations are paid a per member per month rate for each enrolled member.

The Department reimburses nursing facilities based on the requirements specified in statute which mandates that the Department establish a reimbursement schedule for administrative and general services; establish per diem rates for direct and indirect care, capital assets, and performance quality; provide an additional per diem payment for members with severe mental health conditions or dementia; and reimburse nursing facilities for speech therapy services. State statute also requires the Department to charge and collect a quality assurance fee from nursing facilities, with certain exceptions. These fees are intended to allow for increased payments to Medicaid nursing facilities based on the current reimbursement system. 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 current skilled nursing facility reimbursement methodology is cost-based, with a skilled nursing facility receiving a per diem rate that is based on audited cost reports.

PACE has seen tremendous growth since its establishment in Colorado in 1990. The program has undergone recent changes with a conversion of Colorado's largest PACE provider to for-profit and the passage of the PACE Innovation Act[1], which allows the Centers for Medicare & Medicaid (CMS) Services to expand eligibility for PACE. Currently, PACE serves approximately 4,000 individuals in Colorado and continues to grow. Recently, CMS released the PACE Final Rule[2] (CMS-4168-F), and decided to eliminate crucial review elements for PACE organizations, such as reviewing contract providers, completing physical site inspections, and conducting PACE participant interviews.

Problem or Opportunity:

The Department has identified several areas of opportunity to improve the quality of care provided to members that make up Colorado's older adult population who are receiving long-term care services, while ensuring sound stewardship of the State's financial resources. The State Demographer indicated that the aging and older adult population in Colorado (ages 65 and over) increased by 43% from 2010-2017,

[1] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACEInnovationAct.html

[2] Centers for Medicare and Medicaid Services (CMS) recent passed the final rule, CMS-4168-F, which makes the onsite review process for PACE organizations less prescriptive and frequent. For the trial period onsite review, the Final Rule calls for "observation of program operations." This replaces more prescriptive current regulation, which requires chart reviews and interviews, among other items. It removes the requirement for onsite audits every two years after the trial period, reducing the burden for both PACE organizations and CMS.

compared to 14% for the rest of the State population, and is projected to increase by nearly 70% by 2030. The effective management of Medicaid services for older adults is, and will continue to be, one of the most pressing budget challenges the State will face. The Department has identified areas in nursing facilities and PACE that need greater focus on innovation and oversight to ensure the State is able to meet the demand for services among the rising older adult population in the most cost-effective ways.

Nursing Facility Program Capacity

State statute currently defines a nursing facility reimbursement methodology that is based on nursing facility costs without considering the quality of care provided to Medicaid residents in nursing facilities. This reimbursement methodology has several cost control limits, but it still incentivizes skilled nursing facilities to increase their costs year-over-year. The consequence of this has been a 3 percent increase in the nursing facility rates every year over the last decade, the maximum allowable by statute. There is a need to create a new reimbursement methodology that takes into consideration how the needs of this population have changed over the last decade and incentivizes better quality and more cost-effective care for Medicaid recipients staying in nursing facilities.

Program of All-Inclusive Care for the Elderly Oversight

The Department has two full-time staff members dedicated to PACE but lacks the resources to appropriately administer the program as it has grown in enrollment and complexity. Limited resources prevent adequate onsite reviews and surveys, implementation of performance and quality review plans, collection of encounter data for use in the development of performance-based metrics, tracking and monitoring of corrective action plans, and extensive communication with internal and external stakeholders.

Additionally, the lack of resources prevents the Department from actively addressing the findings and recommendations found in a recent review of the program[3] ("PACE Review") submitted to the Department by the Division of Health Care Policy and Research at the University of Colorado's Anschutz Medical Campus. One of the three significant findings in the PACE Review was the need to strengthen the administration of PACE as Colorado's administrative resources fell far below programs of comparable size in other states. For example, the state of Virginia has four full-time and two part-time staff in its PACE office whose program serves 1,500 members, and North Carolina has five full-time staff for its PACE program of 2,000 members. Additional FTE would bring Colorado's staff to a comparable level consistent with other states and allow the implementation of the oversight measures listed above, as well as improve the capacity to address the two other significant findings in the PACE Review which are Care Transitions Following Disenrollment in PACE and Improving the PACE Enrollment Process.

The Department previously relied on federal auditing practices for revealing program vulnerabilities. Recently, CMS began limiting their auditing practices of PACE and are spending less time onsite, reducing

[3] Review of the Colorado Program for All-Inclusive Care for the Elderly (PACE) Program: Summary Report, submitted July 9, 2018, The Division of Health Care Policy and Research School of Medicine, University of Colorado Anschutz Medical Campus, R. Mark Gritz, PhD, Carter Sevick, MS

program elements being audited, and acting independently without state collaboration. Since PACE facilities rely heavily on providing services within their own center, the lack of adequate oversight could negatively affect the health, safety, and welfare of Medicaid members as fewer corrective measures are identified. The Department needs additional resources to fill this recent gap in CMS processes.

Proposed Solution:

The Department requests an increase of $558,020 total funds, including an increase of $184,147 General Fund and 0.9 FTE in FY 2020-21; and, an increase of $163,488 total funds, including $53,951 General Fund and 1.0 FTE in FY 2021-22 to implement several initiatives to meet the growing needs of Colorado's aging population.

The Department would use the requested funding to: hire a PACE analyst to increase operational and financial oversight of PACE; hire a contractor to develop performance-based measures of PACE providers utilizing encounter data and to perform a satisfaction survey of PACE participants; hire a contractor for the study and analysis of potential options for changing the reimbursement methodology for nursing facilities; and finally, the Department is proposing technical changes to the current nursing facility statute which requires legislation.

Nursing Facility Reimbursement Methodology

The Department requests an increase of $263,200 total funds, including an increase of $86,856 General Fund in FY 2020-21 to hire a contractor to conduct a study and an analysis for exploring possible options for changing the nursing facility rate reimbursement methodology and to perform stakeholder engagement and facilitation on those options.

The Department requests contractor funding to analyze how the Department can change how it currently reimburses nursing facilities to a methodology that relies less on provider costs and more on quality of care and patient outcomes. The Department requests funding to facilitate stakeholder meetings to review the options from the analysis with relevant stakeholders. The Department would use the results of the contractor study and stakeholder feedback to propose a new reimbursement methodology that takes into consideration the case-mix of nursing facility residents, the acuity level of residents, and anticipated resources needed for a patient. The goal is to create a payment methodology that would require nursing facilities to carefully manage how they deliver services in order to provide the most appropriate level of care for each resident. After this process, the Department may consider legislation to implement changes to the payment methodology, but the Department does not believe it would be proposed until the 2022 legislative session at the earliest.

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

The Department is requesting $294,820 in total funds, including $97,291 General Fund and 0.9 FTE in FY 2020-21 and $89,238 total funds, including $29,449 General Fund and 1.0 FTE in FY 2021-22 and ongoing to enhance the administration and oversight of PACE. This includes funding for one FTE as well as one-time

funding for a vendor contract to develop a satisfaction survey and to create performance-based measures utilizing encounter data from PACE facilities.

PACE Analyst

The Department is requesting one FTE to review, analyze and use the encounter data that it is collecting from PACE organizations, as well as to ensure appropriate oversight, administration, and programmatic improvement. The PACE Policy Advisor would be responsible for developing changes to the MMIS to ensure proper payments to PACE providers. Along with this, the position would develop and present PACE regulations to the Department's Medical Services Board; develop evidence-based, operational policies and procedures; oversee the clinical audit components of the program; and advise Departmental PACE staff and PACE providers on clinical concerns. The PACE analyst would work with the requested contractor to develop policy recommendations and develop alternative payment models.

Performance Based Measures

The requested contractor funding would be used to develop performance-based measures based on encounter data. The Department would use the encounter data to develop ways to measure the performance of PACE providers and the quality of care given to its members and to analyze the benefits and value of the PACE compared to other long-term care programs.

Satisfaction Survey

The contractor would produce and conduct an initial satisfaction survey of PACE members to establish a baseline measure of quality care and services. After the baseline year, the Department would administer the survey annually using existing resources. This supports the Department's goal for Medicaid cost control in Pillar Two of the Department's Performance Plan, which is to control costs through the use of value-based payment reform and tying more provider payments to value and quality of care provided.

Technical Changes to Nursing Facility Statute

In order to streamline administration of the Department's nursing facilities programs, the Department continues to work to identify the appropriate legislative route to make technical changes to the nursing facility statute in part 2 of article 6 of title 25.5, C.R.S., which would be budget neutral. This includes making terminology changes to be more generic as industry tools and systems change. For example, statute currently refers to the "Boeckh tool" for determining the fair rental value as part of the nursing facility reimbursement methodology. The name of the tool has changed, and statute is therefore out of alignment with current practice.

The Department is also pursuing an exemption from the rate methodology described in section 25.5-6-201 C.R.S. for facilities with less than six Medicaid beds, which would use the statewide average of beds instead. Within the state of Colorado, there are currently no facilities with less than 6 beds and there are approximately 30 nursing facilities that are not Medicaid providers. However, the nursing facilities that are not Medicaid providers occasionally have long-term care members who outlive their financial resources and are then forced to be discharged to a Medicaid facility because they can no longer pay the costs to reside in a nursing facility. The intent is to allow for these facilities to have up to five Medicaid beds so that they do not have to discharge

members that outlive their resources. Instead of paying for these individuals using the current rate setting methodology, which is administratively intensive, the Department would pay the statewide average rate in these few cases. The Department assumes that pursuing this exemption would be budget neutral since the statewide average would reflect the average costs the Department would have incurred if the individual was discharged to a Medicaid facility. This would allow the Department to pay for care for a limited number of facilities without setting separate rates, increasing nursing facility enrollment, and preventing any disruption in facility setting for residents, thus mitigating the impact of transfer trauma to those residents.

The Department is proposing to include language in the revised nursing facility statute to add requirements around pursuing options for changing the nursing facility reimbursement methodology, which would be accomplished with the resources through this request.

Anticipated Outcomes:

Nursing Facility Reimbursement Methodology

Hiring a contractor to investigate different reimbursement methodologies for nursing facilities would help the Department mitigate future costs and incentivize nursing facilities to focus on the quality of care and growing needs of nursing facility residents and not on the reported daily costs of nursing facilities. This is part of the Department's goal to transform the broader health care system through value-based payment reform and part of its long-range goal to improve health for low-income and vulnerable Coloradans. If this request is approved, the Department would be better able to address the continual increase in the daily costs of care and costs of services for nursing facility providers. This gradual increase creates a financial strain on both the Department and the skilled nursing facility provider community, without tying those payments to the quality of care received by Medicaid residents within nursing facilities.

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

Increasing oversight of the PACE providers would make those providers more accountable for the care they are providing to Medicaid members. Further, approval of this request would help to ensure proper and timely disenrollment and enrollment of PACE members, which would decrease the amount of inappropriate and inaccurate claims paid to PACE providers. Developing the performance-based measures along with administering a satisfaction survey to PACE members would help to determine how PACE providers are performing based on the quality of care given to its members and health outcomes. Further, approval of this request would put measures in place to ensure that Medicaid members have their medical needs met and that each member's well-being and quality of life are appropriately considered. The requested funding to boost oversight of the PACE would help to assure that member benefits are correctly priced based on encounter data, both of which would help to manage expenditure and improve the quality of care provided to PACE members.

Assumptions and Calculations:

Please see Appendix A for details of calculations and tables.

Nursing Facility Reimbursement Methodology

Contractor Resources

The Department estimates it would need $263,200 in FY 2020-21 and $30,000 in FY 2021-22 to hire a contractor to analyze available options for a new rate reimbursement methodology for nursing facilities. The costs are estimated assuming a rate of $200 per hour for 1,316 hours in FY 2020-21 and 150 hours in FY 2021-22. This is based on the estimated number of hours required for each deliverable. The contractor scope of work in FY 2020-21 would include evaluating multiple payment options and reimbursement methodologies for nursing facilities, fiscal impact analysis, incorporating quality metrics, and evaluating the trade-offs and the benefits of each methodology. The contractor would also research the statutory changes and State Plan amendments needed for each option. In FY 2021-22, the funding would be for ad hoc work to analyze any changes to the methodology needed to inform discussions during the 2022 legislative session.

Stakeholder Facilitation Costs

The Department estimates it would need $44,250 total funds in contractor funding in FY 2021-22 for a contractor to facilitate stakeholder engagement meetings as the Department determines the most appropriate methodology prior to the 2022 legislative session. The Department estimates it would require 150 hours of work at a rate of $295 per hour.

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

Satisfaction Survey Contractor

The Department estimates it would need $123,510 in FY 2020-21 for a contractor to conduct a satisfaction survey of all PACE enrolled members and recently disenrolled members and develop a baseline satisfaction rating for each PACE center in Colorado. The costs are estimated assuming a rate of $230 per hour for 537 hours based on the estimated number of hours required for each deliverable. This survey would be administered through telephone, email, and mail. The ratings of the satisfaction survey would provide guidance into creating a performance-based metric. The contractor would develop and run reports analyzing PACE against other long-term care programs, the utilization rates of each PACE center, and assessment data from each PACE center. The contractor would take this information and develop performance measures that can be audited on a yearly basis and analyzed against other State programs.

Performance Based Measures Contractor

The Department estimates it would need $80,600 in FY 2020-21 for a contractor to develop performance-based measures for PACE. The Department estimates that this would take 403 hours of work based on the estimated number of hours required for each deliverable at a rate of $200 per hour. The scope of work would include analyzing and reviewing data from PACE facilities, developing an assessment tool to report data, communicating and working with stakeholders, researching and developing PACE and Long-Term Care performance measures that will serve as a quantifiable indicator that will assess how well PACE organizations are doing compared to other Long-Term Services and Supports programs.

Department Staff

The Department requests one Policy Advisor IV FTE starting on July 1, 2020 to collect encounter data to run reports on the kind of care provided by PACE facilities and to help make policy recommendations based on that collected data. Other responsibilities would include staying in contact with PACE providers to resolve any eligibility system changes causing improper enrollment and disenrollment of PACE members into and out of PACE as well as helping to resolve any payment or claims issues and monitoring the amount of money owed to PACE providers.

Table 1.1 - Summary by Line Item FY 2020-21								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Comments**
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$68,988	0.9	$22,766	$11,728	$0	$34,494	From FTE Calculations
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$10,042	0.0	$3,314	$1,707	$0	$5,021	From FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Short-Term Disability	$104	0.0	$34	$18	$0	$52	From FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,070	0.0	$1,013	$522	$0	$1,535	From FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,070	0.0	$1,013	$522	$0	$1,535	From FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,436	0.0	$1,794	$924	$0	$2,718	From FTE Calculations
G	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$467,310	0.0	$154,212	$79,443	$0	$233,655	Table 3.1, Row AA
H	**Total Request**	**$558,020**	**0.9**	**$184,146**	**$94,864**	**$0**	**$279,010**	**Sum of Rows A through G**

Table 1.2 - Summary by Line Item FY 2021-22								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Comments**
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$71,752	1.0	$23,678	$12,198	$0	$35,876	From FTE Calculations
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$10,042	0.0	$3,314	$1,707	$0	$5,021	From FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Short-Term Disability	$110	0.0	$36	$19	$0	$55	From FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,194	0.0	$1,054	$543	$0	$1,597	From FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,194	0.0	$1,054	$543	$0	$1,597	From FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$951	0.0	$314	$162	$0	$475	From FTE Calculations
G	(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$74,251	0.0	$24,503	$12,623	$0	$37,125	Table 3.2 Row E
H	**Total Request**	**$163,494**	**1.0**	**$53,953**	**$27,795**	**$0**	**$81,746**	**Sum of Rows A through G**

Table 1.3 - Summary by Line Item FY 2022-23								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Comments**
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$71,752	1.0	$23,678	$12,198	$0	$35,876	From FTE Calculations
B	(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$10,042	0.0	$3,314	$1,707	$0	$5,021	From FTE Calculations
C	(1) Executive Director's Office; (A) General Administration, Short-Term Disability	$110	0.0	$36	$19	$0	$55	From FTE Calculations
D	(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$3,194	0.0	$1,054	$543	$0	$1,597	From FTE Calculations
E	(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$3,194	0.0	$1,054	$543	$0	$1,597	From FTE Calculations
F	(1) Executive Director's Office; (A) General Administration, Operating Expenses	$951	0.0	$314	$162	$0	$475	From FTE Calculations
H	**Total Request**	**$89,243**	**1.0**	**$29,450**	**$15,172**	**$0**	**$44,621**	**Sum of Rows A through F**

Table 2.1 - Summary By Initiative
FY 2020-21

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP	Comments
	Nursing Facility Reimbursement Methodology							
A	Contractor Funding for Study and Analysis	$263,200	0.0	$86,856	$44,744	$131,600	50.00%	Table 3.1 Row K
B	**Total Funding for Nursing Facility Reimbursement Methodology**	**$263,200**	**0.0**	**$86,856**	**$44,744**	**$131,600**	50.00%	**Row A**
	PACE Ovesight							
C	PACE Analyst	$90,710	0.9	$29,934	$15,421	$45,355	50.00%	From FTE Calculations
D	Contractor Funding for satisfaction survey	$123,510	0.0	$40,758	$20,997	$61,755	50.00%	Table 3.1 Row Z
E	Contractor funding perfromance based measures	$80,600	0.0	$26,598	$13,702	$40,300	50.00%	Table 3.1 Row R
F	**Total Funding for PACE Oversight**	**$294,820**	**0.9**	**$97,290**	**$50,120**	**$147,410**	50.00%	**(Row C) + (Row D) + (Row E)**
G	**Total in FY 2020-21**	**$558,020**	**0.9**	**$184,146**	**$94,864**	**$279,010**	50.00%	**(Row B) + (Row F)**

Table 2.2 - Summary By Initiative
FY 2021-22

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP	Comments
	Nursing Facility Reimbursement Methodology							
A	Ad-hoc work to analyze needed changes in current rate methodology	$30,000	0.0	$9,900	$5,100	$15,000	50.00%	Table 3.2 Row B
B	Stakeholder Facilitation Costs	$44,251	0.0	$14,603	$7,523	$22,125	50.00%	Table 3.2 Row D
C	**Total Funding for Nursing Facility Reimbursement Methodology**	**$74,251**	**0.0**	**$24,503**	**$12,623**	**$37,125**	50.00%	**(Row A) + (Row B)**
	PACE Oversight							
D	PACE Analyst	$89,238	1.0	$29,450	$15,170	$44,619	50.00%	From FTE Calculations
E	**Total Funding for PACE Oversight**	**$89,238**	**1.0**	**$29,450**	**$15,170**	**$44,619**	50.00%	**(Row D)**
F	**Total in FY 2021-22**	**$163,494**	**1.0**	**$53,953**	**$27,795**	**$81,746**	50.00%	**(Row C) + (Row E)**

Table 2.3 - Summary By Initiative
FY 2022-23

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP	Comments
	Nursing Facility Reimbursement Methodology							
A	Ad-hoc work to analyze needed changes in current rate methodology	$0	0.0	$0	$0	$0	50.00%	Table 3.3 Row B
B	Stakeholder Facilitation Costs	$0	0.0	$0	$0	$0	50.00%	Table 3.3 Row D
C	**Total Funding for Nursing Facility Reimbursement Methodology**	**$0**	**0.0**	**$0**	**$0**	**$0**	50.00%	**Row A + Row B**
	PACE Oversight							
D	PACE Analyst	$89,243	1.0	$29,450	$15,172	$44,621	50.00%	From FTE Calculations
E	**Total Funding for PACE Oversight**	**$89,243**	**1.0**	**$29,450**	**$15,172**	**$44,621**	50.00%	**(Row D)**
F	**Total in FY 2022-23**	**$89,243**	**1.0**	**$29,450**	**$15,172**	**$44,621**	50.00%	**(Row C) + (Row E)**

Table 3.1 - Program Capacity for Older Adults Contract Costs
FY 2020-21

Contractor Costs for NF Reimbursement Rate Methodology

Row	Task	Hours	Hourly Rate	Cost Per Task
A	Environmental Scan of NF reimbursement methodologies	120	$200	$24,000
B	Recommendation Report of Options for SNF reimbursement	220	$200	$44,000
C	Final Report	120	$200	$24,000
D	Stakeholder Multiple Regions of State	239	$200	$47,800
E	Department Engagement	84	$200	$16,800
F	Development of Rules	80	$200	$16,000
G	Development of Statuatory Changes	80	$200	$16,000
H	State Plan Amendment	33	$200	$6,600
I	Stakeholder Engagement for Implementation	180	$200	$36,000
J	Supplemental Payment and Provider Fee Interaction	160	$200	$32,000
K	**Total Expenditure for NF Rate Methodology Contractor**	**1,316**		**$263,200**

Contractor Costs for PACE Performance Based Measures

Row	Task	Hours	Hourly Rate	Cost Per task
L	Operations Guide	60	$200	$12,000
M	Meeting Deliverables	28	$200	$5,600
N	Project Timeline Development	6	$200	$1,200
O	Uniform Assessment Tool for Data Reporting	42	$200	$8,400
P	Data Collection	101	$200	$20,200
Q	Performance Measures	166	$200	$33,200
R	**Total Expenditure for PACE Performance Based Measures Contract**	**403**		**$80,600**

Contractor Costs for PACE Satisfaction Survey

Row	Task	Hours	Hourly Rate	Cost Per Deliverable
S	Run test survey and information gathering	50	$230	$11,500
T	Final Survey Printing and Survey Distribution Plan	200	$230	$46,000
U	Response rate monitoring and data entry	100	$230	$23,000
V	Implementation of secondary surveys to increase response rate	75	$230	$17,250
W	Data entry for mail surveys and data cleaning	30	$230	$6,900
X	Survey data analysis and preliminary reporting	50	$230	$11,500
Y	Final Survey Report	32	$230	$7,360
Z	**Total Expenditure for PACE Satisfaction Survey**	**537**		**$123,510**
AA	**Total Contract Expenditure for FY 2020-21**			**$467,310**

Table 3.2 - Program Capacity for Older Adults Contract Costs FY 2021-22				
Contractor Costs for NF Reimbursement Rate Methodology				
Row	**Task**	**Hours**	**Hourly Rate**	**Cost Per Deliverable**
A	Ad-hoc work to analyze needed changes in current rate methodology	150	$200	$30,000
B	**Total Expenditure for Ad-hoc work**			**$30,000**
Contract for Stakeholder Facilitation				
Row	**Task**	**Hours**	**Hourly Rate**	**Cost Per Deliverable**
C	Determining Final Methodology	150	$295	$44,250
D	**Total Expenditure for Stakeholder Facilitation**	**150**		**$44,250**
E	**Total Contract Expenditure for FY 2021-22**			**$74,250**

Table 3.3 - Program Capacity for Older Adults Contract Costs FY 2022-23				
Contractor Costs for NF Reimbursement Rate Methodology				
Row	**Task**	**Hours**	**Hourly Rate**	**Cost Per Deliverable**
A	Ad-hoc work to analyze needed changes in current rate methodology	0	$0	$0
B	**Total Expenditure for Ad-hoc work**			**$0**
Contract for Stakeholder Facilitation				
Row	**Task**	**Hours**	**Hourly Rate**	**Cost Per Deliverable**
C	Collecting Stakeholder input	0	$0	$0
D	**Total Expenditure for Stakeholder Facilitation**	**0**		**$0**
E	**Total Contract Expenditure for FY 2022-23**			**$0**

PACE Policy Analyst FTE Calculations

FTE Calculation Assumptions:

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 -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
Policy Advisor IV	$2,456	0.962	$61,405	1.0	$63,864
PERA			$6,693		$6,961
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$104		$109
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, #.# FTE		**1.0**	**$85,274**	**1.0**	**$88,288**
Subtotal Personal Services		1.0	**$85,274**	1.0	**$88,288**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	1.0	$481	1.0	$500
Telephone Expenses	$450	1.0	$433	1.0	$450
PC, One-Time	$1,230	1.0	$1,183	-	
Office Furniture, One-Time	$3,473	1.0	$3,339	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$5,436**		**$950**
TOTAL REQUEST		1.0	**$90,710**	1.0	**$89,238**
	General Fund		*$29,934*		*$29,449*
	Cash Fund		*$15,421*		*$15,170*
	Reappropriated Funds		*$0*		*$0*
	Federal Funds		*$45,355*		*$44,619*

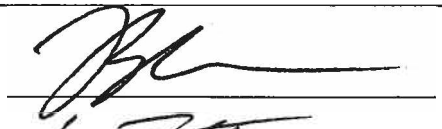
Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-18 Public School Health Services Program Expansion

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,018,048,258**	**$0**	**$8,049,593,760**	**$75,000**	**$26,987,386**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,286,561,174	$0	$2,295,241,911	$0	$0
	CF	$1,043,983,663	$0	$1,050,848,865	$0	$13,431,193
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,598,627,131	$0	$4,614,626,694	$75,000	$13,556,193

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($75,000)**	**($125,000)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($75,000)	($125,000)
	CF	$983,543,298	$0	$984,608,781	$0	$0
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	$0	$0
06. Other Medical Services, (A) Other Medical Services, (1) Other Medical Services - Public School Health Services Contract Administration	**Total**	**$1,750,000**	**$0**	**$1,750,000**	**$150,000**	**$250,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$875,000	$0	$875,000	$75,000	$125,000
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$875,000	$0	$875,000	$75,000	$125,000

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$120,880,730**	**$0**	**$132,480,170**	**$0**	**$26,862,386**
	FTE	0.0	0.0	0.0	0.0	0.0
06. Other Medical Services, (A) Other Medical Services, (1) Other Medical Services - Public School Health Services	GF	$0	$0	$0	$0	$0
	CF	$60,440,365	$0	$66,240,084	$0	$13,431,193
	RF	$0	$0	$0	$0	$0
	FF	$60,440,365	$0	$66,240,086	$0	$13,431,193

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-18
Request Detail: Public School Health Services Program Expansion

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$75,000**	**$26,987,386**
FTE	0.0	0.0	0.0
General Fund	$0	$0	$0
Cash Funds	$0	$0	$13,431,193
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$75,000	$13,556,193

Summary of Request:

The Department requests $75,000 total funds, consisting of $75,000 federal funds in FY 2020-21; and $26,987,386 total funds, including $13,431,193 cash funds and $13,556,193 federal funds in FY 2021-22 and ongoing, to allow public school districts participating in the Public School Health Services Program to receive reimbursement for Medicaid allowable services outside of those listed in an Individualized Education Program (IEP) and Individualized Family Service Plans (IFSP). The decision to expand the program is based on guidance from the Centers for Medicare and Medicaid Services (CMS) to State Medicaid Directors regarding Medicaid Payment for Services Provided without Charge (Free Care)[1]. The cash funds are funds certified as public expenditures (CPE). This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

Current Program:

The Public School Health Services (SHS) Program, established in Colorado in 1997 via SB 97-101 "Medicaid Reimbursement For Schools"[2], allows Colorado's public school districts and state-operated educational institutions access to federal Medicaid funds for the partial reimbursement of their costs of providing medically-necessary health services to Medicaid eligible students as prescribed in the student's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP)[3]. Covered services may include direct medical services including rehabilitative therapies, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, Targeted Case Management, and Specialized Non-Emergency Transportation services for students from kindergarten through 12th grade.

The non-federal share of this reimbursement comes from certified public expenditures (CPE) which is a statutorily recognized Medicaid financing approach by which a governmental entity, such as a public school district, incurs an expenditure eligible for federal financial participation (FFP) under the State's approved Medicaid State Plan. The governmental entity then certifies that the funds expended are public funds and used to support the full cost of providing the Medicaid-covered service or the administrative activity. Based on this certification, the state can claim the federal share of these costs and no other state funds are required.

CPE-based financing must recognize actual costs incurred. CMS requires providers to use a federally approved cost reporting methodology to document the actual cost of providing the services, typically determined through a statistically valid time study, periodic cost reporting, and reconciliation of any interim payments to actual incurred cost. For qualifying school-based administrative activities, the amount of time that school staff members spend on Medicaid-related activities is also determined based on time studies.

The SHS Program facilitates provider reimbursements through its federally-approved, cost-based methodology whereby the Department and its contractor calculate the amount of CPE to assure compliance with federal requirements. The methodology used to determine the amount of allowable CPE is described below:

- For each participating provider, the vendor first compiles cost pool information, including salary, benefits and contracted costs for all random moment time study (RMTS)[4] participants, and indirect costs.

[2] https://leg.colorado.gov/sites/default/files/images/olls/1997a_sl_222.pdf

[3] The IEP is a written plan developed by the school's IEP team that describes a plan for the child's education. Every IEP is tailored to a child's specific circumstances and needs. Required components of an IEP include: an assessment of a child's academic and functional performance level; annual educational goals; the educational and related services that a school will provide to help a child reach his or her goals; any program modifications or accommodations for school personnel to help support the child participate or make progress in their education; and a plan to measure a child's progress toward annual goals. The IFSP is similar to an IEP but focused on the needs of infants and toddlers.

[4] The Random Moment Time Study (RMTS) is a federally-approved statistical sampling technique used to determine Medicaid reimbursement at school districts and BOCES. Participants are randomly selected to complete the survey regarding a 1-minute

- The costs are adjusted by applying the statewide RMTS percentages against the direct service (DS) and targeted case management (TCM) cost pools, respectively.
- The costs are then adjusted to reflect the program's qualifying clients by applying the IEP student utilization ratio[5].
- Costs of supplies, materials, transportation and other costs are added.

Program reimbursements are made to providers via monthly interim payments and, upon final reconciliation of annual cost report data, a cost settlement payment. A separate but similar calculation is used for determining the amount of administrative services, known as the Medicaid administrative claiming (MAC). The MAC payments are quarterly reimbursements attributed to qualifying school-based administrative activities that are considered necessary for the proper and efficient administration of the Medicaid state plan. School-based administrative activities generally fall into two categories: outreach and enrollment, and efforts that support the provision of Medicaid-eligible services, including outreach to potentially eligible children and families and for making enrollment determinations.

Problem or Opportunity:

The Department can expand the reimbursement of covered services in the SHS program to Medicaid eligible students, regardless of when there is any charge to the student or community, and beyond services included in an IEP and IFSP.

Historically, CMS held the position that services available without charge to Medicaid beneficiaries, including services available without charge to others in the community, could not be covered by Medicaid. For example, schools that provided free health screenings to all students could not seek payment for the screenings for children with Medicaid coverage. This was sometimes known as the free care policy[6]. In 2005, however, the U.S. Department of Health and Human Services' Department Appeals Board (DAB) concluded that this policy was not an interpretation of either the Medicaid statute or existing regulations. Finally, in December 2014, CMS provided new guidance in a letter to State Medicaid Directors (SMD #14-006)[7], withdrawing its previous guidance on free care and revising the policy to permit Medicaid payment for covered services to Medicaid beneficiaries under the approved state plan, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, federal financial participation (FFP) is now available for Medicaid payments for care provided through providers that do not charge individuals for the service, if all other Medicaid requirements are met.

---

moment in time. The time study, conducted on a quarterly basis, gathers information on how staff members spend their time on certain health-related activities.

[5] The IEP Student Utilization Ratio is a program participant-specific ratio where the numerator is the total Medicaid IEP students on December 1st, as identified through the eligibility verification match from MMIS, and the denominator is the total number of IEP students on December 1st.

[6] The free care policy included an exception for services provided to children as part of their IEP or IFSP

[7] See footnote 1

This policy revision will allow public school districts participating in the SHS Program to receive reimbursement for Medicaid allowable services outside of those listed in an IEP and IFSP. These services include the costs associated with providing Medicaid allowable services to any student on a formal, school-developed plan such as an Individualized Health Plan (IHP)[8] or a 504 Plan.[9]

Proposed Solution:

The Department is requesting $75,000 total funds, consisting of $75,000 federal funds in FY 2020-21; and $26,987,386 total funds, including $13,431,193 cash funds and $13,556,193 federal funds in FY 2021-22 and ongoing to support expansion of the Public School Health Services (SHS) Program. The cash funds are funds certified as public expenditures (CPE).

The Department, along with its contracted vendor, has been conducting a multi-phased analysis to evaluate the feasibility of expanding SHS Program services to include these additional "free care" services. Phase one of the analysis utilized existing data to project the potential financial impact of program expansion. Phase two used existing data and interviews with various district staff to assess existing systems and processes in place, and to identify any additional new costs that may be reimbursable. Lastly, phase three ran a pilot program with a sample of districts that gathered real time data around possible expansion of services as well as looking at potential new provider type groups.

Phase three was the final phase of the analysis. On June 4, 2019, the Department hosted a meeting to share the results of the "free care" analysis and the pilot program. Additional agenda items included the potential financial impact of program expansion, the accompanying risks involved, and the options regarding next steps. The meeting also presented a forum for discussion among all stakeholders in the SHS Program as well as the community at large.

Following the June 4th meeting the Department received overwhelming support from program stakeholders and community organizations to expand the SHS program to include the "free care" services and negotiate with CMS the inclusion of additional program provider types. To do so the Department will need to update the SHS state plan amendment and seek CMS approval. The timeline for CMS approval is uncertain, however, the Department and its contractor are following the efforts of other states to similarly update their state plans and are encouraged by the progress including Massachusetts as the first state to receive approval.

[8] The IHP is a written document that outlines the provision of student healthcare services intended to achieve specific student outcomes. The management of school healthcare services for students with significant or chronic health problems is a vital role for school nurses.

[9] The 504 Plan is a plan developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.

Anticipated Outcomes:

Increasing the services and providers would allow school districts to receive more reimbursement and expand health services to all students according to the school district's Local Services Plan (LSP). Historically, this funding has been used for increased nurse-provided services and mental health services.

The Medicaid funds received though the SHS Program are entirely federal funds. The federal funds are made available to deliver new and expanded primary and preventative health service to Colorado's public school children identified and specified under the providers' LSP. The LSP written by the school district, with community input, describes the types and cost of services to be provided with the funds. This allows providers to address some of the health care needs unique to their local communities. The most common areas to use the funds according to a provider's LSP are to fund additional nursing services and for mental health needs for all students. Types of services that can be funded include, but are not limited to, the following:

- Enhanced clinic aid or nurse services;
- Dental, vision and pharmacy vouchers to uninsured or under-insured students;
- Outreach and enrollment assistance toward access of medical assistance benefits for uninsured families;
- Health supplies and equipment; and
- Enhanced physical or mental health services.

By allowing the Department to reimburse SHS providers on a timely basis for their incurred Medicaid costs, the approval of this request would ensure the retention of current participating providers and help attract new providers to the program, thus furthering the Department's mission of improving health care access and outcomes. In addition, the expansion of these services aligns with the Governor's goals around mental health and education services.

Assumptions and Calculations:

Detailed calculations for this request are provided in the attached appendix.

Table 1.1 shows a summary by line item for this request. The fiscal impact for FY 2020-21 is expected to be only for administrative costs due to the timing of the implementation and standard program reimbursement mechanics. For FY 2020-21 the Department is only requesting an increase in spending authority to support the expected costs of start-up services provided by the Department's contracted vendor. These services include system updates for data collection and compilation along with increases in provider communication and training costs as well as periodic meetings with Department staff and stakeholders. Based on conversations with the current contracted vendor, the Department estimates the maximum amount required to be $150,000, equal to 500 hours at the vendor rate of $300 per hour. As a result of the General Assembly's approval of the Department's FY 2018-19 S-7, FY 2019-20 BA-7 Public School Health Services Funding

Adjustments[10] request, the SHS Program's administrative expenses are financed with General Fund appropriations and a corresponding General Fund offset in the Medical Services Premiums line. This financing structure allows the Department to maximize federal funds while reducing the financial burden on participating school districts. The funding for the General Fund offset is sourced from the withhold[11] that the Department retains from the federal reimbursements.

Table 1.2 shows the fiscal impact expected in FY 2021-22. The Department expects the contractor funding to increase to $250,000 due to the projected number of hours for administering the updated policy. The ongoing tasks include creating and maintaining training materials, conducting annual training sessions and providing customer service support for the Department and the 54 participating districts. Additional contractor tasks would be managing the data collection changes within the online cost-reporting portal and the expanded scope of the annual cost-settlement payment process, as well as performing comprehensive reviews and analysis of district data. Table 1.2 also shows the projected increase in allowable reimbursements driven by the policy change. The figure was arrived at by the Department's contracted vendor following completion of a pilot program involving eight districts whose providers volunteered to contribute time and effort by completing sample survey requests that simulated the random moment time study component of a "free care" service implementation. Taken together with the expected inclusion of additional provider types such as psychologists and other mental health providers, and applying the expected federally-approved reimbursement methodology, the result is an additional $26,862,386 in reimbursement to districts in FY 2021-22.

Tables 2.1 and 2.2 show the fiscal impact by initiative and includes the relationship of the General Fund appropriation and offset.

---

[10] https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY20%20JAN%2C%20S-07%20BA-07%2C%20PUBLIC%20SCHOOL%20HEALTH%20SERVICES.pdf

[11] The Department withholds 2.5% from all federal reimbursement payments within the SHS Program. This amount is applied as a General Fund offset and effectively is the state share of the Department's costs of administering the program.

Table 1.1 - Summary By Line Item
FY 2020-21

Row	Description	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($75,000)	0.0	($75,000)	$0	$0	$0	Table 2.1, Row B
B	(6) Other Medical Services; Public School Health Services Contract Administration	$150,000	0.0	$75,000	$0	$0	$75,000	Table 2.1, Row A
C	**Total Request**	**$75,000**	**0.0**	**$0**	**$0**	**$0**	**$75,000**	**Sum of Rows A through B**

Table 1.2 - Summary By Line Item
FY 2021-22 and Ongoing

Row	FY 2020-21	Total Funds	FTE	General Fund	Cash Funds[(1)]	Reappropriated Funds	Federal Funds	Source
A	(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($125,000)	0.0	($125,000)	$0	$0	$0	Table 2.2, Row B
B	(6) Other Medical Services; Public School Health Services Contract Administration	$250,000	0.0	$125,000	$0	$0	$125,000	Table 2.2, Row A
C	(6) Other Medical Services; Public School Health Services	$26,862,386	0.0	$0	$13,431,193	$0	$13,431,193	Table 2.2, Row E
D	**Total Request**	**$26,987,386**	**0.0**	**$0**	**$13,431,193**	**$0.0**	**$13,556,193**	**Sum of Rows A through C**

[(1)]Cash funds represent funds certified as public expenditures incurred by school districts or boards of cooperative educational services that are eligible for federal financial participation under Medicaid

Table 2.1 - Summary by Initiative
FY 2020-21

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Federal Funds	FFP	Source
Public School Health Services - Department Administration								
A	Increased Funding for Department's SHS Program Contractor	$150,000	0.0	$75,000	$0	$75,000	50%	The expected costs of start-up services provided by the Department's contracted vendor. See narrative for further detail.
B	General Fund Offset	($75,000)	0.0	($75,000)	$0	$0	NA	Row A [General Fund] * -1
C	**Incremental Request**	**$75,000**	**0.0**	**$0**	**$0**	**$75,000**	**NA**	**Row A + Row B**

Table 2.2 - Summary by Initiative
FY 2021-22 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds[(1)]	Federal Funds	FFP	Source
Public School Health Services - Department Administration								
A	Increased Funding for Department's SHS Program Contractor	$250,000	0.0	$125,000	$0	$125,000	50%	The expected costs of additional, ongoing services provided by the Department's contracted vendor. See narrative for further detail.
B	General Fund Offset	($125,000)	0.0	($125,000)	$0	$0	NA	Row A [General Fund] * -1
C	**Incremental Request**	**$125,000**	**0.0**	**$0**	**$0**	**$125,000**	**NA**	**Row A + Row B**
Public School Health Services - Provider Reimbursement								
D	Increase from "Free Care" Policy Update	$26,862,386	0.0	$0	$13,431,193	$13,431,193	50%	The expected increase in provider reimbursements provided by the Department's contracted vendor. See narrative for further detail.
E	**Incremental Request**	**$26,862,386**	**0.0**	**$0**	**$13,431,193**	**$13,431,193**	**NA**	**Row D**
F	**Total Incremental Request**	**$26,987,386**	**0.0**	**$0**	**$13,431,193**	**$13,556,193**	**NA**	**Row C + Row E**

[(1)]Cash funds represent funds certified as public expenditures incurred by school districts or boards of cooperative educational services that are eligible for federal financial participation under Medicaid

Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-19 Leased Space

Dept. Approval By: _____

OSPB Approval By: _____

____	**Supplemental FY 2019-20**
____	**Budget Amendment FY 2020-21**
X	**Change Request FY 2020-21**

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$2,514,035**	**$0**	**$2,514,035**	**$111,119**	**$203,385**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,042,319	$0	$1,042,319	$46,070	$84,324
	CF	$214,699	$0	$214,699	$9,490	$17,369
	RF	$0	$0	$0	$0	$0
	FF	$1,257,017	$0	$1,257,017	$55,559	$101,692

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$2,514,035**	**$0**	**$2,514,035**	**$111,119**	**$203,385**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Leased Space	GF	$1,042,319	$0	$1,042,319	$46,070	$84,324
	CF	$214,699	$0	$214,699	$9,490	$17,369
	RF	$0	$0	$0	$0	$0
	FF	$1,257,017	$0	$1,257,017	$55,559	$101,692

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-19
Request Detail: Leased Space

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$72,035**	**$111,119**	**$203,385**
FTE	0.0	0.0	0.0
General Fund	$29,865	$46,070	$84,324
Cash Funds	$6,152	$9,490	$17,369
Reappropriated Funds	$0	$0	$0
Federal Funds	$36,018	$55,559	$101,692

Summary of Request:

The Department requests $111,119 total funds, including $46,070 General Fund in FY 2020-21; $203,385 total funds, including $84,324 General Fund in FY 2021-22 for technical adjustments to the Leased Space to align with contractual agreements. Additionally, the Department anticipates a need for supplemental funding in FY 2019-20 of $72,035 total funds, including $29,865 General Fund in FY 2019-20. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund, Children's Basic Health Plan Trust, Adult Dental Fund, Medicaid Nursing Facility Cash Fund, Nursing Home Penalty Cash Fund, Primary Care Fund, Intellectual and Developmental Disabilities Services Cash Fund, Service Fee Fund, Colorado Autism Treatment Fund and Breast and Cervical Cancer Prevention and Treatment Fund. This request represents an increase less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

The Department occupies two locations in Denver at 1570 Grant Street and 303 E. 17th Avenue. The State owns the building at 1570 Grant Street and leases commercial space at 303 E. 17th Avenue, including suites 335, 700, 1000, 1060, 1080, 1100 and 1200. The leases have a negotiated rate through the term end date of June 30, 2022. The contract currently has seven amendments for the different suites and various annual rates. The lease terms are also subject to additional payments for operating expenses, above the expense stop amount, which is a lease provision that establishes the maximum expenses to be paid by the landlord. The remaining operating expenses over the limit must be paid by the tenant. Additional rent is calculated as the Department's proportionate share of actual building operating expenses. Proportionate share is defined in the lease as the number of square feet in the Department's leased units divided by the total rentable square footage available for lease in the building. The operating proportionate share of the rentable square feet (RSF) is 36.32% (103,726 RSF is the Department's share over the 285,571 RSF in the Building).

Problem or Opportunity:

The current Leased Space line item appropriation is insufficient to cover the projected leased space expenditures as rental rates and operating expenses for which the Department is liable for have increased. The current appropriation is not sufficient to adequately support leased space expenses necessary to continue to administer the Department's programs.

Proposed Solution:

The Department requests $111,119 total funds, including $46,070 General Fund, $9,490 cash funds and $55,559 federal funds in FY 2020-21; $203,385 total funds, including $84,324 General Fund, $17,369 cash funds and $101,692 federal funds in FY 2021-22 for technical adjustments to the Leased Space line item. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund, Children's Basic Health Plan Trust, Adult Dental Fund, Medicaid Nursing Facility Cash Fund, Nursing Home Penalty Cash Fund, Primary Care Fund, Intellectual and Developmental Disabilities Services Cash Fund, Service Fee Fund, Colorado Autism Treatment Fund and Breast and Cervical Cancer Prevention and Treatment Fund.

Additionally, the Department anticipates a need for supplemental funding in FY 2019-20 of $72,035 total funds, including $29,865 General Fund, $6,152 cash funds and $36,018 federal funds in FY 2019-20. The Department has increased leased space expenditures as rental rates and operating expenses have increased since FY 2013-14. The increase in expenses is no longer absorbable within the existing appropriation.

The funding would ensure the Department has appropriate funding for leased space to ensure that staff have reasonable work space necessary to provide services to customers as required by the Office of State Architect. This request would serve to true-up the Leased Space line item appropriation due to the increase in leased space needs and operating costs since FY 2014-15 when the last lease space true-up occurred.

Anticipated Outcomes:

This request would enable Department to meet contractual obligations and retain sufficient space for staff to continue serving the health care needs of Colorado citizens enrolled in Medicaid, Children's Basic Health Plan Plus (CHP+), and many other health-based programs for eligible Coloradans. In addition, the Department would comply with the Office of the State Architect on employee workspace requirements.

Assumptions and Calculations:

Detailed calculations for this request are provided in Appendix A attached.

To estimate the funding need for this request, negotiated rental rates from signed leases were used, in addition to projected additional rents for operating expenses. The annual base rent of units funded through the leased space appropriation were summed and then multiplied by the annual adjusted price per square foot (less property tax credit) and the net increase in operating expenses. For FY 2020-21, rental rates were forecasted using the average increase of $0.50 per rented square foot as experienced in the most recent rent renewals contract executed on February 14, 2019. Operating expense increases were forecasted using an annual 2.73% increase based on the Consumer Price Index (CPI) for the Denver-Aurora-Lakewood area for local governments.

Table 1.1: Summary by Line Item FY 2019-20								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office, (A) General Administration, Leased Space	$72,035	0.0	$29,865	$6,152	$0	$36,018	Table 2.1 Row E
B	**Total Request**	**$72,035**	**0.0**	**$29,865**	**$6,152**	**$0**	**$36,018**	**Row A**

Table 1.2: Summary by Line Item FY 2020-21								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office, (A) General Administration, Leased Space	$111,119	0.0	$46,070	$9,490	$0	$55,559	Table 2.2 Row E
B	**Total Request**	**$111,119**	**0.0**	**$46,070**	**$9,490**	**$0**	**$55,559**	**Row A**

Table 1.3: Summary by Line Item FY 2021-22								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office, (A) General Administration, Leased Space	$203,385	0.0	$84,324	$17,369	$0	$101,692	Table 2.3 Row E
B	**Total Request**	**$203,385**	**0.0**	**$84,324**	**$17,369**	**$0**	**$101,692**	**Row A**

Table 1.4: Summary by Line Item FY 2022-23 and Ongoing								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
A	(1) Executive Director's Office, (A) General Administration, Leased Space	$313,381	0.0	$129,927	$26,763	$0	$156,691	Table 2.4 Row E
B	**Total Request**	**$313,381**	**0.0**	**$129,927**	**$26,763**	**$0**	**$156,691**	**Row A**

Table 2.1: Summary by Initiative - FY 2019-20									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	FY 2019-20 Long Bill Appropriation	$2,510,515	0.0	$1,042,319	$212,939	$0	$1,255,257	50%	Long Bill SB 19-207
B	Special Bills HB 19-1302	$3,520	0.0	$0	$1,760	$0	$1,760	50%	HB 19-1302 Cancer Treatment & License Plate Surcharge
C	FY 2019-20 Total Spending Authority	$2,514,035	0.0	$1,042,319	$214,699	$0	$1,257,017	50%	Row A + Row B
D	Current Leased Space True-up	$2,586,070	0.0	$1,072,184	$220,851	$0	$1,293,035	50%	Table 3.1 Row F (FY 2019-20)
E	**Total**	**$72,035**	**0.0**	**$29,865**	**$6,152**	**$0**	**$36,018**		**Row D - Row C**

Table 2.2: Summary by Initiative - FY 2020-21									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	FY 2019-20 Long Bill Appropriation	$2,510,515	0.0	$1,042,319	$212,939	$0	$1,255,257	50%	Long Bill SB 19-207
B	Special Bills HB 19-1302	$3,520	0.0	$0	$1,760	$0	$1,760	50%	HB 19-1302 Cancer Treatment & License Plate Surcharge
C	FY 2019-20 Total Spending Authority	$2,514,035	0.0	$1,042,319	$214,699	$0	$1,257,017	50%	Long Bill SB 19-207 Plus Special Bills HB 19-1302
D	Current Leased Space Needs	$2,625,154	0.0	$1,088,389	$224,189	$0	$1,312,576	50%	Table 3.1 Row F (FY 2020-21)
E	**Total**	**$111,119**	**0.0**	**$46,070**	**$9,490**	**$0**	**$55,559**		**Row D - Row C**

Table 2.3: Summary by Initiative - FY 2021-22									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	FY 2019-20 Long Bill Appropriation	$2,510,515	0.0	$1,042,319	$212,939	$0	$1,255,257	50%	Long Bill SB 19-207
B	Special Bills HB 19-1302	$3,520	0.0	$0	$1,760	$0	$1,760	50%	HB 19-1302 Cancer Treatment & License Plate Surcharge
C	FY 2019-20 Total Spending Authority	$2,514,035	0.0	$1,042,319	$214,699	$0	$1,257,017	50%	Long Bill SB 19-207 Plus Special Bills HB 19-1302
D	Current Leased Space Needs	$2,717,420	0.0	$1,126,643	$232,068	$0	$1,358,709	50%	Table 3.1 Row F (FY 2021-22)
E	**Total**	**$203,385**	**0.0**	**$84,324**	**$17,369**	**$0**	**$101,692**		**Row D - Row C**

Table 2.4: Summary by Initiative - FY 2022-23 and Ongoing									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	FY 2019-20 Long Bill Appropriation	$2,510,515	0.0	$1,042,319	$212,939	$0	$1,255,257	50%	Long Bill SB 19-207
B	Special Bills HB 19-1302	$3,520	0.0	$0	$1,760	$0	$1,760	50%	HB 19-1302 Cancer Treatment & License Plate Surcharge
C	FY 2019-20 Total Spending Authority	$2,514,035	0.0	$1,042,319	$214,699	$0	$1,257,017	50%	Long Bill SB 19-207 Plus Special Bills HB 19-1302
D	Current Leased Space Needs	$2,827,416	0.0	$1,172,246	$241,462	$0	$1,413,708	50%	Table 3.1 Row F (FY 2022-23)
E	**Total**	**$313,381**	**0.0**	**$129,927**	**$26,763**	**$0**	**$156,691**		**Row D - Row C**

Table 3.1: Leased Space True-up Funding Request						
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Source**
A	Spending Authority	$2,514,035	$2,514,035	$2,514,035	$2,514,035	Tables 2.1 thru 2.4 Row C
B	Rentable Square Foot - 303 E. 17th Avenue, Denver, CO 80203	$103,726	$103,726	$103,726	$103,726	Table 3.2 Row A
C	Average Adjusted Annual Rent / Rentable Square Foot (RSF)	$24.80	$24.78	$25.65	$26.15	Lease Agreement Amendment 7
D	**Current Leased Space Costs**	**$2,572,849**	**$2,570,071**	**$2,660,831**	**$2,712,694**	**Row B * Row C**
E	Leased Space Operating Expenses	$13,221	$55,083	$56,589	$114,722	Table 3.2 Row O
F	**Total Costs**	**$2,586,070**	**$2,625,154**	**$2,717,420**	**$2,827,416**	**Row D + Row E**
G	**Total Request**	**$72,035**	**$111,119**	**$203,385**	**$313,381**	**Row F - Row A**

Table 3.2: Leased Space Operating Expenses						
Row	**Item**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**Source**
A	Rentable Square Foot - 303 E. 17th Avenue, Denver, CO 80203	103,726	103,726	103,726	103,726	Lease Agreement Amendment 7
B	Total Square Footage - 303 E. 17th Avenue, Denver, CO 80203	285,571	285,571	285,571	285,571	Lease Amendment 1 Operating Expense
C	Department's Proportional Share of total RSF in the Building	36.32%	36.32%	36.32%	36.32%	Row A / Row B
D	Annual Inflationary Factor for Operating Expenses	2.73%	2.73%	2.73%	2.73%	US Dept. of Labor CPI Index Denver March 2019
E	Projected Operating Expenses					
F	Utilities	$467,721	$480,495	$493,618	$507,099	Lease Amendment 1 =Prior Year + (Prior Year x Annual Inflation Factor)
G	Janitorial	$369,699	$379,796	$390,169	$400,825	
H	Building Repair & Maintenance / Contracts / Heating, Ventilation, Air-Conditioning (HVAC)	$536,681	$551,338	$566,396	$581,865	
I	Building & Grounds Maintenance	$40,360	$41,463	$42,596	$43,760	
J	Security / Fire Life Safety	$200,501	$205,977	$211,603	$217,382	
K	Management Fee / Administration	$401,897	$412,873	$424,149	$435,733	
L	**Total Operating Expenses**	**$2,016,859**	**$2,071,942**	**$2,128,531**	**$2,186,664**	**Sum of Row F through Row K**
M	Expense Stop Per Square Foot[1]	$1,798,026	$1,798,026	$1,798,026	$1,798,026	Lease Amendment 1 Operating Expense
N	**Annual Operating Expense added to Lease Cost**	**$218,833**	**$273,916**	**$330,505**	**$388,638**	**Row M - Row L**
O	**Incremental Change in Operating Expenses**	**$13,221**	**$55,083**	**$56,589**	**$114,722**	**Row N Current Year - Row N Prior Year**

[1] Expense Stop - A lease provision that establishes the maximum expenses to be paid by the landlord. The remaining expenses over the limit have to be paid by the tenant.

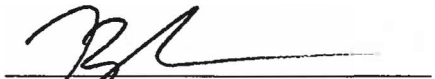
Schedule 13

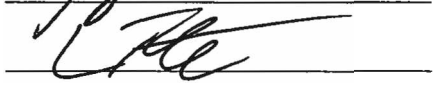
Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-20 Safety Net Provider Payments Adjustment

Dept. Approval By: 

OSPB Approval By: 

	Supplemental FY 2019-20
	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$8,206,713,714**	**$0**	**$8,226,659,776**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	$2,285,686,174	$0	$2,294,366,911	$0	$0
	CF	$1,139,191,391	$0	$1,140,256,874	$0	$0
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,692,959,859	$0	$4,703,159,701	$0	$0

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$7,895,417,528**	**$0**	**$7,915,363,590**	**$91,759,573**	**$88,532,386**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	GF	$2,285,686,174	$0	$2,294,366,911	$0	$0
	CF	$983,543,298	$0	$984,608,781	$45,879,786	$44,266,193
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	$45,879,787	$44,266,193
	Total	**$311,296,186**	**$0**	**$311,296,186**	**($91,759,573)**	**($88,532,386)**
	FTE	0.0	0.0	0.0	0.0	0.0
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Safety Net Provider Payments	GF	$0	$0	$0	$0	$0
	CF	$155,648,093	$0	$155,648,093	($45,879,786)	($44,266,193)
	RF	$0	$0	$0	$0	$0
	FF	$155,648,093	$0	$155,648,093	($45,879,787)	($44,266,193)

Auxiliary Data			
Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-20
Request Detail: Safety Net Provider Payments Adjustment

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$0**	**$0**
FTE	0.0	0.0	0.0
General Fund	$0	$0	$0
Cash Funds	$0	$0	$0
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$0	$0

Summary of Request:

The Department requests a net $0 technical adjustment to more accurately align funding to current policy for Safety Net Provider Payments and Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) programs. The Department is requesting a budget neutral transfer of funding between line items for technical adjustments to the Safety Net Provider Payments funding to align with current timelines and policies.

Current Program:

The Safety Net Provider Payments line item is comprised of Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) funding allotments for the Colorado Indigent Care Program (CICP). CICP is not an insurance program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the low-income Coloradans who are not eligible for Medicaid or the Child Health Plan Plus (CHP+). The services offered at a discount vary from provider to provider and there is no defined benefit package. The number of persons receiving services has decreased since the implementation of the Affordable Care Act (ACA). Many clients previously covered under CICP are now covered under Medicaid. At its peak, the CICP reimbursed clinics and hospitals for approximately 225,000 Coloradans in FY 2010-11 who were uninsured or underinsured. In FY 2017-18, 49,118 Coloradans received services through the CICP, a 78%[1] reduction. While the number of persons receiving services has decreased since the implementation of the Affordable Care Act (ACA), CICP remains an important safety net for low-income Coloradans who are not eligible for Medicaid or the Child Health Plan Plus (CHP+) and who cannot afford their out of pocket health care costs. The uncompensated care payment has been redirected to be used as a Medicaid supplemental payment to reimburse hospitals for uncompensated care costs incurred by serving Medicaid clients. CICP and non-CICP hospitals receive the upper payment limit financing portion of the Safety Net Provider Payments for uncompensated care incurred serving Medicaid and uninsured patients. Only CICP hospitals are eligible to receive the Disproportionate Share Hospital payment portion of the Safety Net Provider Payments line.

The General Assembly first issued a Legislative Request for Information (LRFI) in FY 2008-09, which requires the Department to report by February 1 of each year the expected disbursement to each CICP hospital from the Safety Net Provider Payments line item. The LRFI has been requested each year since then and is currently the Department's FY 2019-20 LRFI number 4.

Problem or Opportunity:

With the implementation of Medicaid expansion under CHASE and SB 13-200 "Expand Medicaid Eligibility," the number of people served by CICP hospitals has declined by more than 78%. In FY 2014-15, the Hospital Provider Fee Oversight and Advisory Board recommended that CICP Hospitals continue to receive DSH funding and that all hospitals receive UPL funding for uncompensated care costs. Due to this change in these programs, it would be more appropriate to align the uncompensated care payment with the other Medicaid supplemental payments in Medicaid Services Premiums line item.

In FY 2014-15, the Hospital Provider Fee Oversight and Advisory Board recommended that CICP hospitals continue to receive DSH funding and that all hospitals receive UPL funding for uncompensated care costs. Due to this change in these programs, the Safety Net Payments line item should only reflect the DSH allotment of $219,536,613 in FY 2020-21. The remaining UPL allotment of $91,759,573 should be moved

[1] Colorado Indigent Care Program and Primary Care Fund Fiscal Year 2017-18 Annual Report: https://www.colorado.gov/pacific/sites/default/files/2017-18%20CICP%20Annual%20Report%20Web.pdf

to the Medical Services Premiums line item, where the other CHASE fee-funded supplemental payments are appropriated.

The Joint Budget Committee issued the LRFI to monitor expected CICP disbursements for each hospital. Prior to the Hospital Provider Fee/CHASE programs that began in FY 2009-10, the State share was primarily funded via certified public expenditure (CPE), along with a small portion of General Fund, to make CICP payments to private hospitals. Private hospitals could not certify public expenditures, so they received smaller CICP payments, and the General Assembly wanted a way to track payments to ensure adequate funding to these hospitals. The annual LRFI is no longer needed because the CICP payments are no longer funded with CPE. As all CICP hospitals (public and private) are now eligible for DSH funds with CHASE fees as the State share, the disparity no longer exists that led to the need for the LRFI. Additionally, CHASE also requires an annual report that details the payments and fees to all hospitals. Furthermore, section 25.5-3-107, C.R.S. (2019) requires the Department to prepare and annual report to the Health and Human Services committees of the Senate and House of Representatives concerning the status of the CICP. These reports contain the same information that would otherwise be included in the LRFI, rendering the LRFI duplicative.

Proposed Solution:

The Department requests a net $0 technical adjustment to more accurately align funding to current policy for Safety Net Provider Payments and Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) programs. To do this, the Department requests a funding adjustment to reduce the Safety Net Provider Payments line item in the Indigent Care Program Long Bill Group by $91,759,573 total funds in FY 2020-21, which includes $45,879,786 cash funds and $45,879,787 federal funds with a corresponding increase to the Medical Services Premiums – Medical and Long-Term Care Services for Medicaid Eligible Individuals line item. This would allow the Safety Net Provider Payments to reflect the DSH payments only. In FY 2021-22, the Department requests a funding adjustment to reduce the Safety Net Provider Payments line item by $88,532,386 total funds, including $44,266,193 cash funds and $44,266,193 federal funds with a corresponding increase to the Medical Services Premiums – Medical and Long-Term Care Services for Medical Eligible Individuals line item. Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund.

The requested adjustments would align the Safety Net Provider Payments appropriation to the expected DSH payment allotment and would move the UPL portion to the Medical Services Premiums appropriation. Overall, there would be no change in cash fund or federal fund expenditures and this would align appropriations with current practice. Payment allotments can change from year to year based on updates to the federal funding methodology (DSH reductions and delays). The Department will reevaluate the funding adjustment amount in future years and will use the regular budget process to request adjustments to the allotments when necessary.

Further, the Department requests the elimination of the FY 2019-20 LRFI #4, which requires the Department to report by February 1 of each year the expected disbursement to each CICP hospital from the Safety Net

Provider Payments line item. This report is no longer needed because it is outdated and duplicative with other reporting requirements.

Anticipated Outcomes:

This request would align funding with actual utilization. Approval of the Department's net $0 technical adjustment request would allow for a more accurate representation of the Department's budget and align appropriations to anticipated expenditures. Eliminating the LRFI associated with CICP hospital payments would relieve the Department of redundant and unnecessary administrative burdens, as CHASE now requires an annual report that details the payments and fees to all hospitals.

Assumptions and Calculations:

Detailed calculations for this request are provided in Appendix A attached. The expenditure data presented in this request is the most up-to-date expenditure forecasts of DSH allotments and payments as of submission.

Table 1.1: Summary by Line Item
FY 2020-21

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Source
A	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$91,759,573	0.0	$0	$45,879,786	$0	$45,879,787	Table 2.1 Row C
B	(5) Indigent Care Program, Safety Net Provider Payments	($91,759,573)	0.0	$0	($45,879,786)	$0	($45,879,787)	Table 2.1 Row C * -1
C	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**Row A + Row B**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund.

Table 1.2: Summary by Line Item
FY 2021-22

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Source
A	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$88,532,386	0.0	$0	$44,266,193	$0	$44,266,193	Table 2.2 Row C
B	(5) Indigent Care Program, Safety Net Provider Payments	($88,532,386)	0.0	$0	($44,266,193)	$0	($44,266,193)	Table 2.2 Row C * -1
C	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**Row A + Row B**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund.

Table 1.3: Summary by Line Item
FY 2022-23

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds[1]	Reappropriated Funds	Federal Funds	Source
A	(2) Medical Services Premiums and Long-Term Care Services for Medicaid Eligible Individuals	$85,257,758	0.0	$0	$42,628,879	$0	$42,628,879	Table 2.3 Row C
B	(5) Indigent Care Program, Safety Net Provider Payments	($85,257,758)	0.0	$0	($42,628,879)	$0	($42,628,879)	Table 2.3 Row C * -1
C	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**Row A + Row B**

[1]Cash funds are from the Health Care Affordability & Sustainability Fee Cash Fund.

Table 2.1: FY 2020-21 Safety Net Provider Payments Funding Realignment									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	Safety Net Provider Payments Total Appropriation	$311,296,186	0.0	$0	$155,648,093	$0	$155,648,093	50%	Long Bill Line Item (SB 19-207)
B	Projected Disproportionate Share Hospital Allotment[1]	$219,536,613	0.0	$0	$109,768,307	$0	$109,768,307	50%	Table 3.1 Row A
C	**Upper Payment Limit Adjustment to Medical Services Premiums**	**$91,759,573**	**0.0**	**$0**	**$45,879,786**	**$0**	**$45,879,787**	**50%**	**Row A - Row B**
D	Medical Services Premiums - Medical and Long-Term Care Services for Medicaid Eligible Individuals Appropriation	$7,869,382,428	0.0	$2,273,815,619	$982,744,312	$88,876,290	$4,523,946,207	57%	Long Bill Line Item (SB 19-207)
E	Upper Payment Limit Adjustment from Safety Net Provider Payments	$91,759,573	0.0	$0	$45,879,786	$0	$45,879,787	50%	Row C
F	**Total Medical Services Premiums**	**$7,961,142,001**	**0.0**	**$2,273,815,619**	**$1,028,624,098**	**$88,876,290**	**$4,569,825,994**	**57%**	**Row D + Row E**
G	**Net Appropriation Adjustment**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**NA**	**Row C - Row E**

Table 2.2: FY 2021-22 Safety Net Provider Payments Funding Realignment									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	Safety Net Provider Payments Total Appropriation	$311,296,186	0.0	$0	$155,648,093	$0	$155,648,093	50%	Long Bill Line Item (SB 19-207)
B	Projected Disproportionate Share Hospital Allotment[1]	$222,763,801	0.0	$0	$111,381,900	$0	$111,381,900	50%	Table 3.1 Row B
C	**Upper Payment Limit Adjustment to Medical Services Premiums**	**$88,532,386**	**0.0**	**$0**	**$44,266,193**	**$0**	**$44,266,193**	**50%**	**Row A - Row B**
D	Medical Services Premiums - Medical and Long-Term Care Services for Medicaid Eligible Individuals	$7,869,382,428	0.0	$2,273,815,619	$982,744,312	$88,876,290	$4,523,946,207	57%	Long Bill Line Item (SB 19-207)
E	Upper Payment Limit Adjustment from Safety Net Provider Payments	$88,532,386	0.0	$0	$44,266,193	$0	$44,266,193	50%	Row C
F	**Total Medical Services Premiums**	**$7,957,914,814**	**0.0**	**$2,273,815,619**	**$1,027,010,505**	**$88,876,290**	**$4,568,212,400**	**57%**	**Row D + Row E**
G	**Net Appropriation Adjustment**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**NA**	**Row C - Row E**

Table 2.3: FY 2022-23 and Ongoing Safety Net Provider Payments Funding Realignment									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Source**
A	Safety Net Provider Payments Total Appropriation	$311,296,186	0.0	$0	$155,648,093	$0	$155,648,093	50%	Long Bill Line Item (SB 19-207)
B	Projected Disproportionate Share Hospital Allotment[1]	$226,038,428	0.0	$0	$113,019,214	$0	$113,019,214	50%	Table 3.1 Row C
C	**Upper Payment Limit Adjustment to Medical Services Premiums**	**$85,257,758**	**0.0**	**$0**	**$42,628,879**	**$0**	**$42,628,879**	**50%**	**Row A - Row B**
D	Medical Services Premiums - Medical and Long-Term Care Services for Medicaid Eligible Individuals	$7,869,382,428	0.0	$2,273,815,619	$982,744,312	$88,876,290	$4,523,946,207	57%	Long Bill Line Item (SB 19-207)
E	Upper Payment Limit Adjustment from Safety Net Provider Payments	$85,257,758	0.0	$0	$42,628,879	$0	$42,628,879	50%	Row C
F	**Total Medical Services Premiums**	**$7,954,640,186**	**0.0**	**$2,273,815,619**	**$1,025,373,191**	**$88,876,290**	**$4,566,575,086**	**57%**	**Row D + Row E**
G	**Net Appropriation Adjustment**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**NA**	**Row C - Row E**

[1]DSH allotments are estimated using prior year Federal Fiscal Year (FFY) allotment grown by the 12-month average or estimated Consumer Price Index. A reduction is applied reflecting current federal statute, and calculated by applying Colorado's proportion of the FFY 2018-19 reductions to national reductions. DSH payments are estimated by applying a federal matching rate of 50.00%. Quarterly amounts are calculated for the three year period and combined to find State Fiscal Year payments.

Table 3.1: State Disproportionate Share Hospital (DSH) Allotments							
Row	**Item**	**Total Annual Payments**	**Quarter Ending 9/30**	**Quarter Ending 12/31**	**Quarter Ending 3/31**	**Quarter Ending 6/30**	**Source**
A	FY 2020-21	**$219,536,613**	$54,285,654	$55,083,653	$55,083,653	$55,083,653	QE 9/30: Table 3.2 Row A QE 12/31, 3/31, 6/30: Table 3.2 Row B
B	FY 2021-22	**$222,763,801**	$55,083,653	$55,893,383	$55,893,383	$55,893,383	QE 9/30: Table 3.2 Row B QE 12/31, 3/31, 6/30: Table 3.2 Row C
C	FY 2022-23	**$226,038,428**	$55,893,383	$56,715,015	$56,715,015	$56,715,015	QE 9/30: Table 3.2 Row C QE 12/31, 3/31, 6/30: Table 3.2 Row D

Table 3.2: Federal Disproportionate Share Hospital (DSH) Allotments				
Row	**Item**	**Total Annual Payments**	**Quarterly Allotment**	**Source**
A	FFY 2019-20	**$217,142,616**	$54,285,654	Department Forecast - Fund Split Calculations
B	FFY 2020-21	**$220,334,612**	$55,083,653	Department Forecast - Fund Split Calculations
C	FFY 2021-22	**$223,573,530**	$55,893,383	Department Forecast - Fund Split Calculations
D	FFY 2022-23	**$226,860,061**	$56,715,015	Department Forecast - Fund Split Calculations