



Department of Health Care Policy and Financing  
Medical Services Premiums  
and  
Medicaid Mental Health Community Programs

FY 2010-11 and FY 2011-12 Budget Request

February 15, 2011

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## **(2) MEDICAL SERVICES PREMIUMS**

### **I. BACKGROUND**

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, 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.

Several key points should be made evident before further discussion. These change-producing issues cause this line item to be complicated to project. They are summarized as follows:

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

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

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

This request does not account for the FY 2010-11 payment of the delayed claims. The Department will use the standard budget process to account for the impact of the delay.

2. As a result of recent federal legislation, the Department has submitted an early supplemental request on August 23, 2010 to account for the extension of the American Recovery and Reinvestment Act (ARRA) and the phase down in the federal medical assistance percentage over the second half of FY 2010-11. The Department anticipates that FMAP will be, on average, 59.71% for FY 2010-11. The Department incorporates this FMAP figure throughout all exhibits where appropriate.

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To prevent double counting with the Department's early supplemental request, the Department has calculated its official request net of the early supplemental request. In effect, the Department treats the early supplemental request as if it was included in its spending authority. This methodology prevents double counting of the early supplemental request and this request. The totals shown in Exhibit A, page EA-1, reflect the correct incremental request when the early supplemental is taken into account.

3. The Department's request includes a number of references to various budget reduction items and early supplemental budget reductions. Effective July 1, 2009, September 1, 2009, December 1, 2009, and again on July 1, 2010, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding.
4. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom line impacts. Bottom line impacts can be found by service category (e.g. Acute Care, Community Based Long Term Care, Long Term Care, Insurance, etc.) in the respective sections of this request. Those bottom line impacts include the identification number of the originally submitted request, so that the bottom line impact in the current year may be traced to that originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom line impacts.
5. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information, and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J
6. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations which gain eligibility as a result of HB 09-1293. This includes continuously eligibility for eligible children and foster care clients, and the implementation of the Disabled Buy-In program in FY 2011-12. These expansions increase Medicaid caseload, and are discussed further in Sections II and III of this narrative.
7. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for administration and case management are included in Exhibit I.
8. The Department's request includes revisions to SB 10-169, which allowed the Department to use certain funds from the Hospital Provider Fee Cash fund to pay for Medicaid services in FY 2009-10 and FY 2010-11.

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9. The Department is proposing a substantial change to its methodology for allocating expenditure to the Health Care Expansion Fund for clients who gain eligibility as a result of the removal of the Medicaid Asset test. See the narrative for Exhibit J for details.

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 in section IV.

## **II. MEDICAID CASELOAD**

The Medicaid caseload analysis, including assumptions and calculations, are included in a separate section of this Request.

## **III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS**

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

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

### ***Rationale for Grouping Services for Projection Purposes***

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

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services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

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

***Acute Care:***

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

***Community Based Long Term Care:***

- Home and Community Based Services: Elderly, Blind and Disabled
- Home and Community Based Services: Mental Illness
- Home and Community Based Services: Disabled Children

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- Home and Community Based Services: Persons Living with AIDS
- Home and Community Based Services: Brain Injury
- Home and Community Based Services: Children with Autism
- Home and Community Based Services: Pediatric Hospice
- Private Duty Nursing
- Hospice

***Long Term Care:***

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

***Insurance:***

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

***Service Management:***

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

Note that for services in the Long Term Care, Insurance, and Service Management categories, separate forecasts are performed. Only Acute Care and Community Based Long Term Care are 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.<sup>1</sup> The total spending authority is compared to the total projected estimated current year expenditures from page EA-4. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

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

Totals for the base request on this page correspond with Columns 3, 5, and 8 on the Schedule 13, where appropriate.

For FY 2010-11, Column 5 in the Schedule 13 will not match Exhibit A. Exhibit A shows the correct total need for Medical Services Premiums, not the Schedule 13. See the section "Alternative Calculation of Request" for further information.

***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, as reported through the Federal Register, or as specified in federal law and/or regulation. The FMAP for Medicaid is recomputed by the Federal Funds Information Service each year and is based on a statewide per capita earnings formula that is set in federal law.

The FMAP is impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA is an enhanced FMAP for specified Medicaid programs; the effective period of this enhanced rate was originally October 1, 2008 through December

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<sup>1</sup> For FY 2010-11, the Department's totals on this page differ from the actual spending authority due to the inclusion of the budget balancing items submitted and implemented (labeled with priority numbers beginning with "ES"). Page EA-3 shows the actual total spending authority. Annualizations of budget balancing items are included in the FY 2011-12 base request.

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31, 2010. However, recent legislation, HR 1586, extended the effective period of ARRA to June 30, 2011. The enhanced FMAP from ARRA beyond December 31, 2010 undergoes a staged phase out. Additional relief is available for states which experience increased unemployment; there are three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA includes a ‘hold harmless period’; if the FMAP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 would be less than the FMAP for the preceding quarter, the higher percent shall continue in effect for each subsequent calendar year ending before July 1, 2010. Below is a table detailing the Department’s FMAP for FY 2008-09 through FY 2011-12.

FMAP Rate		Effective Period	Fiscal Year Quarters
50.00%	Pre-ARRA	Through September 2008	Through first quarter of FY 2008-09
58.78%	Enhanced rate per ARRA	October 2008 through March 2009	Second and third quarters of FY 2008-09
61.59%	Enhanced rate per ARRA	April 2009 through December 2010	FY 2009-10, First and second quarters of FY 2010-11
58.77%	First stage of ARRA phase out	January 2011 through March 2011	Third quarter of FY 2010-11
56.88%	Final stage of ARRA phase out	April 2011 through June 2011	Fourth quarter of FY 2010-11
50.00%	Post-ARRA	July 2011 forward	First quarter of FY 2011-12 forward

The resulting FMAP for FY 2010-11 is a weighted average of the multiple FMAPs available during the fiscal year, totaling 59.71%.

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

- Family Planning: The Department receives a 90% federal medical assistance percentage available for all documented family planning expenditures. This includes those services that are rendered through health maintenance organizations. Please see Exhibit F for calculations. This line also included reappropriated funds from the Department of Public Health and Environment to fund the state share of a family planning waiver program; see section V for additional details.

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- **Breast and Cervical Cancer Program:** This program receives a 65% federal financial participation rate. To determine state funding, the population is separated into two groups: traditional clients, and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308 (9), C.R.S. (2009). For FY 2010-11 and FY 2011-12, 100% of state funding for traditional clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive state funding through the Prevention, Early Detection, and Treatment fund, which is administered by the Department of Public Health and Environment. Please see Exhibit F for calculations.
- **Prenatal Costs for Optional Legal Immigrants:** A portion of Acute Care expenditure is for prenatal care for Non-Citizens. Through FY 2008-09, prenatal services were provided as a state-only option and therefore required to be funded through 100% General Fund with the exception that delivery costs qualify for the standard 50% federal financial participation rate. However, effective July 1, 2010, the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Please see Exhibit F for calculations.
- **Health Care Expansion Fund Programs:** Expenditures for clients granted eligibility through HB 05-1262 are funded through the Health Care Expansion Fund. Separate adjustments are made to Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management. In addition, in instances where the Department cannot isolate certain expenditures, the Department performs a bottom-line adjustment to allocate expenditure to the Health Care Expansion Fund. Please see Exhibit J for calculation of the fund splits for programs funded through the Health Care Expansion Fund.
- **Nursing Facility Supplemental Payments and Nursing Facility General Fund Cap:** 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.
- **Indian Health Services:** The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.
- **Tobacco Tax Funded Disease Management:** The Department annually receives funding from the Department of Public Health and Environment for the operation of disease management programs that address cancer, heart disease, lung disease and the risk

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factors associated therewith. The funding for these programs is a constant \$2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by the Department of Public Health and Environment. For FY 2010-11, the Department is using the full amount to fund current expenditures for clients related to the factors above. For FY 2011-12, the Department is requesting to use a portion of the funding for the adult medical home pilot program; see Exhibit I for further details.

- **Physician Supplemental Payments:** The Department draws a federal financial match on uncompensated expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The state share of funding is through certification of public expenditure.
- **Hospital Provider Fee Programs:** HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medical assistance; and 3) pay the administrative costs to the Department in implementing and administering the program. The expansion populations will be funded through revenue generating from federal funds and two State cash funds: the Hospital Provider Fee Fund and the Medicaid Buy-in Fund. Because these populations were not provided benefits prior to the passage of ARRA, they are not eligible to receive the enhanced federal match. However, supplemental payments will receive the enhanced federal match.
- **Children with Autism Waiver Services:** This program provides case management and behavioral therapy services to 75 children living with autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to \$1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Typically eligible for a FMAP rate of 50%, the program is eligible for enhanced federal financial participation during the ARRA period. Clients are limited to a cap of \$25,000 in waiver services. The Department estimates the funding need from the Colorado Autism Treatment Fund at 85% of the cap for each of the 75 clients, plus \$163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.
- **Supplemental Medicare Insurance Benefit:** Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 80% of the total will receive federal financial participation, while 20% will be provided with state-only funding.
- **Coordinated Care for People with Disabilities Program:** The coordinated care for people with disabilities pilot program, as authorized by SB 06-128, allows the Department to pay per member per month administration fees to a nonprofit organization

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which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations.

- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom-line adjustment to total expenditures. This is further described in Exhibit K.
- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2010-11 and FY 2011-12 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2009-10.
- 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.
- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is budget neutral to the state. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure.
- The incremental amount of pharmacy rebates that can be attributed to the Affordable Care Act represents an amount that is federal funds only.
- Class II Nursing Facility Adjustment: A portion of payments made to class II nursing facilities in FY 2010-11 do not qualify for federal financial participation. Additional information can be found in exhibit H.
- PACE Reconciliation: Prior year PACE reconciliations qualify receive a federal fund participation rate based on when the expenditure was incurred.
- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers. The table below shows the impact, by cash fund for FY 2010-11 and FY 2011-12.

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<b>Cash Fund</b>	<b>FY 2010-11</b>	<b>FY 2011-12</b>
Primary Care Fund (HB 10-1378)	\$12,800,000	\$0
Supplemental Old Age Pension Health and Medical Care Fund (HB 10-1380)	\$4,850,000	\$3,000,000
Tobacco Education Program Fund (HB 10-1381)	\$15,521,625	\$0
Prevention, Early Detection, and Treatment Fund (HB 10-1381)	\$5,679,358	\$0
Hospital Provider Fee (SB 10-169)	\$53,223,690	\$0
<b>Total</b>	<b>\$92,074,673</b>	<b>\$3,000,000</b>

In addition, the item includes a \$2.0 million transfer of reappropriated funds for FY 2010-11 and \$1.75 million in FY 2011-12, from the Prevention, Early Detection and Treatment fund. These funds are transferred from the Department of Public Health and Environment for disease management (described above), although the Department has statutory flexibility to use the funding for the treatment of the specified conditions. This program is detailed in Exhibit I.

***Alternative Calculation of Request***

The Department has submitted supplemental requests prior to this request as a result of budget balancing actions. On August 23, 2010, the Department submitted supplemental request ES-1 - "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" to account for the phase down of the enhanced FMAP. On November 1, 2010, the Department submitted request S-5, "Medicaid Delayed Claims Payment", to request additional funding to account for the FY 2009-10 payment delay. As a result of these requests, the Department's Schedule 13 and other pages from Exhibit A do not always reflect the Department's final need for Medical Services Premiums.

For FY 2010-11, the Department presents two alternative calculations for Exhibit A:

- On page EA-3, the Department presents the calculation of the FY 2010-11 request without accounting for any other requests, including the Department's November 1, 2010 S-1. This page differs from the standard Exhibit A in that it adds only the total incremental request (from page EA-1) to the total spending authority. The total expenditure on this page matches the Schedule 13. Please note that this figure is for reference only for the purpose of showing the derivation of the Schedule 13, and does not reflect the Department's total request for Medical Services Premiums.
- On page EA-4, the Department shows the total request for Medical Services Premiums, including the total amounts requested in ES-1, S-1, and S-5. This page demonstrates the true incremental funding need for Medical Services Premiums. This figure differs

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from the amounts requested on page EA-1 in order to show the sum of all FY 2010-11 requests for Medical Services Premiums through November 1, 2010.

**EXHIBIT B - MEDICAID CASELOAD PROJECTION**

This exhibit is described in the Medicaid Caseload Budget Narrative section.

**EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS**

Medical Services Premiums per capita costs history (through FY 2009-10) 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 ES-2, the Department provides the per capita cost history adjusted for the FY 2009-10 payment delay; that is, the claims which were delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals.

**EXHIBIT D - CASH FUNDS REPORT**

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

**EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP**

Page EE-1 of this exhibit is a summary of the requests by service group and by eligibility category for the current year and the request year.

Starting with page EE-2, this exhibit contains a detailed summary of the Department's Budget Request, by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation, as determined by the Department's March 16, 2010 Figure Setting and subsequent actions by the Joint Budget Committee and the General Assembly. This exhibit includes all bottom-line impacts and financing, but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

**EXHIBIT F – ACUTE CARE**

***Calculation of Acute Care Expenditure***

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

In light of the Medicare Modernization Act of 2003, the Department has added a separate page of trends on page EF-2. On this page, expenditures for pharmacy and drug rebate recoveries have been removed from the historical expenditure. This page is particularly relevant, as per capita costs for eligibility categories with significant amounts of dual-eligibles are skewed by the new Part D benefit. In Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (AND/AB), the per capita costs experienced a significant downturn as Medicare became responsible for most pharmacy claims. Selecting trends that incorporate FY 2005-06 would incorporate the shift in expenditure and may not be appropriate. This portion of the exhibit enables the Department to analyze and select trends without the net cost of pharmaceuticals, which has historically been a significant cost driver.

***Calculation of Per Capita Percent Change***

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2009-10. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-3, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 2007-08, FY 2008-09, and FY 2009-10. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs, although the Department makes adjustments to the selected trend where necessary.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or

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changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category.

The table below describes the trend selections for FY 2010-11 and FY 2011-12. In some cases, though not all, the Department has held the trend constant between the two years. On Exhibit F, the selected trend factors have been bolded for clarification. By convention, any trend factor selected based on expenditure without prescription drugs and drug rebate is labeled “w/o RX.”

As described in the Department’s caseload narrative, populations which are sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth leads to per capita declines, due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting, where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance, and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2010-11 and FY 2011-12 with the rationale for selection, are as follows:

Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.60% One half the average per capita change from FY 2005-06 to FY 2008-09	0.60% One half the average per capita change from FY 2005-06 to FY 2008-09	Historical per capita trends have been on the rise. Expenditure containment and efficiency measures coupled with only mild growth in caseload have resulted in declining per capita expense. While some of these measures will have lasting impacts, it is unlikely that the Department will experience the same magnitude of reduction in the upcoming years. Reverting to a dampened historical trend will best reflect the Departments expectation of future growth.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Disabled Adults 60 to 64 (OAP-B)	5.35% Percentage change in per capita from FY 2008-09	2.68% One half the per capita change from FY 2010-11	Although the last fiscal year saw declines in per capita trends, it is impossible to ignore the strong growth in two years prior. Pharmacy was a strong driver a costs increases in the last year where as inpatient hospital and HMOs have seen a decline. Ultimately, these opposing forces balance each other out. As the trends for each stabilize, it is likely this population will continue to see the historical growth, but with a dampened magnitude.
Disabled Individuals to 59 (AND/AB)	2.81% Average per capita change from FY 2006-07 to FY 2009-10	2.81% Average per capita change from FY 2006-07 to FY 2009-10	The primary cost driver in this aid category is acute home health services; despite rate reductions, per capita expenditure for home health expenditure increased by 7.27% in FY 2009-10, and is expected to continue to be a driver of future costs. Despite this, expenditure for other service categories mostly declined, leading to an overall per capita decline in FY 2009-10. The Department anticipates that these trends will likely continue, but at a dampened pace, leading to per capita growth in future years. The average of FY 2006-07 to FY 2009-10 will capture the strong historical growth while accounting for the recent years decline.
Categorically Eligible Low-Income Adults (AFDC-A)	0.69% One quarter the FY 2005-06 per capita growth rate	0.69% One quarter the FY 2005-06 per capita growth rate	With high growth in caseload, per capita figures have declined in the last two years. Caseload is anticipated to continue to grow in this eligibility category in FY 2010-11. Consequently, the Department anticipates that this aid category will continue to see marginal per capita growth in future years.
Expansion Adults to 60% (Page EF-6)	6.65% Percentage change in per capita from FY 2009-10	3.33% One-half the per capita change from FY 2010-11	This population continues to mature; prior year growth overstates the natural trend as it reflects a population new to receiving services. Additional detail on this trend selection can be found in Exhibit F.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Expansion Adults to 100% (Page EF-6)	114.22%	33.79%	The Department assumes that the per capita cost of this population will quickly reach the same level as Expansion Adults to 60%. Early experience with this population indicates a high per capita cost compared to the early experience of Expansion Adults to 60%; this reflects that many clients in this aid category were transitioned from other aid categories at the beginning of the program. The estimated FY 2010-11 per capita trend is based on a cash flow analysis of current year expenditure. For FY 2011-12, the selected trend is the percent change required to equalize the per capita costs between the expansion adult populations.
Breast & Cervical Cancer Program (Page EF-7)	0.51%	0.51%	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)	-1.00%	1.09% FY 2004-05 expenditure growth rate	Growth in per capita costs have been decreasing over the last three fiscal years. However, the magnitude of the most recent years decrease includes factors such as rate cuts, efficiency measures and increases in caseload. Continued strong caseload growth indicates continuation of decline in per capita. The Department anticipates the effect of caseload growth on per capita trends will stabilize in FY 2011-12 and there will a return to per capita growth for this eligibility category.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Foster Care	6.62% Average per capita change from FY 2005-06 to FY 2008-09	3.31% One half the FY 2010-11 per capita trend	Foster care per capita costs have experienced declined in the past two years; the most recent year showed a larger decline as a result of rate cuts. However, the prior history indicates the potential for large growth. The Department anticipates that per capita costs with return to growth in FY 2010-11, although this growth will be dampened by the continued effect of the FY 2009-10 and FY 2010-11 rate cuts.
Baby Care Program - Adults (BCKC-A)	0.51% Average per capita change from FY 2008-09 to FY 2009-10	0.51% Average per capita change from FY 2008-09 to FY 2009-10	Recent history for this populations shows virtually no per capita growth; this is true even after the inclusion of the former prenatal state-only population in FY 2009-10, which added roughly \$6.5 million in expenditure. As such, the Department selected a conservative growth factor for this population.
Non-Citizens	8.85% Average per capita change from FY 2007-08 to FY 2009-10	4.43% Half of the FY 2010-11 growth rate	This population experienced a large expenditure decline as the former prenatal state-only population was moved to Baby Care Program – Adults effective July 1, 2009. Per capita experienced a decline in FY 2009-10, and the Department anticipates this decline was a result of budget balancing policies, including rate cuts; these clients use primarily inpatient hospital and physician services, which were both targeted as part of budget balancing. Caseload continues to decline, however, prior history indicates that expenditure for this population will remain relatively stable; the Department chooses a per capita trend which allows for stable expenditure in FY 2010-11 and FY 2011-12.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Partial Dual Eligibles	3.85% Average per capita change from FY 2007-08 to FY 2009-10	3.85% Average per capita change from FY 2007-08 to FY 2009-10	The last year saw a significant decline in per capita expenditure; this population was affected by budget balancing as the Department's payments for Medicaid coinsurance decreased in concert with the Department's other rate reductions. The Department anticipates that this reduction is a level shift, as opposed to a new trend, and that this population will return to growth in FY 2010-11 and FY 2011-12.

*Legislative Impacts and Bottom-line Adjustments*

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

- BRI-1 (FY 2010-11), Prevention and Benefits for Enhanced Value (P-BEV) and BA-12 (FY 2010-11) Evidence Guided Utilization Review (EGUR), increased utilization review funding in order to provide an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures to be performed by dental hygienists, and improve non-emergency medical transportation policies.
- BRI-2 (FY 2010-11), Coordinated Payment and Payment Reform, implements proposed steps toward payment coordination and payment reform. Payment coordination is characterized by streamlined payment processes, enhanced recovery efforts and proactive integration of care. The payment reform component supports performance-based payment structures which incentivize desired outcomes.
- BRI-3 (FY 2010-11), Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology reduces total funds as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. This will allow the Department to take advantage of an approved reimbursement methodology, increasing opportunities for reimbursement savings associated with pharmacy claims.
- BRI-6 (FY 2010-11), Medicaid Program Reductions - Limitation on Incontinence Products - this request reduces Medicaid physical health provider rates by 1% (effective July 1, 2010) and imposes restrictions on certain durable medical equipment.
- S-6 (FY 2010-11), Accountable Care Collaborative – the Accountable Care Collaborative is a client/family-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of members. The Department

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anticipates clients being enrolled in the ACC effective April 1, 2010; this bottom line impact reflects the estimated savings the Department expects as a result of the program.

- BA-16 (FY 2010-11), Implementation of Family Planning Waiver transfers funds from the Department of Public Health and Environment (DPHE) to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. Transferring this funding to the Department will allow for an enhanced federal financial participation rate of 90% to fund family planning services for uninsured, low-income Coloradans who would otherwise be receiving services funded by the unmatched General Fund dollars currently appropriated to the Department of Public Health and Environment.
- HB 10-1005, Home Health Care – Telemedicine Changes, clarifies and enhances the Department’s ability to reimburse for telemedicine services. Payment for telemedicine services comes from the newly created Home Health Telemedicine Cash Fund for FY 2010-11 and FY 2011-12.
- HB 10-1033, Add Screening, Brief Intervention and Referral to Treatment to Optional Services, adds screening, brief intervention, and referral for treatment for substance abuse to the list of optional services covered by Medicaid.
- SB 10-167, Colorado False Claims Act, has three components. The first component increases enrollment in the Health Insurance Buy-in (HIBI) program. Beginning in April, 2011, 1,500 new enrollees will be added incrementally to the HIBI program. The second component of SB 10-167 is an automated prepayment review of claims. This system will produce savings by identifying coding errors prior to reimbursement of claims. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid that are eligible to enroll in the Medicaid programs of other states.
- The Estimated Impact of PACE Enrollment line accounts for the Department’s initiative to increase enrollment of new PACE providers. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community Based Long Term Care service groups to the PACE service category.
- Benefits Limits on Echocardiograms limits the number of echocardiograms available without prior authorization as defined through the Department’s community engaged Benefits Collaborative process. This policy was implemented in FY 2009-10; the FY 2010-11 impact represents an annualization of the expected savings.
- Remove Manual Pricing of Durable Medical Equipment (DME), Injectibles, and Medical Services sets reimbursement rates to a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists rates are set using the Department’s average paid, other states’ Medicaid average paid, or the commercial average paid rate. These policies were implemented in FY 2009-10; the FY 2010-11 impact represents an annualization of the expected savings.
- The Colorado Access contract for the Colorado Regional Integrated Care Collaborative (CRICC) was altered from a risk-based, capitated program to an Administrative Services Organization (ASO), generating a one-time cash-flow reduction in FY 2009-10 as the Department ceased paying risk-based capitations. The FY 2010-11 impact represents an annualization of the cash-flow reduction in FY 2009-10.

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- The Average Wholesale Pricing Reduction line accounts for a reduction in the average wholesale price (AWP) of certain drugs due to a lawsuit involving First DataBank, which provided the Department with AWP information used in the pricing of Medicaid pharmacy claims. The FY 2010-11 impact represents an annualization of expected savings.
- ES-2 (FY 2009-10), Provider Rate Reductions, included a permanent 1.5% reduction, effective September 1, 2009, in the reimbursement rate paid for most Acute Care services. The effective date for managed care provider payments was October 1, 2009, to allow time to actuarially certify rates. The FY 2010-11 impact represents an annualization of expected savings.
- ES-6 (FY 2009-10), Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid to providers for Acute Care Services effective December 1, 2009. The FY 2010-11 impact represents an annualization of expected savings.
- BA-33 (FY 2009-10), Prior Authorization of Anti-convulsant Drugs, adds anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses of anti-convulsants in coordination with the BRI-1, Pharmacy Efficiencies (see below). The FY 2011-12 annualization represents expected savings above what was achieved in FY 2010-11.
- BA-33 (FY 2009-10), Promote Use of VA for Veterans, increases efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system beginning in July 2009. The Department has reduced the estimate from previous budget requests, but still anticipates a small amount of savings in FY 2010-11 and FY 2011-12.
- BRI-2 (FY 2009-10), Medicaid Program Efficiencies: Fluoride Varnish, allows trained medical and dental professionals to administer fluoride varnish treatments to children up to age 6, beginning in July 2009. Studies demonstrate that fluoride varnish is the safest and most effective form of topical fluoride for young children and helps reduce the need for more expensive dental care in the future. This benefit was added in FY 2009-10; the FY 2010-11 impact represents an annualization of expected expenditures.
- BRI-1 (FY 2009-10), Pharmacy Efficiencies, reduces expenditure as a result of implementing an automated prior authorization system and changing the reimbursement rates of drugs using a state maximum allowable cost structure. Automating prior authorizations increases efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process makes it easier for providers to submit requests, in turn making it easier and faster for clients to obtain drugs with prior authorization restrictions. The FY 2010-11 impact represents an annualization of expected savings.
- NEMT Supplemental Payments – this allowed for additional funds to be expended on its fixed price contract to provide Non-Emergency Transportation Services in the 8 metro counties. The contractor had recently informed the Department that it would need to cease to provide services, as the fixed price contract did not accommodate the unprecedented caseload growth facing the Department and the provider. Through contract negotiations, the Department was able to adjust the fixed price on the contract in order to ensure vital services continued. The annualization of this impact for FY 2010-11 represents the incremental difference in expense between fiscal years.
- Increased Drug Rebates due to the Affordable Care Act – the estimated impact of increased pharmacy rebates the Department will receive as a direct result of the implementation of the Affordable Care Act.

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- Recoveries Adjustment - The recoveries adjustment represents the amount of Department recoveries that would have otherwise offset to expenditure. Additional information on this adjustment can be found in Exhibit L.
- HB 09-1293 Children's Continued Eligibility Adjustment – as caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of this population will be 75% of the per capita rate of traditionally eligible population in the same category. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population.
- HB 09-1293 Disability Buy-In Adjustment – as caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of this population will be 75% of the per capita rate of traditionally eligible population in the same category. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population.
- HB 09-1293 Foster Care Adjustment – as caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of this population will be 75% of the per capita rate of traditionally eligible population in the same category. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population.

### *Calculation of Expansion Adults Expenditure and Fund Splits*

The Department's Expansion Adults population is comprised of two distinct groups; adults between the AFDC income limit and 60% of the federal poverty level (FPL) ("Expansion Adults to 60%"), and adults over 60% FPL up to 100% of the FPL ("Expansion Adults to 100%"). These populations have distinct funding sources: Expansion Adults to 60% are funded through the Health Care Expansion Fund, while Expansion Adults to 100% are funded through the Hospital Provider Fee Cash Fund.

This exhibit calculates the per capita cost of each population so that the Department can appropriately request the correct amount of funding from each cash fund. The presentation of the exhibit varies from other exhibits; in this case, expenditure and per capita costs are shown on the left side, while percent changes are shown on the right side. Projections for the current year and the request year are shown at the bottom. The calculations remain the same as the base Acute Care calculations; total per capita is trended forward and multiplied by projected caseload to calculate expenditure totals. Bottom line impacts, as calculated in the base Acute Care calculations, are added into the total to calculate the final expenditure. Fund split calculations for these populations are performed in Exhibit J.

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The trends for each population are described in detail above. For FY 2010-11 and FY 2011-12, assumes that the per capita cost of the Expansion Adults to 100% population will quickly reach the same level as Expansion Adults to 60%. Early experience with this population indicates a high per capita cost compared to the early experience of Expansion Adults to 60%; this reflects that many clients in this aid category were transitioned from other aid categories at the beginning of the program.

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

### ***Per Capita Cost***

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

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per capita expenditures. The Department assumes that the decline in the per capita expenditures is a temporary product of the increasing caseload, and that as the new clients incur costs, the per capita rate will begin to slow down in its decline. Using the previous methodology, which calculated the rolling average percent changes from the most recent seven months, the trend factor would be calculated as -13.69%. This is far larger in magnitude than the Department anticipates for the breast and cervical cancer treatment

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program, especially since the program has historically incurred more costs in the second half of the year than the first. The Department used the monthly caseload for the program (presented in Exhibit B) to calculate a monthly per capita, and calculated a trend factor by using the average percent change between the rolling 3-month averages for the past twelve months. Because this factor is the average increase for each 3-month period, the Department adjusts the factor to obtain a full-year trend factor to apply for its FY 2010-11 estimate of per capita expenditure; the resulting trend factor is -5.47%.

For FY 2011-12, the Department analyzed per capita data since April 2007, when there were enough clients in the program for a robust time-series analysis. The Department regressed rolling average per capita expenditure on caseload, monthly dummy variables, and a time trend, producing a model that explained much of the variation in the per capita expenditures with an R-squared of 0.9975. The Department calculated the average of the percent changes of the predicted values produced by the regression model for FY 2011-12 and annualized the average for a full-year effect. The resulting trend factor is -2.94% for FY 2011-12. The trend factors for both FY 2010-11 and FY 2011-12 are applied to the base per capita on page EF-4.

### *Fund Splits*

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

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

SB 09-262 revised the statute, requiring that in FY 2009-10 through FY 2011-12, 100% of state funding for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Beginning FY 2012-13, state funding will be split with 50% coming from the General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2009), state funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund. Using the allocation methodology described above, 70% of clients are funded through the Breast and Cervical Cancer Prevention and Treatment Fund, while the remaining 30% of clients are funded through the Prevention, Early Detection, and Treatment Fund. All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

***Antipsychotic Drugs***

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-7 through EF-8, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The rebate calculation excludes supplemental rebates, as antipsychotic drugs are not including on the Department's preferred drug list. 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.

***Prenatal Care Costs for Optional Legal Immigrants***

Pursuant to 25.5-5-103 (3), C.R.S. (2009), Colorado opted to provide prenatal care at its sole expense for certain non-citizens (legal immigrants not eligible for full Medicaid). SB 03-176 eliminated this service for legal immigrants, however, due to legal challenges there was no interruption in services. HB 05-1086 officially reinstated the services. The Department receives a 50% federal match for any emergency services provided for these clients, in particular, labor and delivery. Effective with the November 1, 2006 Budget Request, the Department has revised its reporting of expenditure. In Budget Requests prior to FY 2006-07, the Department's exhibit incorrectly listed the state-only portion of expenditure as the total amount spent on the program.

Upon federal approval in FY 2009-10, as per the Department's request ES-2, these clients began to receive full Medicaid benefits and therefore will receive a federal match on all Medicaid provided services. This population does not receive the enhanced federal medical assistance percentage (FMAP) specified in the American Recovery and Reinvestment Act (ARRA) because this population was granted full Medicaid eligibility after ARRA was enacted. Prior to FY 2009-10, expenditure for clients in the state-only prenatal care program was included in the Non-Citizens aid category. As a result of granting these clients eligibility, expenditure is now recorded in the Baby Care Adults column.

An analysis of yearly expenditure reveals that total expenditure for this population has been relatively stable in the past three years. The last three year-to-year changes in expenditure growth were 15.06%, 15.48%, and 16.08%. Given the economic climate, the Department anticipates continued rapid growth, but slowing as the economy begins to improve. Based on this assumption, the Department estimates total expenditure from the average percent change over the last three years for FY 2010-11 and half that growth rate for FY 2011-12. The reduction of the trend in FY 2011-12 models the anticipated economic recovery, and slowing of expenditure growth.

***Family Planning - Calculation of Enhanced Federal Match***

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

As of FY 2005-06, the Department no longer has any contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Additionally, historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced.

The total estimate for FY 2010-11 and the out-year is based on a linear regression analysis of FY 2002-03 through FY 2006-07 and the addition of FY 2010-11 BA-16 "Implementation of Family Planning Waiver". More recent family planning data was eliminated from the model because the Department assumes that recent expenditure increases have been a result of the Departments considered effort to educate providers as to what services are billable as family planning services. Research by the Department had indicated that only a fraction of allowable services were being appropriately billed. The Department believes that the recent double-digit percentage increases in family planning expenditure are due to this education effort, and anticipates growth to now return to historical levels.

BA-16 "Implementation of Family Planning Waiver", adds \$1,903,500 in FY 2011-12 to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. This additional funding was added to the family planning estimates and appears as a bottom line impact in Acute Care. The state share of the funding is transferred from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds. The implementation timeline of this budget item has been shifted out one year to account for the approval of the program from CMS and to allow time for CBMS and MMIS system changes. The Department anticipates the program will start serving clients in FY 2011-12.

***Indian Health Service***

In 1976, the Indian Health Care Improvement Act (PL 94-437) was passed with the goal of improving the health status of American Indians and Alaskan Natives and encouraging tribes to participate as much as possible in the management of their health services. The law specified that the payments for inpatient and outpatient services and emergency transportation for Medicaid clients who are Indians with a legal tribe affiliation receive 100% federal financial participation. The Indian Health Service is the federal agency

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within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities.

The Department uses historical and year-to-date expenditure to estimate total expenditure for services to these clients for the current and request years, all of which is federally funded. In FY 2008-09 and FY 2009-10, an average of 56.48% of the total annual expenditure was paid in the first six months of the year (please see table below). Prior to this, expenditure fluctuated from year-to-year, producing no pattern that the Department could use for trending. The Department assumes that the experience of the last two fiscal years will continue in FY 2010-11, and estimates total expenditure as the year-to-date expenditure divided by 56.48%. The trend selected for FY 2011-12 is one-fourth of the percentage change in expenditure from FY 2009-10 to FY 2010-11.

<b>Indian Health Service Cash Flow Analysis</b>		
	Percentage of Total Expenditure Complete in First Half of the Year	Percentage of Total Expenditure Complete in Second Half of the Year
FY 2005-06	43.36%	56.64%
FY 2006-07	52.90%	47.10%
FY 2007-08	33.62%	66.38%
FY 2008-09	56.90%	43.10%
FY 2009-10	56.07%	43.93%
Average of FY 2008-09 and FY 2009-10	<b>56.48%</b>	<b>43.52%</b>

***Prior Year Expenditure***

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

**EXHIBIT G - COMMUNITY BASED LONG TERM CARE**

The increased emphasis on utilizing community based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home and Community Based Service (HCBS) waivers, Class I

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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 2009-10, the Department paid HCBS claims for an average of 18,975 clients per month.

In response to budget balancing in FY 2002-03, rules were passed by the Medical Services Board to improve utilization management, which resulted in a reduction of per capita spending. Among these changes, the Department clarified the requirements necessary to meet the level of care required to qualify for nursing facility care or Home and Community Based Services. In addition, a requirement was added that in order to be eligible for long term home health, a client 18 years and over had to meet the need for that level of care. Although home health costs are in the Acute Care portion of the Premiums calculation, long term home health costs do correlate to community based long term care costs. High cost clients in the community were reviewed by Single Entry Points and transitioned to less expensive alternatives if their care plans and services did not assure that all services being provided were required. The assessment, which was a functional assessment to determine whether a client meets the long term care level of care, was redone with the help of providers, Single Entry Points, and clients. Responsibilities were shifted to ensure that Single Entry Points are the primary entities through which clients access long term care. Additionally, responsibilities required Single Entry Points to have tools and the authority to act as gatekeepers for long term care benefits. Federal requirements were more completely enforced, ensuring that clients regularly receive Home and Community Based Services waiver services in order to retain eligibility for the waiver.

HB 05-1243 extended the option of receiving home and community-based services (HCBS) through the Consumer-Directed care service model to all Medicaid recipients who are enrolled in a home and community-based services waiver for which the Department has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current home and community-based services waiver in order to receive services through the Consumer-Directed care service model. Additionally, the bill specifies that certain professional licensing requirements do not apply to a person who is directly employed by an individual participating in the Consumer-Directed care service model and who is acting within the scope and course of such employment. The restrictions that apply to this professional licensure exclusion and the circumstances under which the exclusion does not apply are noted in the bill. A consumer of attendant support is allowed to have an authorized representative who has the judgment and ability to assist the consumer in acquiring and using services under the program.

In 2005, the Centers for Medicare and Medicaid Services completely revised the home and community-based services waiver application forms, requiring additional components that needed to be researched and addressed by the Department prior to submission. This caused a substantial extension to the timeframe required for the implementation of this bill. Approval by the Centers for Medicare and Medicaid Services for the implementation of Consumer Directed Care for the Elderly, Blind, and Disabled waiver and the Mental Illness waiver was granted in mid-2007. Services became available to clients in January 2008. The Department has incorporated the estimated costs and savings of this program in the base trends for Community-Based Long Term Care.

***Calculation of Community Based Long Term Care Expenditure***

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2003-04 through FY 2009-10. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EG-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 2007-08, FY 2008-09, and FY 2009-10.

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

The selected per capita trend factors for FY 2010-11 and FY 2011-12, with the rationale for selection, are as follows:

<b>Aid Category</b>	<b>FY 2010-11 Trend Selection</b>	<b>FY 2011-12 Trend Selection</b>	<b>Justification</b>
Adults 65 and Older (OAP-A)	3.73% FY 2009-10 Per Capita Growth Rate	3.73% FY 2009-10 Per Capita Growth Rate	The FY 2010-11 trend is based on the current expenditure and prior-year cash flow. The primary drivers in this eligibility category are expenditure for Elderly, Blind and Disabled waiver and Hospice clients. Elderly, Blind, and Disabled waiver clients account over 70% of expenditure. The growth rate of expenditure for these waiver services has slowed substantially from FY 2008-09 to FY 2009-10, from approximately 12% growth between FY 2007-08 and FY 2008-09 to 3% from FY 2008-09 to FY 2009-10. The same overall trend appears to be true for Hospice. As such, the Department has selected a moderate growth trend of 3.73%. The FY 2011-12 trend is held constant from FY 2010-11.
Disabled Adults 60 to 64 (OAP-B)	2.76% FY 2009-10 Per Capita Growth Rate	1.38% Half the FY 2009-10 Per Capita Growth Rate	Expenditure growth in FY 2009-10 was primarily driven by growth in hospice expenditure caused by retroactive adjustments. Per capita growth has slowed significantly from FY 2007-08 through FY 2009-10. To reflect this decline in per capita growth, the selected trend factor in FY 2010-11 is the FY 2009-10 Per Capita growth rate. The FY 2011-12 trend factor is half of the FY 2010-11 trend.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	6.22% Half the average of FY 2008-09 through FY 2009-10	2.07% One third of the FY 2010-11 Trend	Expenditure for Elderly, Blind and Disabled waiver clients is over half of the expenditure for this aid category; the growth rate for expenditure for these waiver services dampened in FY 2008-09, but expenditure growth for disabled clients is still higher than for the Adults 65 and Older Category. Two other significant drivers of expenditure are the Mental Illness waiver client and Private Duty Nursing service categories. Growth in FY 2008-09 was relatively stable for the Mental Illness clients and decreased for clients who received Private Duty Nursing services. The Department anticipates some overall moderating of recent trends. The FY 2010-11 trend is half the FY 2008-09 to FY 2009-10 growth rate. The Department takes one third of that trend factor in FY 2011-12 to account for the anticipated slowing in growth.
Categorically Eligible Low-Income Adults (AFDC-A)	9.09% Average of overall per capita spending between FY 2005-06 through FY 2009-10	9.09% Average of overall per capita spending between FY 2005-06 through FY 2009-10	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their aid category changes to AND/AB. The FY 2010-11 trend factor is based on the average overall CBLTC change in per capita spending between FY 2005-06 through FY 2009-10. The FY 2011-12 trend is kept at the same level as the FY 2010-11 trend.
Expansion Adults	28.13% Average per capita spending between FY 2007-08 through FY 2009-10	28.13% Average per capita spending between FY 2007-08 through FY 2009-10	Similar to the low-income adults category, clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be a relatively small level of expenditure in waiver services. However, from the first half of FY 2009-10 to the first half of FY 2010-11 this category experienced expenditure growth of over 100%. To account for this the FY 2010-11 trend 28.13% and is held constant through FY 2011-12.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Eligible Children (AFDC-C/BCKC-C)	-12.70% Average of FY 2005-06 through FY 2009-10 Total Expenditure	-6.35% Half the average of FY 2005-06 through FY 2009-10 Total Expenditure	Eligible Children only receive private duty nursing and hospice care. Because a very small number of clients receive services, per capita trends are skewed by changes in caseload, and are unreliable. The Department compared first half actual expenditure from FY 2009-10 to FY 2010-11 which showed a strong decrease in total expenditure. To reflect this change the Department chose a FY 2010-11 trend of -12.70% and half that trend for FY 2011-12.
Foster Care	19.95% FY 2009-10 Per Capita Growth Rate	19.95% FY 2009-10 Per Capita Growth Rate	Per capita growth rates in this aid category has been high for the past three years. Continuing this trend, from FY 2009-10 to the first half of FY 2010-11 the Department has seen significant growth in CBLTC expenditure for this aid category. To reflect this growth the Department selected a 19.95% trend factor for FY 2010-11, and carried it through to FY 2011-12.
Baby Care Program - Adults (BCKC-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

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Aid Category	FY 2010-11 Trend Selection	FY 2011-12 Trend Selection	Justification
Partial Dual Eligibles	-69.06% FY 2008-09 Per Capita Growth Rate	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits. In some cases, however, clients who are eligible for these services are incorrectly being assigned to this aid category. This began in January 2007, and appears to be abating. Clients receiving these services are generally eligible for OAP-A. Based on expenditure to date, the Department has seen a decline in expenditure for this aid category and therefore chose trends to reflect a continuing decrease in expenditure in FY 2010-11, leveling off in FY 2011-12.

*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. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the Request for Community Based Long Term Care:

- **FY 2010-11 BRI-2 Coordinated Payment and Payment Reform:** This request, estimated to be implemented July 2010, requested a reduction in totals funds as a result of savings generated by payment coordination and payment reform. An initiative directed at Home and Community Based Services waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. The timeline for implementation of this program has been shifted to April 2011. To reflect this change, the savings estimated has been reduced in FY 2010-11, but carried over to FY 2011-12.
- **FY 2010-11 BRI-6, Medicaid Program Reductions,** included a 1% reduction to Medicaid physical health provider rates effective July 1, 2010.
- **FY 2009-10 BA-15 Community Transitions Services for Mental Illness Waiver Clients:** This request, after being delayed in FY 2009-10, was to be implemented by the Department in FY 2010-11. However, the Department will not implement this program in anticipation of the receipt of the Money Follows the Person federal grant. This grant aims to offer transition services to help clients move from nursing facilities and institutions into community based services. One of the target populations of the grant are those Medicaid clients with Mental Illness. Grant funds are anticipated in April 2011 with the first clients being enrolled in the program in January 2012. Therefore, to avoid overlapping efforts, the Department will not implement this request.
- **FY 2009-10 ES-2, Provider Rate Reductions,** included a permanent 1.5% reduction, effective September 1, 2009, in the reimbursement rate paid for most Community Based Long Term Care services.

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- FY 2009-10 ES-2, Medicaid Program Reductions: This request included a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients are limited to 2 roundtrips per week, with the exception of trips to adult day programs, which are not subject to the cap. The implementation of this program has been delayed to FY 2011-12 to allow time for necessary rule changes or waiver amendments. Savings derived from the limitation have been shifted to FY 2011-12, annualizing in FY 2012-13.
- Impact of Retroactive Increase of HB 08-1114 on FY 2008-09 Hospice Rates: Since hospice rates are a function of the reimbursement rate for Class I Nursing Facilities, the reimbursement methodology changes directed by HB 08-1114 have a fiscal impact on hospice expenditure. This impact was not anticipated and is included as a retroactive adjustment in FY 2009-10, annualized as a corresponding reduction in FY 2010-11.
- FY 2009-10 ES-6, Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid for Community Based Long Term Care for FY 2009-10, effective December 1, 2009.
- Estimated Impact of PACE Enrollment: The Department has reduced its projection under the assumption that increased enrollment in new PACE providers will cause a shift in expenditure from the CBLTC group to the PACE service category. The Department's calculations are contained in Section V of this part of the line item description.
- FY 2009-10 BA-33 Provider Volume and Rate Reductions: In addition to a 2% permanent provider volume and rate reduction in FY 2009-10, the proposal estimates the FY 2009-10 implementation of a reduction in expenditure by increasing efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system. The implementation of this initiative is pending and therefore has been removed from the CBLTC calculation. All savings derived from the program are allocated to Acute Care.
- HB 10-1146 State Funded Public Assistance Programs: This bill clarifies that persons currently receiving both Home Care Allowance program and Medicaid Home and Community Based Services benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010. While the Department anticipated an increase in HCBS enrollment as a result of this bill, implementation of the project has been delayed. DHS has assumed responsibility for payment to SEPs for enrollment of clients into the HCA program but system changes necessary to move clients into solely HCBS waivers are still in progress. The Department anticipates these changes will be made to allow the complete shift by FY 2011-12. Therefore, the cost estimate to CBLTC for this bill has been shifted to FY 2011-12.

***Prior Year Expenditure***

As an additional reasonableness check, the Department has split FY 2009-10 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

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

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% (through the FY 2009-10 total) since FY 1999-00. This is due to efforts by the Department to place clients in Home and Community Based Services (HCBS), and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Recent history indicates the rate of decline is slowing.

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

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facilities which do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

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

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

For complete information regarding specific calculations, the footnotes in pages EH-4 through EH-7 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows<sup>2</sup>:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2010-11.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment for claims that will be incurred in FY 2010-11. 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 2010-11 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2010-11.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2010-11.
- Of the estimated total reimbursement for claims incurred in FY 2010-11, only a portion of those claims will be paid in FY 2010-11. The remainder is assumed to be paid in FY 2011-12. The Department estimates that 92.89% of claims incurred in FY 2010-

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<sup>2</sup> For clarity, FY 2010-11 is used as an example. The estimate for FY 2011-12 is based on the estimate for FY 2010-11, and follows the same methodology.

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11 will also be paid during FY 2010-11. Footnote 5 details the calculation of the percentage of claims that will be incurred and paid in FY 2010-11.

- During FY 2010-11, the Department will also pay for some claims incurred during FY 2009-10 and prior years (“prior year claims”). In Footnote 6, the Department applies the percentages calculated in Footnote 5 to claims incurred during FY 2009-10 to calculate an estimate of outstanding claims to be paid in FY 2010-11.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2010-11 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program and out of state placements, estimated estate and income trust recoveries, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 6 through 9.
- Legislative impacts are added as bottom-line adjustments. For FY 2010-11, this includes HB 10-1324, which introduced a 1.5% rate reduction effective March 1, 2009. Additionally, HB 10-1379 introduced an additional 1% rate reduction effective July, 1 2010.
- Once the “non-rate” factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2010-11 expenditure.

For FY 2011-12, the same methodology is applied, taking into account the estimate for FY 2010-11.

*Legislative Impacts and Bottom-Line Adjustments*

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2010-11 and FY 2011-12 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2010-11 and FY 2011-12. Please refer to footnote 7 on page EH-6 for more detail.
- Prior to FY 2010-11 the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2010-11 and FY 2011-12. Footnote 9 on page EH-7 contains additional detail about these recoveries.
- FY 2010-11 BRI-2: Coordinated Payment and Payment Reform – Expand Audits Performed by the Nursing Facilities Section adds an additional auditor to the Nursing Facilities Section to increase Department recoveries.

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- HB 10-1324 resulted in a rate reduction to Class I nursing facilities of 1.5% effective March 1, 2010 and continuing through June 30, 2011. Due to a portion of claims for both FY 2009-10 and FY 2010-11 not being paid in the fiscal year in which they are incurred, the fiscal impact of this bill extends into FY 2011-12. Footnote 10 on page EH-7 contains additional detail regarding the fiscal impact of this bill.
- HB 10-1379 resulted in a rate reduction to Class I nursing facilities of an additional 1% above HB 10-1324 reductions effective July 1, 2010 and continuing through June 30, 2011. Due to a portion of claims for FY 2010-11 not being paid in the fiscal year in which they are incurred, the fiscal impact of this bill extends into FY 2011-12. Additionally, this bill reduced the maximum allowable general fund growth cap to 1.9%. The general fund growth cap reduction is not included in the bottom line impacts as it is incorporated into the base calculation of the core component rate. To include it as a bottom line reduction would double count the impact. Additional detail regarding the fiscal impact of the rate reduction can be found in Footnote 10 on page EH-7.

*Incurred But Not Reported Adjustments*

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

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

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department’s estimate of claims paid in the current year for current year dates of service, particularly footnotes 5 and 6 of Exhibit H, page EH-4. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2010-11 which will be paid in FY 2010-11, and the percentage of claims incurred in FY 2010-11 which will be paid in FY 2011-12 and subsequent years. The Department applies the same factor to the FY 2011-12 estimate.

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The Department uses the IBNR adjustment calculation for the November 2010 Budget Request, using paid claims data through December 2010. For reference, the following table lists IBNR factors calculated over the previous four Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting that there is a decreasing lag time between the date of service and the payment of a typical claim.

<b>Date of Change Request:</b>	<b>IBNR Factor:</b>
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009, November 2009, February 2010	92.27%
November 2010	92.89%
February 2011	92.46%

*Patient Days Forecast Model*

To forecast patient days, the Department selected a seasonal, auto-regressive model with a linear trend. This model was selected because the data exhibits monthly seasonality and follow a trend over time. In addition, the value in a given month is partially a function of the value in the previous month; this is represented by an auto-regressive term in the forecasting model.

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. Second, the stationarity of the model needs to be tested to determine the validity of the forecasts. A non-stationary time series cannot be forecast without additional manipulation to the data. The Department tested for stationarity by performing a Dickey-Fuller unit root test. In this test, the first difference of the values predicted by the forecast model are a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the lagged term is the calculated d-statistic. This is compared again the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation, and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Testing the Overall Predictive Ability of the Model

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

Testing the Stationarity of the Model

The second set of statistics test the stationarity of the models. This is important, because if a model is not stationary, it cannot be used to predict values for time periods outside of the period represented by the actual data. The Department tested stationarity by performing a Dickey-Fuller unit root test. Theoretically, this test checks to see if the predictive components defined in the forecasting model are actually generating random predictions even though the overall model is statistically significant. With any model, a portion of the predicted value will be random. So, while having a random element in the model is not in itself a problem; stationarity issues result from a model in which the components assumed to be generating defined results are actually generating random results.

Technically, the test is performed by creating a model where the first difference (the current month minus the previous month's value) of each value predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The corresponding coefficient from this regression can be used to test for a unit root. The Department utilized EViews statistical analysis software to test for a unit root in the FTE series. The result is summarized in the following table:

<b>Augmented Dickey-Fuller Unit Root Test of Stationarity</b>		
	<b>T-Statistic</b>	<b>P-Value</b>
Augmented Dickey-Fuller Test Statistic	<b>-3.5989</b>	<b>0.0389</b>
Conclusion: Reject that null hypothesis that there is a unit root at the 95 percent confidence level. An auto-regressive model can be used with this series.		

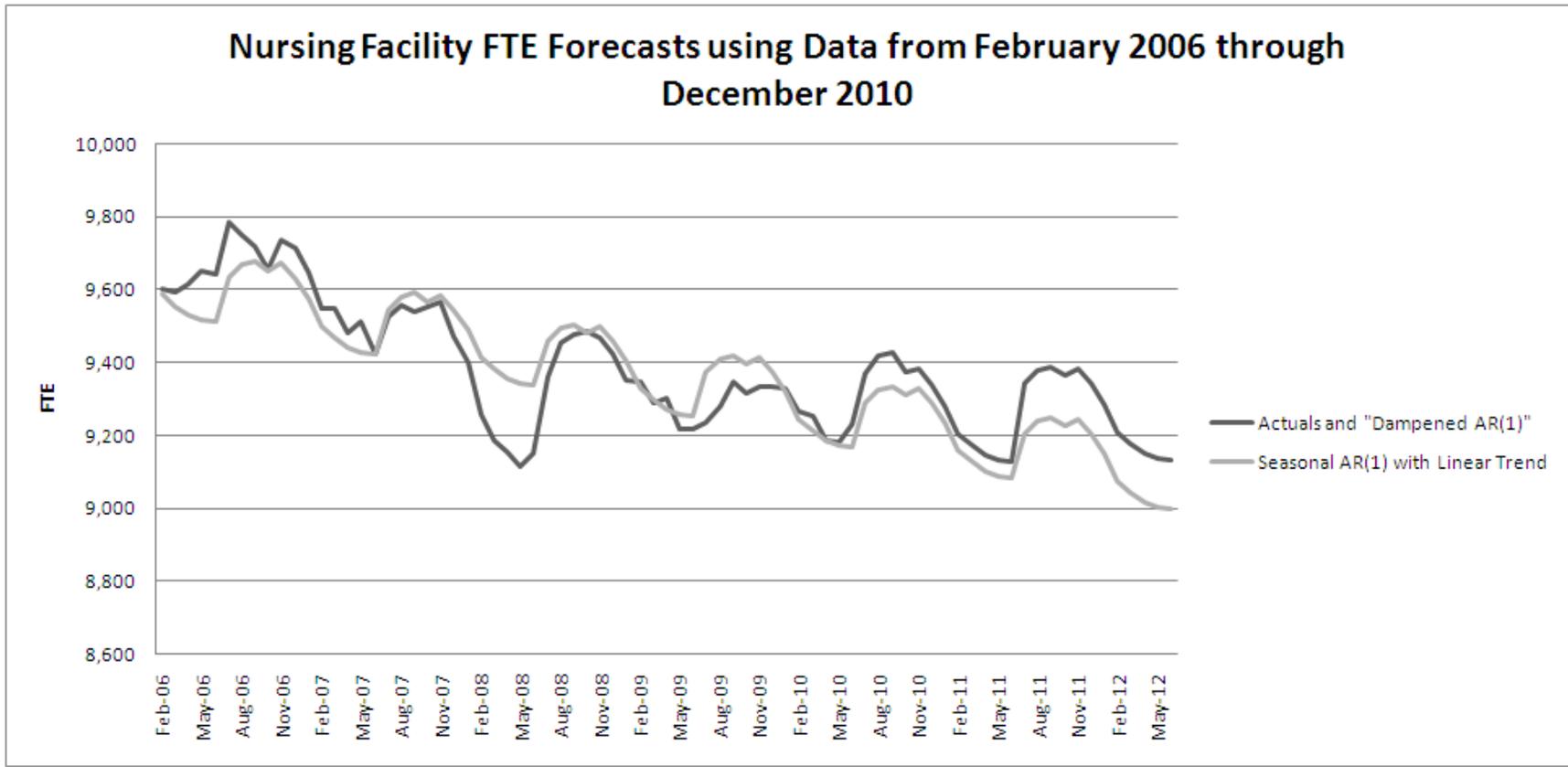
Forecasting Patient Days

Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the number of FTEs, full time equivalent days. Trending is done using the FTEs, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month.

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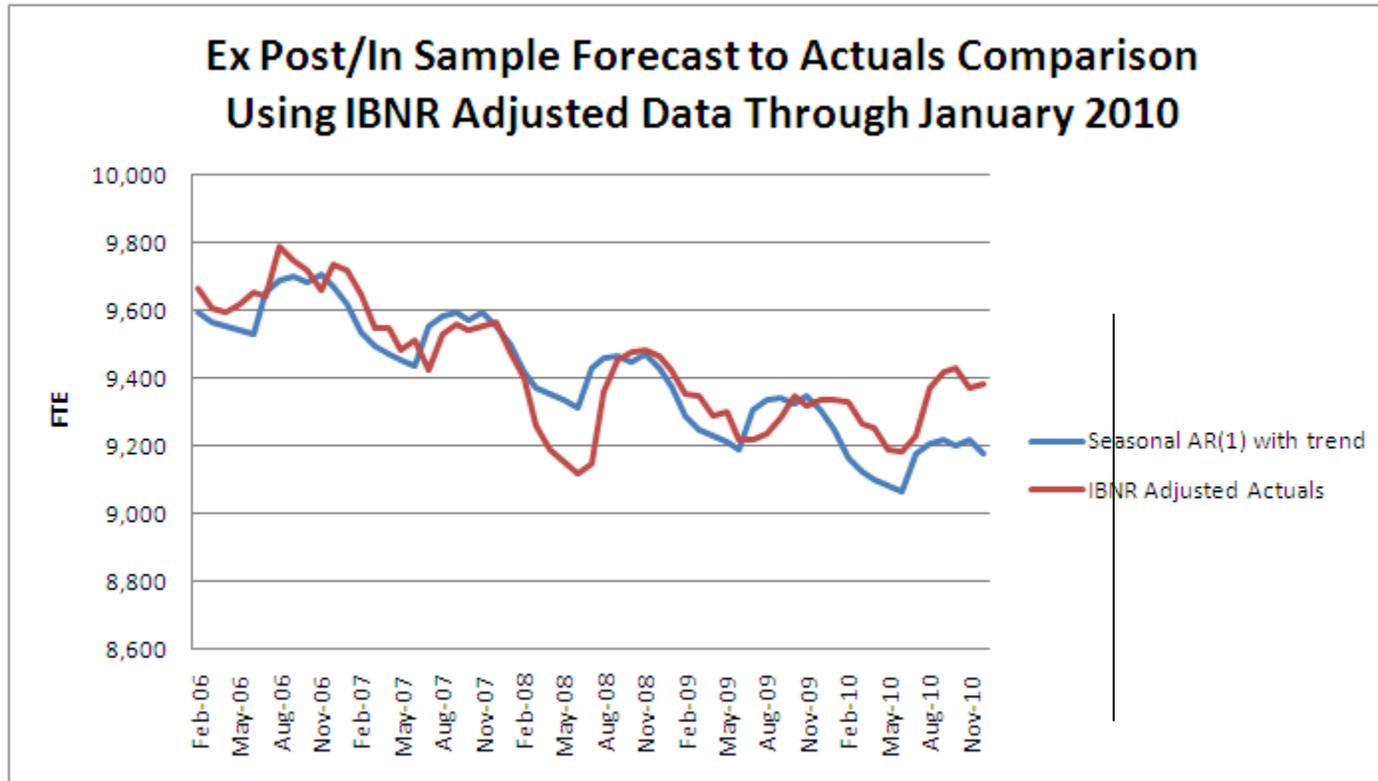
The declining trend in patient days is consistent with Department program policies; clients are enrolled in home care or alternative care facilities rather than nursing facilities, if appropriate. From FY 2005-06 to FY 2009-10, the average annual patient days decreased by -5.02%. From FY 2005-06 to FY 2009-10, home and community-based services average monthly paid enrollment was up approximately 29.61% (from 14,640).

The Department believes that the pronounced negative trend observed in recent data will carry forward into FY 2010-11 and FY 2011-12, but at a dampened rate. Data through December 2010 indicate the declining trend in class I nursing facility days is slowing significantly. Therefore, the Department utilizes the seasonal and autoregressive components of the forecast model, but dampens the forecast by 0.5% in FY 2010-11 and 1% in FY 2011-12. The dampening factor has the result of increasing the forecast FTEs above the results of the model. The graph below shows actual FTEs, the seasonal auto-regressive model with trend, and the seasonal auto-regressive model with trend and in has forecasted values which are dampened.



Ex Post/In-sample Forecasts

As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from January 2006 through January 2010) and compared the results to actual data reported for January 2010 through November 2010.



With an p-value of 0.0000, the ex post forecast is statistically significant at the 99% confidence level; the model’s adjusted R-squared of 0.92 indicates that 92% of the variation in the FTE series can be explained by the model. As a test of robustness, this suggests that the FTE series can be strongly predicted using a seasonal auto-regressive with trend model. It is of note that IBNR adjusted actuals

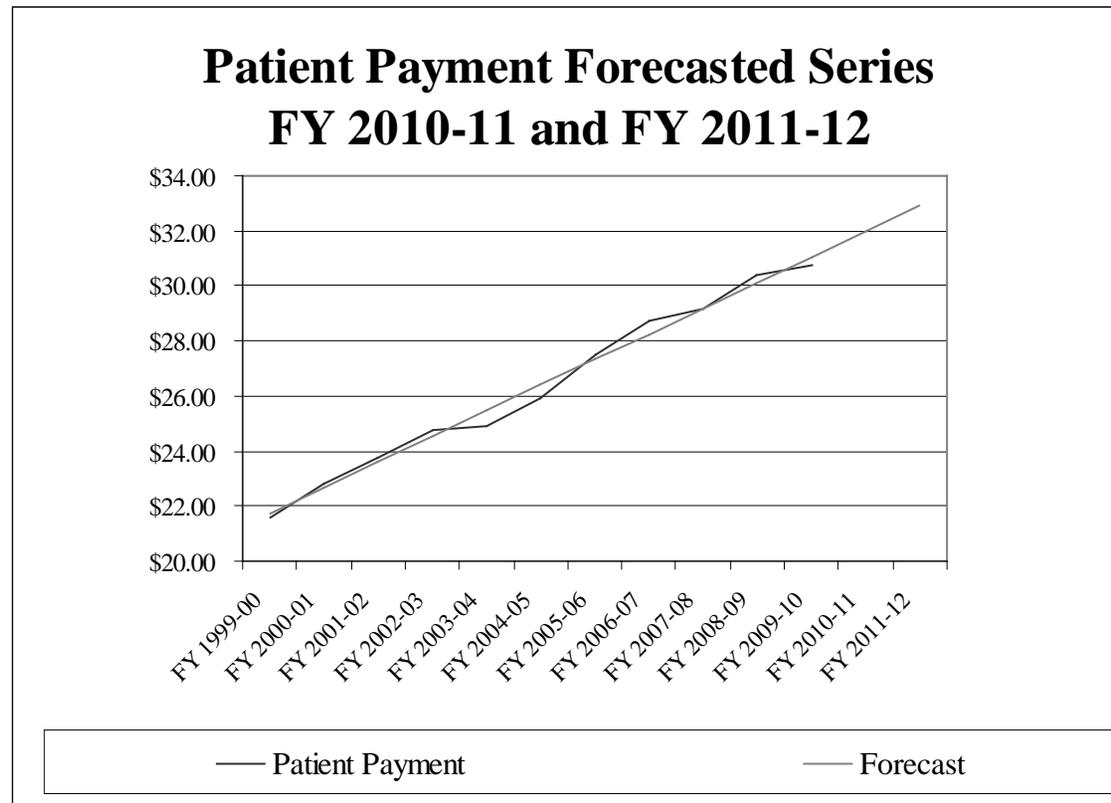
Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

series are consistently higher than the forecasted values for the period of omitted actuals. This supports the conclusion that the historical downward trend is diminishing.

*Patient Payment Forecast Model*

The FY 2008-09 patient payment data was adjusted for use in calculating projections; mass adjustments to all claims caused a number of claims which were originally 100% patient paid to have a portion of the payment paid by the Department. Claims for which the Department does not make a Medicaid payment are not included in the calculation of the effective per diem rate. When the mass-adjusted claims which were originally excluded from the calculation became part of the data set, the effective per diem rates were skewed by claims for individuals who would have been responsible for 100% of the claim before the mass adjustment. However, these claims could not be retroactively billed to the client, so the Department paid a small share of the claim; this share was covered by the nursing facility provider fee. In order to obtain an appropriate patient payment per diem rate for FY 2008-09, the Department backed out any claims which were originally 100% patient paid.

In previous submissions, patient payment was forecasted using a seasonal auto-regressive model with trend. Due to structural changes in the last fiscal year's monthly data series, the time series is no longer stationary, and an autoregressive process will no longer produce a statistically valid result. However, this series has historically demonstrated a strong linear relationship. As a result, the Department has selected a linear trend based on the annual average patient payment. The F-statistic and R-squared are presented as justification of the Department's selection of this model.



**Testing the Overall Predictive Ability of the Model**

Again utilizing the F-statistic, an analysis of the model’s overall statistical significance can be done. Like the patient days model, the patient payment model also has a p-value of 0.0000, and is statistically significant at the 99% confidence level. R-squared for the linear model is 0.989 suggesting that 98.9% of the variation in this series can be explained by the linear trend.

***Nursing Facility Rate Methodology Changes***

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

FY 1997-98 8% Health Care Cap and 6% Administrative Cap Implemented

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

FY 1998-99	No change
FY 1999-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 2000-01	No change
FY 2001-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
FY 2002-03	Administrative Incentive Allowance removed for three months then reinstated
FY 2004-05	8% Health Care Cap reinstated
FY 2005-06	No change
FY 2006-07	8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
FY 2007-08	Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
FY 2008-09	New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.
FY 2009-10	The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and, made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.
FY 2010-11	HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010 through June 30, 2011. This bill also reduced the maximum general funds portion of the core per diem rate to 1.9% growth for FY 2010-11.

***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-2. 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. Beginning in FY 1998-99, the service category was limited to one facility, Good Shepherd Lutheran. There are no plans to eliminate this facility as it essentially functions more like a group home than an institutional facility. At the end of FY 2005-06, Good Shepherd Lutheran increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility has remained constant. Additionally, this facility received an annual cost-based rate adjustment, similar to Class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. FY 2009-10 enrollment rates were slightly lower than in the previous year. The facility averaged between 18 and 19 clients. However, for FY 2010-11 and FY 2011-12 there the Department anticipates enrollment will return to the 20 client enrollment level. The estimated growth rates for FY 2010-11 and FY 2011-12 are the average of overall growth in expenditures from FY 2007-08 to FY 2008-09. Because all clients are paid the same rate regardless of aid category, it is anticipated that change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

Early in FY 2010-11, a class II nursing facility was found to be out of compliance with federal regulations. As a result, the Department has not been receiving a federal match on payments made to the facility since August 1, 2010. The facility has been placed under temporary management at the facility's expense. Pursuant to 42 CFR 483.400- 483.480 the facility must meet condition of participation in order to qualify for federal financial participation. With the temporary management in place, a new survey will be conducted in February of 2011. The Department anticipates that following the survey, the facility will again qualify for federal financial participation. Adjustments to fund splits can be found in Exhibit A.

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An additional adjustment is made to expenditure in FY 2010-11. Corrections to claims for facilities incorrectly classified as Class II nursing facilities resulted in significant under expenditure in FY 2009-10 and over expenditure in FY 2010-11. As this is a one-time adjustment, FY 2011-12 expenditure returns to historical levels.

***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-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

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

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

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

The FY 2010-11 projection for PACE is computed in several parts: First, the Department estimates the growth in the average enrollment, and applies the selected trend factor to the FY 2009-10 average enrollment. Estimated enrollment at new PACE providers, which are not reflected in historical trends, is added as a bottom-line adjustment. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2009-10 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2010-11 base expenditure. Then, the Department adjusts for any bottom-line impacts not incorporated in the trend (described below). The sum of the base expenditure and the bottom-line adjustments is the estimated FY 2010-11 total expenditure. FY 2011-12 is calculated in the same fashion.

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To estimate the increase in enrollment in FY 2010-11, the Department selected one third of the FY 2009-10 growth rate for Adults 65 and Older. For the Disabled Adults 60 to 64 category, 45.05% was selected to model a significant growth in actual enrollment from FY2009-10 to the first half of FY 2010-11. The trend for Disabled Individuals to age 59 aid category also represents the half year growth in enrollment from FY 2009-10 to the first half of FY 2010-11, 31.03%. The Department anticipates that enrollment in FY 2011-12 will be equal to additional enrollment from provider expansions, and therefore selected a trend of 0%.

To estimate the average increase in cost per enrollee in FY 2010-11, the Department selected the average percent increase in cost per enrollee between FY 2006-07 and FY 2009-10 for Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to age 59 aid categories. For FY 2011-12, the Department halved the FY 2010-11 trend selections.

In recent years, the Department has added a number of new PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in Spring 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. Total Longterm Care, the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo and is looking to expand facilities to additional locations in Spring 2011. The organization also plans to expand the current facility in the Brighton area; this is planned for Spring 2011.

### *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. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2010-11 and FY 2011-12 calculations for the Program of All-Inclusive Care for the Elderly (PACE):

- FY 2009-10 ES-2, Medicaid Program Reductions: This request included a reduction in fee-for-service reimbursement rates. This indirectly reduced the reimbursement rate paid for PACE for FY 2009-10, as PACE rates are based on the Department's fee-for-service rates. This annualized reduction is a bottom line adjustment for FY 2010-11.
- FY 2009-10 ES-6, Medicaid Program Reductions: This request included a reduction in fee-for-service reimbursement rates. This indirectly reduced the reimbursement rate paid for PACE for FY 2009-10, as PACE rates are based on the Department's fee-for-service rates. This annualized reduction is a bottom line adjustment for FY 2010-11.
- FY 2010-11 BRI-6, Medicaid Program Reductions: This request included a 1% reduction to Medicaid physical health provider rates for both FY 2010-11 and FY 2011-12, effective July 1, 2010. In addition, the request impacts the PACE program by imposing restrictions on certain durable medical equipment and restricting nursing facility per diem growth to 0% in FY 2010-11.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

- FY 2010-11 Reconciliation for Payments prior to FY 2009-10 Q1: The Department will pay one of its PACE providers a one-time reconciliation of \$3,000,000. This settlement adjusts for rates which were paid below the true cost of providing services due to erroneous patient payment reporting.
- FY 2010-11 Reconciliation for Payments between FY 2009-10 Q2 - Q4: The Department will pay one of its PACE providers a onetime settlement of \$3,014,310. This settlement adjusts for rates which were paid below the true cost of providing services due to erroneous patient payment reporting in FY 2009-10, quarters two through four (October 2009 through June 2010).

***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 have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B, and in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.<sup>3</sup> The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types, and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

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

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<sup>3</sup> 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.

Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

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:<sup>4</sup>

**History of Medicare Premiums**

<b>Calendar Year</b>	<b>Part A</b>	<b>% Change</b>	<b>Part B</b>	<b>% Change</b>
2003	\$316.00		\$58.70	
2004	\$343.00	8.54%	\$66.60	13.46%
2005	\$375.00	9.33%	\$78.20	17.42%
2006	\$393.00	4.80%	\$88.50	13.17%
2007	\$410.00	4.33%	\$93.50	5.65%
2008	\$423.00	3.17%	\$96.40	3.10%
2009	\$443.00	4.73%	\$96.40	0.00%
2010	\$461.00	4.06%	\$110.50	14.63%
2011	\$450.00	-2.39%	\$115.40	4.43%

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.

During FY 2007-08, the Department made its July 2007 payment for Medicare premiums several days late. As a result, Medicare automatically deducted the balance from the Department’s Medicaid grant. As a result, from the perspective of Medicare, the Department effectively double-paid July, and the difference became a credit against the September total. As a result, the total expenditure for this line does not reflect payment for one month, because the federal funds Medicare received directly from the Medicaid grant did not pass through the state’s accounting system. Therefore, in order to accurately project expenditure, the Department used the actual Medicare invoice totals for FY 2007-08 instead of the actual expenditure for FY 2007-08. This ensures that the projection base is not understated, which would lead to a material under-projection in the forecast.

<sup>4</sup> Premium information taken from the Centers for Medicare and Medicaid Services, <http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop>

## Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

To forecast FY 2010-11, the Department inflates the actual expenditure from the first half of FY 2010-11 by the increase in the Medicare premium, 4.43% in 2011, and the anticipated caseload growth from the first half of FY 2010-11 to the second half of FY 2010-11. The total estimated expenditure for FY 2010-11 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2011-12, the Department first inflates the estimated expenditure from the second half of FY 2010-11 by the estimated caseload trend for FY 2011-12 from Exhibit B, Caseload. This figure represents the approximate expenditure for the first half of FY 2011-12. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2011-12 is the sum of the first half and second half estimates.

### ***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. (2009). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB), for clients who do not qualify for the Medicare Part D benefit.

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

The Department selected 3.39%, the per capita growth rate between FY 2007-08 and FY 2009-10 to trend expenditure in FY 2010-11 for the Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), Eligible Children, Categorically Eligible Low-Income Adults (AFDC-A), and Baby Care Program Adults aid categories. All FY 2010-11 trend selections were held constant for FY 2011-12.

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*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. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2010-11 and FY 2011-12 calculations for the Health Insurance Buy-In Program:

- SB 10-167 Medicaid Efficiency and Colorado False Claims Act impacts the HIBI program in FY 2010-11 by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the state. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. This request is then annualized in FY 2011-12. The implementation of this program has been delayed to April 2011 to allow final contract negotiations. In April clients will be enrolled in the program at a rate of approximately 250 clients per month until the maximum of 2,000 clients is reached. The payment methodology for enrollment has also been adjusted from a contingency fee to a per member per month rate which will be paid to the contractor.

**EXHIBIT I – SERVICE MANAGEMENT**

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

***Summary of Service Management***

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

***Single Entry Points***

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to 25.5-6-105, C.R.S. (2009). A single entry point agency is an agency in a local community through which persons eighteen years or older, who are in need of long-term care services, can access needed long-term care services.

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home and Community Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home

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care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

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

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

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

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

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

Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

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

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

For FY 2010-11, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2010-11 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For FY 2011-12, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2006-07 through FY 2009-10 for the Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 aid categories. The overall HCBS utilization growth rate from FY 2008-09 to FY 2009-10 was selected to trend expenditure for the remaining aid categories; Categorically Eligible Low-Income Adults, Eligible Children, Foster Care, Non-Citizen, and Partial Dual Eligibles. The estimated FY 2010-11 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2011-12 expenditure.

### *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. For complete information on legislative impacts, see section V, Additional

## Line Item Description: Medical Services Premiums and Medicaid Mental Health Community Programs

Calculation Considerations. The following impacts have been included in the FY 2010-11 and FY 2011-12 calculations for Single Entry Points:

- FY 2009-10 ES-2: Medicaid Program Reductions: This request included a 1.5% reduction in the reimbursement rate paid for Single Entry Points for FY 2009-10. This reduction is annualized as a bottom line adjustment for FY 2010-11.
- FY 2009-10 ES-6: Provider Rate Reductions: This request included a 1.0% reduction in the reimbursement rate paid for Single Entry Points for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, the annualized impact is a bottom line adjustment for FY 2010-11.
- FY 2010-11 BRI-6, Medicaid Program Reductions: This request included a 1% reduction to single entry points effective July 1, 2010.
- HB 10-1146 State Funded Public Assistance Programs: This bill clarifies persons currently receiving both Home Care Allowance program and Medicaid Home and Community Based Services benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010.

### *Disease Management*

Beginning in July 2002 the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized “to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases” (25.5-5-316, C.R.S. (2009)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

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

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

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

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma; congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD); high risk obstetrics; and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117 (2) (d) (IV.5), C.R.S. (2009), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

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

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2010) (further described in Exhibit A). The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered amount of \$63,488 is included in the FY 2009-10 request. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

In the estimate of expenditure for FY 2011-12, the Department requests \$500,000 total funds to continue its Adult Medical Home pilot program. Although currently funded through the Department's Health Resources and Services Administration (HRSA) grant, the state share for this program would be paid for from the Prevention, Early Detection, and Treatment funds described above.

### ***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

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

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care. Because the administrative fees remain the same in FY 2010-11 and FY 2011-12, the Department has used actual enrollment in its current administrative service organizations to forecast expenditure in FY 2010-11 and FY 2011-12 for programs with available enrollment data (Rocky Mountain Health Plans and Colorado Access) and its projections for capped enrollment for the newest programs, as described below. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group; for this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The shift to an ASO did not affect enrollment trends, however, allowing the Department to use enrollment data from the program's inception in June 2008 to the present to forecast future enrollment. The contract for Colorado Access in the CRICC program will expire on June 30, 2011, at which time all of the clients in the program will be disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access will be completed and available to the Department at the beginning of 2012.

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Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. To forecast future enrollment, the Department averaged the expected capped enrollment by month for the current and request years. At the end of FY 2009-10, the Department had not yet paid for the last four months of administrative fees incurred in that fiscal year, and as a result, the payments for these months were made in FY 2010-11. The Department assumes that the payments are now caught up to the point where the lag time between month of service and month paid is only one month. For this reason, it is assumed that the Department will make payments to Kaiser for fifteen months of case management fees in FY 2010-11, including four from FY 2009-10 plus eleven from FY 2010-11. It is assumed that the payments will continue to be lagged by one month in FY 2011-12, resulting in twelve months of payments to be made in FY 2011-12 (one from FY 2010-11 plus eleven from FY 2011-12). Kaiser will continue to serve CRICC clients until June 30, 2012, when its part of the pilot program will end. MDRC is currently studying the effectiveness of the program at Kaiser, and will complete the evaluation for the Department at the beginning of 2013.

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64, designed to provide a network of services that are high-quality and cost effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. Similar to Kaiser, the claims for CAHI are not paid for through the MMIS, preventing the Department from forecasting enrollment based on actual clients served by month. The enrollment forecasts for FY 2010-11 and FY 2011-12 were based on the Department's estimate of when periods of passive enrollment would take place and how many clients the provider would be allowed to enroll, as well as its brief historical experience of how many clients were enrolled from January to December of 2010. The payments to CAHI were lagged by one month at the end of FY 2009-10, and they continued to be lagged in the first two quarters of FY 2010-11. The Department assumes that there will be a one-month lag in payment at the end of FY 2010-11, resulting in payments of twelve months in that fiscal year, including one from FY 2009-10 plus eleven from FY 2010-11. Similarly, it is assumed that the Department will make payments for twelve months in FY 2011-12 (one from FY 2010-11 plus eleven from FY 2011-12).

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6, "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5, "Accountable Care Collaborative." The cost savings estimated for this program are included in acute care; please see Exhibit F and Section V for more information on its impact to acute care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2010-11 include \$750,000 paid to the SDAC, \$12.00 PMPM paid to the RCCOs, and \$3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month. The fees in FY 2011-12 include \$3,000,000 paid to the SDAC; \$12.00 PMPM paid to the RCCOs; \$3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, with the exception of children, for whom providers will only be paid \$1.23 PMPM; and a \$2.00 monthly incentive payment divided between the providers and the RCCOs. The Department plans to begin enrolling clients into RCCOs in April 2011 and reach

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full enrollment of 60,000 clients by July 2011. Enrollment and PMPM figures reflect the Department's implementation plan and were used to forecast expenditure directly instead of including the ACC as a bottom line impact.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans for cost avoidance in FY 2005-06 through FY 2008-09. During FY 2007-08, the Department and Rocky Mountain Health Plans were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was paid. At that time, the Department anticipated that it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09, with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. The FY 2009-10 figure was estimated based on the percentage enrollment increase of 1.37% in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). Concurrent with the project to include all encounter data in the MMIS system, the Department has adopted a new payment methodology effective FY 2009-10. This change is directed by HB 07-1346. Under the new methodology, the annual cost avoidance payments are no longer made, and payments for administrative fees are recorded on a cash-accounting basis.

The Department holds the estimated amount of cost avoidance for the contract years FY 2005-06 and FY 2006-07 constant from prior budget requests. This bottom line adjustment of \$943,802 is projected to impact FY 2010-11. The estimated amount of cost avoidance for the contract years FY 2007-08 and FY 2008-09 is estimated as the amount originally estimated for FY 2007-08 in the February Request. Since there may or may not be cost avoidance savings realized for these years, the Department holds the FY 2007-08 figure constant at \$956,606, though now as an estimate of the cost avoidance amount both years, and projects a FY 2011-12 impact.

The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

*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. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2010-11 and FY 2011-12 calculations for Prepaid Inpatient Health Plan Administration:

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- In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.
- FY 2010-11 ES-2: Medicaid Program Reductions: This request included a 1.5% reduction in the reimbursement rate paid to Rocky Mountain Health Plans for FY 2009-10, which was implemented on September 1, 2009. FY 2010-11 ES-6, “Medicaid Provider Rate Reductions” included an additional 1.0% reduction to the reimbursement rate paid to Rocky Mountain and was implemented on December 1, 2009. Since expenditure was calculated using the actual rate paid to Rocky Mountain for FY 2010-11 and FY 2011-12, this adjustment is already implicitly accounted for in the expenditure calculation.

**EXHIBIT J - CASH FUNDED EXPANSION POPULATIONS**

***Summary of Cash Funded Expansion Populations***

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

***Health Care Expansion Fund Populations***

The Health Care Expansion Fund is administered by the Department. Items funded include 1) the additional Categorically Eligible Low-Income Adults and Eligible Children estimated to become eligible for Medicaid due to the removal of the Medicaid asset test, 2) expansion of child enrollment under the Children’s Home and Community Based Services Waiver and the Children’s Extensive Support Waiver programs, 3) Medicaid for legal immigrants, 4) increased Eligible Children due to the impact from marketing the Children’s Basic Health, 5) providing presumptive eligibility to pregnant women in Medicaid, 6) parents of children enrolled in Medicaid or the Children’s Basic Health Plan from 36% to least 60% of the federal poverty level, and 7) additional foster care clients between 18 and 21 years of age eligible for Medicaid immediately prior to their 18<sup>th</sup> birthday. The request differs from the analysis in the fiscal note due to updating the per capita costs and caseload estimates to those in the request. The total for each program is listed in the table below. Following the tables are short descriptions for each of the programs.

Health Care Expansion Fund Programs	FY 2010-11		FY 2011-12	
	Total Funds	Health Care Expansion Fund	Total Funds	Health Care Expansion Fund
Expansion Adults	\$56,039,634	\$22,594,159	\$62,092,831	\$31,046,416
Expansion Foster Care	\$3,031,041	\$1,221,206	\$3,544,874	\$1,772,437
Presumptive Eligibility	\$3,297,213	\$1,328,447	\$3,360,531	\$1,680,266
Legal Immigrants	\$31,591,134	\$12,728,068	\$35,031,065	\$17,515,533

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Health Care Expansion Fund Programs	FY 2010-11		FY 2011-12	
	Total Funds	Health Care Expansion Fund	Total Funds	Health Care Expansion Fund
Removal of Medicaid Asset Test	\$71,778,355	\$28,919,499	\$76,036,922	\$38,018,461
Children's Home and Community Based Services	\$21,672,941	\$8,732,028	\$21,206,972	\$10,603,486
Children's Extensive Support	\$3,490,718	\$1,406,410	\$3,415,644	\$1,707,822
<b>Total*</b>	<b>\$190,901,036</b>	<b>\$76,929,817</b>	<b>\$204,688,839</b>	<b>\$102,344,421</b>

The Department’s projections for presumptive eligibility, legal immigrants, the removal of the Medicaid asset test (adult and children expansion), Children’s Home and Community Based Services, and Children’s Extensive Support are described in detail in the Tobacco Tax Update included with of this Budget Request.

Expansion Adults

Eligibility for low-income adults was expanded to 60% of the federal poverty level via HB 05-1262. These clients do not qualify as Categorically Eligible Low-Income Adults (AFDC-A), which has an income limit of approximately 29% of the federal poverty level, and have a child that is Medicaid eligible. This population receives the full Family Medicaid benefits package, and is forecast as part of the standard per capita development in Exhibits F, G, H, and I.

Expansion Foster Care

Foster care eligibility was extended to children up to age 21 via SB 07-002 and SB 08-099. The Department began forecasting costs for these clients separately from the traditional Foster Care population as of this Budget Request due to substantial differences in the service utilization patterns between the two populations. In forecasting caseload and per capita costs for this population using historical expenditure data and enrollment levels, the Department assumes that this population is still in the ramp-up phase of program implementation. Therefore, per capita cost and caseload growth rates are expected to exceed those projected for the traditional Foster Care population until at least FY 2011-12.

Presumptive Eligibility

The Department discontinued Medicaid presumptive eligibility on September 1, 2004. Pursuant to HB 05-1262 the Department reinstated the presumptive eligibility process, effective July 1, 2005. Similar to the Children’s Basic Health Plan, presumptive eligibility for Medicaid was handled through the State’s self-funded network through December 2007. To be eligible for presumptive eligibility, a woman shall have a verified pregnancy, declare that her household's income shall not exceed 133% of federal poverty level and declare that she is a United States citizen or a documented immigrant. Eligibility for Medicaid must be determined by the county within 45 days of application. Once eligibility is determined, the client will be taken off presumptive eligibility and may go to

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fee-for-service or another Medicaid health maintenance organization. Previously, the Department made payments to the Children's Basic Health Plan Third Party Administrator that managed the State's self-funded network based on the estimated cost per client per month. Effective January 2008, clients who receive presumptive eligibility are being accounted for through the Medicaid Management Information System.

Using the normalized data, the Department has projected caseload for FY 2010-11 and FY 2011-12 using historical enrollment figures. Expenditure is projected using the current average monthly cost multiplied by the monthly caseload. The Department has forecasted expenditure based on historical monthly expenditure and caseload.

### Optional Legal Immigrants

Citizenship status is collected to determine which applicants are categorized as legal immigrants versus illegal immigrants in the Colorado Benefits Management System. Illegal immigrants have no documentation and are eligible for emergency services only. Legal immigrants with 5 or more years of residency and 40 or more work quarters are categorized as a mandatory Medicaid population and receive full benefits, provided they meet the eligibility requirements other than citizenship status. Optional Medicaid legal immigrants (those who have 5 years of residency but less than 40 work quarters) also receive full medical benefits. When SB 03-176 passed, it was intended to eliminate full Medicaid benefits for optional legal immigrants and provide emergency services only. However, SB 03-176 was never implemented and these clients did not lose their full Medicaid benefits. HB 05-1086 reinstated the benefits for these optional legal immigrants and a provision was added to HB 05-1262 to provide funding from the Health Care Expansion Fund on an ongoing basis. Due to the reinstatement of services to legal immigrants granted by HB 05-1086, \$2,638,343 was funded through the Health Care Expansion Fund for FY 2004-05. Effective August 2007, the Department implemented system changes enabling it to track actual expenditures and monthly enrollment levels for the Optional Legal Immigrants population.

### Removal of the Medicaid Asset Test

Effective July 1, 2006, the asset test no longer applies to children and adults. As a result, clients who were previously ineligible for Medicaid became Medicaid eligible. Additionally, clients who were previously eligible for the Children's Basic Health Plan may now qualify for Medicaid. During FY 2006-07, the Department began to receive data on clients who are affected by the removal of the asset test. Currently, however, the Department's reporting only identifies total expenditure and not expenditure by eligibility category. The Department has forecasted expenditure based on historical monthly expenditure and known caseload.

Because the Department is no longer able to request asset test information for individuals who are not applying for Medicaid and other financial assistance programs, the asset test removal population has been difficult to track. Changes to the Colorado Benefits Management System allow for all individuals applying for Medicaid benefits to be marked with a flag that reports the following: whether the client would have been eligible for Medicaid regardless of the asset test removal; if the client would not qualify for Medicaid if the asset test was still in place; or, if it is unknown whether the client's assets are a factor in determining eligibility.

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Circumstances where this information may not be known include: existing clients who have not gone through a yearly re-determination, or clients who are not required to provide asset information as a result of not applying for other public assistance programs.

For clients who have not provided asset test information, the Department transfers funds from the Health Care Expansion Fund under the assumption that a number of clients who have not reported asset information would not have qualified for Medicaid prior to the rule change. In previous years the Department assumed that of the clients who had not reported asset information, the proportion of these clients who would not have qualified prior to the change was the same as the proportion of clients who had reported asset information and would not have qualified. However, based on analysis performed in FY 2007-08, the number of clients who have reported asset information is well below the original levels anticipated. Therefore, starting in FY 2007-08, the Department has revised the methodology used to allocate expenditure for clients who have not reported asset information. The Department's preliminary research indicates that clients who gained eligibility because of the removal of the asset test have significantly higher income on average than clients who would have qualified regardless of the change. Further, clients who have not reported asset information have significantly higher income than those clients who have reported asset information. Based on this information, the Department believes that there is a significant under-reporting bias in the eligibility data, in that clients who have higher income are less likely to provide asset information.

Given the under-reporting bias, the Department does not believe that it is appropriate to use the strict ratio of clients who would not have qualified to the total population who have reported asset information. Rather, the Department has used that ratio as a base, and inflated it by 100%. This figure is a rough estimate, based on the average difference in incomes between clients who have reported asset information but would not have previously qualified for Medicaid and those that have not provided asset information. Because the results are preliminary, the Department has made a number of assumptions to ensure that the estimate is conservative and reasonable, and has rounded the figure because of the inherent uncertainty of this projection.

The methodology used to forecast costs for these clients assumes that similar patterns of caseload and per capita cost growth exist within eligibility types. The Department uses the executive forecasts of caseload and per capita growth rates amongst the eligibility types potentially affected by the removal of the asset test, weighted by the relative size of those populations, to project total expenditures for the removal of the asset test into future budget years.

### *Changes to the Medicaid Asset Test Allocation Methodology*

Beginning in June 2010, it came to the Department's attention that expenditures for the removal of the Medicaid asset test, which is funded through the Health Care Expansion Fund, began decreasing. Between the quarter ending March 31, 2010 and quarter ending December 31, 2010, quarterly expenditures decreased from \$19,471,945 total funds to \$7,624,377, a 60.8% decrease over three

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quarters. The Department believes that this may be an unintended outcome of the implementation of the eligibility expansion for Medicaid parents effective May 1, 2010. The Department is still investigating the cause of these decreases in order to more accurately forecast asset test expenditures. As such, the Department and the Office of State Planning and Budgeting have decided to keep asset test transfers at the levels forecasted in the November 1, 2010 Budget Request.

### Children's Home and Community Based Services and the Children's Extensive Support Waiver Program Expansion

The Children's Home and Community Based Services (CHCBS) and the Children's Extensive Support (CES) waiver programs are programs that use Medicaid funds to serve children that would not qualify for Medicaid under standard eligibility criteria. The waiver programs waive eligibility requirements for certain populations and apply to receive federal matching funds for the program. Upon approval, the waiver programs are eligible to receive federal matching funds at the Medicaid defined rates for state expenditures. Once a child is on the waiver, he/she must receive at least one state-paid waiver service per month to remain on either of the Waiver programs.

In order to calculate the impact to the Health Care Expansion Fund, the Department calculates the average cost per waiver slot for each program, and multiplies that cost by the total number of slots. The CHCBS waiver has 678 waiver slots, and the CES waiver has 79 slots which are funded via the Health Care Expansion Fund. For the CES waiver, waiver costs are not charged against the Medical Services Premiums Long Bill group; rather, those costs are borne by the Department of Human Services.

In FY 2007-08, the Department changed the methodology to account for the CHCBS waiver slots. In previous years, the Department considered each waiver slot as numbered sequentially; that is, the "last" 678 slots were considered expansion slots. This had the result of effectively reducing the total number of waiver slots eligible for Tobacco Tax funding, as there are delays in filling waiver slots when those slots become available. In its February 15, 2008 Budget Request, the Department requested to move to the methodology described above, where the average per capita cost per slot was used to determine the total expenditure. The Joint Budget Committee approved the Department's methodology during Figure Setting in March 2008. Effective with FY 2008-09, the Department began applying this methodology to the CES waiver program as well.

### ***Hospital Provider Fee Funded Populations***

HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs and using the combined funds to: (I) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; (II) increase the number of persons covered by public medical assistance; and (III) pay the administrative costs to the Department in implementing and administering the program. The Department received federal approval for the Hospital Provider Fee model in March 2010, and clients began to enroll in expansion programs in April 2010.

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The Department began enrolling new clients into Medicaid beginning in May 2010. The populations, described, below, will be funded through two State cash funds, the Hospital Provider Fee Fund and the Medicaid Buy-in Fund, and any matching federal funds.

**Hospital Provider Fee Fund**

HB 09-1293 established this fund which provides for the costs of administering Medicaid programs to the three HB 09-1293 expansion populations that impact the Medical Services Premiums budget (a fourth expansion population will impact a new line item in the (4) Indigent Care Program long bill group, and a fifth expansion population impacts the CHP+ program):

Expansion Adults to 100%

While the Health Care Expansion Fund provides funding for parents of children enrolled in Medicaid from approximately 29% to least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund covers expenditures for parents from 61% to 100% of the federal poverty level. This expansion population receives the standard Medicaid benefits. Eligibility for this population under Medicaid was effective May 1, 2010.

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

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

Continuous Eligibility for Medicaid Children: Family Medical Program and Foster Care

The Department anticipates providing 12 months of guaranteed eligibility to children in Medicaid beginning in February 2012. The Department assumes that it would be necessary to revise its State Medical Services Board rules as well as submit a state plan amendment.

The Department assumes that with 12-month guaranteed eligibility in Medicaid, the average length of stay in Medicaid and the Children's Basic Health Plan would equalize at a lower level than experienced by children currently in Children's Basic Health Plan. This is due to children being able to move between the programs within the same 12-month guaranteed period, which would result in a slightly lower average length of stay in both programs.

The Department assumes that fee-for-service costs for these additional months of service would be lower than the current Medical Services Premiums per capitas. The current per capitas do not assume 12-months of guaranteed eligibility. Low-income clients are assumed to have a pent up demand for services, which drives higher per capita costs at the beginning of their eligibility period. For the additional months created by 12-month guaranteed eligibility, these higher cost services are assumed to be resolved, and the per

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capita should decline. To account for this, the Department has reduced the Eligible Children and Foster Care Medical Services Premiums per capita costs by 25%.

**Medicaid Buy-in Fund**

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

Buy-in for Individuals with Disabilities

Disabled individuals with income up to 450% of the federal poverty level would become eligible to purchase Medicaid benefits beginning in July 2011. The Department assumes that it would be necessary to revise its State Medical Services Board rules, and seek appropriate federal approval in order to establish the proposed Medicaid Disabled Buy-in program.

To project caseload for this population, the Department utilized data from the Colorado Health Institute and the American Community Survey on economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed a baseline enrollment rate for this reduced eligible population of 80%, which reflects historical population figures concerning the eligible but not enrolled population. Furthermore, the Department assumes that as individuals' incomes increase, they will be more likely to obtain their own insurance through other sources than buy in to the program. As the premium contribution from enrolled clients will be a percentage of their income, with increases in income the incentive to purchase alternative coverage will be reinforced, decreasing caseload in higher income tiers.

The Department assumes that the Medical Services Premiums for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department assumes that the Mental Health per capita for the Buy-In program would be equivalent to that for Medicaid Disabled Individuals to 59, and the Medical Services Premiums per capita is adjusted based on the following assumptions:

- The Department assumes that there would be proportionally fewer children in the Buy-In program than in the current Medicaid Disabled Individuals to 59 (AND/AB) population. Parental income is not included in the determination of eligibility for children's waivers, so there should be few high income children that would not already be eligible. On average, children exhibit higher costs than adults, so the per capita is decreased based on the costs of adults in Disabled Individuals to 59 compared to the total per capita.

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- The Department assumes that most clients in the Buy-In program will have lower utilization of many Home and Community Based Services waivers and other Long Term Care services. The Department assumes that few individuals with the ability to work would meet the level of care for either a waiver or nursing facility. In addition, clients that are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. The Medicaid Disabled Individuals to 59 per capita is decreased by 25%, which is the proportion of total expenditures for Medicaid Disabled Individuals to 59 that were for Home and Community Based Services waivers and other Long Term Care services, excluding Private Duty Nursing, Hospice, Program of All-Inclusive Care for the Elderly, and Supplemental Medicare Insurance Benefit, all of which the Department assumes these clients may utilize. This adjustment is applied to the total per capita rather than at the service category level, and the Department will research this methodology for its February 2011 budget submission.

Hospital Provider Fee Programs	FY 2010-11		FY 2011-12	
	Total Funds	Cash Funds	Total Funds	Cash Funds
Expansion Adults to 100%	\$93,212,740	\$37,555,413	\$97,638,082	\$48,819,041
Continuously Eligible Children: Family Medical Program	\$0	\$0	\$10,013,182	\$5,006,592
Continuously Eligible Children: Foster Care	\$0	\$0	\$1,122,771	\$561,386
Buy-in for Individuals with Disabilities	\$0	\$0	\$43,413,116	\$25,025,670
<b>Total</b>	<b>\$93,212,740</b>	<b>\$37,555,413</b>	<b>\$152,187,151</b>	<b>\$79,412,689</b>

**EXHIBIT K - UPPER PAYMENT LIMIT FINANCING**

The Upper Payment Limit financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State’s share of the expenditures.

The basic calculation for Upper Payment Limit 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

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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 Upper Payment Limit for outpatient hospital services are used to offset General Fund expenditures. These offsets started in FY 2001-02. Similar methodologies are used for home health and nursing home premiums. While outpatient hospital services and nursing facilities account for a large portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison, and will experience little impact related to changes in reimbursement rates.

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

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

During FY 2010-11, the Department will only be able to certify public expenditure up to the midpoint of CY 2010 for Outpatient Hospital services. This is due to HB 09-1293 which will allow the Department will use other state funds to draw federal funds to the upper payment limit. In future years, the Department will no longer be able to certify outpatient hospital expenditure.

Projections for all provider types are provided in Exhibit K.

**EXHIBIT L – DEPARTMENT RECOVERIES**

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

In addition to anticipated recovery revenue, Exhibit L also shows anticipated contingency fee to be paid to contractors for recovery efforts. 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.

**EXHIBIT M – CASH-BASED ACTUALS**

Actual final expenditure data by service category for the past eleven years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12 month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is the Medicaid Management Information System, Management and Administrative Reporting Subsystem report named the “REX01/COLD (MARS) 464600.” This report provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

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

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

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

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

Effective with the November 1, 2010 Budget Request, the Department has provided 3 pages for FY 2009-10 expenditure: cash-based actuals, the total amount delayed in FY 2009-10 as a result of a mandated payment delay, and the estimated FY 2009-10 expenditure adjusted for the payment delay.

While trying to recreate the past history of expenditures in a cash-based environment, some documents and spreadsheets with the history of adjustments were no longer available. There is a greater opportunity for manual adjustments in the Colorado Financial Reporting System that do not get recorded in the Medicaid Management Information System (MMIS) during the accounts payable period. This can skew the reconciliation between the Computer Output to Laser Disk (COLD) storage of Medicaid Management Information System report and the Colorado Financial Reporting System (COFRS).

**EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY**

Annual rates of change in medical services by service group from FY 1995-96 through FY 2008-09 final actual expenditures are included in this Budget Request for historical purpose and comparison. This exhibit has been revised to list more recent years first.

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

**EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS**

This exhibit displays the FY 2009-10 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2009-10 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

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

**EXHIBIT P – GLOBAL REASONABLENESS**

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. In addition, on page EP-3, this exhibit displays the FY 2009-10 year-to-date expenditures through September 2010 and the cash flow pattern of actual expenditures for the first quarter of FY 2008-09 to determine a rough estimate of FY 2009-10 expenditures, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends. Exceptions to the cash flow pattern are noted in footnotes on page EP-3.

**EXHIBIT Q – CASELOAD GRAPHS**

This exhibit is described in the Caseload Narrative.

**V. ADDITIONAL CALCULATION CONSIDERATIONS**

Several bills passed during the 2009 and 2010 legislative sessions affect the Department’s Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

***New Legislation and Impacts from FY 2010-11 Budget Cycle Requests***

This section describes the impact from legislation passed during the 2010 legislative session, and also includes impacts from the Department’s FY 2010-11 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

***HB 10-1005 - Concerning Home Health Care through Telemedicine Pursuant to the “Colorado Medical Assistance Act”***

HB 10-1005 alters the provision of home health telemedicine services established in SB 07-196. This bill asserts that telemedicine services are now eligible for Medicaid reimbursement, reimbursement rates are no longer required to be budget-neutral, reductions in travel costs by home health care and home and community-based service providers are no longer required to be considered when setting reimbursement rates, and incorrect references to the way reimbursement payments are made are removed.

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Additionally, payments of telemedicine reimbursements are contingent upon the receipt of gifts, grants, and donations in the newly created Home Health Telemedicine Cash Fund for FY 2010-11 and FY 2011-12. The bill increases Department expenditure \$123,270 in FY 2010-11, annualizing to \$312,572 in FY 2011-12.

As of December 2010 the Department has received sufficient donations to implement the telemedicine program. The Department anticipates client enrollment will begin in April 2011.

*HB 10-1033 - Concerning the Addition of Screening, Brief Intervention, and Referral to Treatment to Optional Services*

In 2006, the Governor's Office, and Departments of Human Services and Public Health and Environment were awarded a five-year \$2.8 million dollar grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), to implement a Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative in Colorado. The initiative teaches health care providers to use the ASSIST tool to conduct screenings for substance and tobacco use; provide brief interventions to persons with positive screening results; and make referrals for more extensive treatment where appropriate. The SBIRT protocol is currently being used in 12 clinics and hospitals in 9 Colorado counties. This bill adds screening, brief intervention, and referral for treatment for substance abuse to the list of optional services covered by Medicaid. The bill is estimated to increase Department expenditure \$870,155 in FY 2010-11, annualizing to \$1,230,285 in FY 2011-12. Billing codes for SBIRT services opened in December 2010 completing the implementation of the program.

*HB 10-1146 - Concerning State-funded Public Assistance Programs*

HB 10-1146 clarifies persons currently receiving both Home Care Allowance program and Medicaid Home and Community Based Services (HCBS) benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010.

As a result, the Department's appropriation was reduced by \$1,000,902 as it will no longer reimburse SEPs for HCA determinations (the Department of Human Services will assume that responsibility). Offsetting this decrease, the Department anticipates an increase in HCBS services of \$296,481 as clients who are currently receiving both HCA and HCBS benefits will shift to receiving HCBS services only.

Implementation of the bill has been partially delayed from the timeline in the fiscal note. The Department of Human Services has assumed responsibility for payment to SEPs for enrollment of clients into the HCA program but system changes necessary to move clients into solely HCBS waivers are still in progress. The Department anticipates these changes will be made to allow the complete

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shift by FY 2011-12. Therefore, the estimated cost for enrolling new clients in HCBS programs for this bill has been shifted to FY 2011-12.

The Department anticipates a reduction in total expenditure of \$1,000,902 in FY 2010-11 and an increase to total expenditure of \$234,124 in FY 2011-12.

*HB 10-1324 – Concerning Medicaid Nursing Facilities Per Diem Rates*

HB 10-1324 initiated a Class I Nursing Facility rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. This bill reduces Department expenditure \$8,416,927 in FY 2010-11. Due to issues related with claims runout, the Department has also estimated an FY 2011-12 impact to this bill which was not incorporated in the fiscal note. See Exhibit H, footnote 10 for further details.

*HB 10-1376 – FY 2010-11 Long Bill*

The FY 2010-11 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2010 Legislative Session which impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- *Evidence Guided Utilization Review (EGUR) (BA-12) and Prevention and Benefits for Enhanced Value (P-BEV) (BRI-1):* This Budget Reduction Item increases FY 2010-11 expenditure by an estimated \$282,653, with an additional \$481,092 in FY 2011-12, in order to provide increased utilization review funding in order to create an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures including fluoride treatment, and improve non-emergency medical transportation policies. Delayed implementation has shifted anticipated Medical Services Premiums savings from FY 2010-11 to FY 2011-12. FY 2011-12 savings total \$1,064,912.
- *Implementation of Family Planning Waiver (BA-16):* This funding will be used to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. Transferring this funding to the Department will allow for an enhanced federal financial participation rate of 90% to fund family planning services for uninsured, low-income Coloradans who would otherwise be receiving services funded by the unmatched General Fund dollars currently appropriated to the Department of Public Health and Environment. The implementation of the program has been delayed to FY 2011-12 to allow

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sufficient time for required CBMS and MMIS system changes and approval from the Centers for Medicare and Medicaid Services. Therefore, the Department has shifted costs of the program implementation from FY 2010-11 to FY 2011-12.

This Budget Reduction Item transfers \$190,350 in FY 2011-12 and an additional \$230,310 in FY 2012-13 from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds.

- *Coordinated Payment and Payment Reform (BRI-2)*: This budget reduction item reduces expenditure in FY 2010-11 and FY 2011-12 for both Acute Care Services and Community Based Long Term Care Services. The table below demonstrates these reductions by service category.

This budget reduction item implements proposed steps toward payment coordination and payment reform. This request included four proposed initiatives which work in tandem to serve the goal of lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care. The initiatives aim to consolidate payment and billing processes, expand audits conducted by the Nursing Facilities Section, initiate a pilot audit of a Community Mental Health Center, and increase enrollment of Medicare-eligible clients into Medicare. In addition, the Department is targeting three payment rate reform initiatives. The first, directed at Home and Community Based Services waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. A similar approach will be taken to investigate the potential to apply outcomes-based approach to the payment of physician payment rates. The third initiative targeted at changing the methodology of Federally Qualified Health Centers (FQHCs) payments aims to investigate the feasibility of creating an outcomes-based performance payment for FQHCs. Due to delay in implementation, the Department anticipates a portion of the FY 2010-11 savings will now be incurred in FY 2011-12.

FY 2010-11 BRI -2 Coordinated Payment and Payment Reform Request		
	FY 2010-11	FY 2011-12
Acute Care	(\$1,602,938)	(\$5,060,838)
Community Based Long Term Care	(\$210,775)	(\$616,405)
Total	(\$1,813,713)	(\$5,122,243)

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- *Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology (BRI-3):* This budget reduction item reduces FY 2010-11 expenditure \$2,206,076. The request reduces total funds as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. This will allow the Department to take advantage of an approved reimbursement methodology, increasing opportunities for reimbursement savings associated with pharmacy claims.
- *Medicaid Program Reductions (BRI-6):* This budget reduction item imposes restrictions on certain durable medical equipment and reduces Medicaid physical health provider rates by 1%.
  - *Limitation on Incontinence Products:* The Department would impose a 210-unit limit on incontinence products (down from the current limit of 240), and eliminate coverage for oral nutritional products for adults 21 years and older, although exceptions would be granted for individuals with innate errors of metabolism or malnourishment conditions. This Budget Reduction Item reduces Acute Care services expenditure \$637,311 in FY 2010-11 and an additional \$457,965 in FY 2011-12.
  - *1% Rate Reduction:* As part of this request, the Department proposes to reduce rates paid to Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2010. This request reduces Acute Care services expenditure \$13,661,969, Community Based Long Term Care services expenditure \$2,773,803, PACE expenditure \$418,628, and Single Entry Point expenditure \$131,499 in FY 2010-11. These reductions are annualized in FY 2011-12 to additional reductions of \$2,698,858 for Acute Care services, \$441,287 for CBLTC services, \$130,355 for PACE expenditures, and \$33,712 for Single Entry Points.
- *Accountable Care Collaborative (S-6, BA-5):* The Department was appropriated an overall reduction in expenditure of \$514,730 in FY 2010-11, annualizing to \$10,268,779 in FY 2011-12 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning January 1, 2011. To ensure that the Department's goals are being achieved, the Department will limit enrollment to 60,000 clients until the efficacy of the program can be demonstrated.

The ACC Program's goals are to improve health outcomes for Medicaid clients through a coordinated, client/family-centered system that proactively addresses clients' health needs, whether simple or complex, and to control costs by reducing avoidable, duplicative and inappropriate use of health care resources. The Department intends to regionally procure services from seven Regional Care Collaboration Organizations (RCCOs) providing enhanced Primary Care Case Management services (ePCCM) clients. The Department also is procuring a Statewide Data & Analytics Contractor (SDAC). Collectively, the Department, the eight contracted organizations, and participating providers would form the "Accountable Care Collaborative" (ACC).

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The Department’s current estimate deviates from the appropriated amount as the implementation date and plan of the program has changed. In the Department’s original request these clients were to be enrolled starting in January 2011 with a gradual enrollment plan of 2,500 clients per month. After further consideration, the Department now believes an accelerated enrollment plan beginning in April, 2011 will be most effective to realize cost savings from the program. Under the April enrollment plan approximately 25,000 clients will be enrolled in April 2011 with the remaining clients enrolling in June 2011, resulting in full enrollment by July 2011. However, due to contract disqualifications the implementation of the program is anticipated to be slower than expected. Currently the Department believes the ACC will enroll two regions in April, rather than three, with the third region being added to the June enrollment. This will result in an enrollment of about 17,000 clients in April and the remaining 43,000 in June. The chart below illustrates the difference between the appropriated amounts and Department’s request by service category.

Accountable Care Collaborative FY 2010-11 Appropriation to Request Comparison				
	FY 2010-11 Appropriated Amount	FY 2010-11 Request	FY 2011-12 Appropriated Amount	FY 2011-12 Request
Estimated Administration Payments (PIHP Admin)	\$1,728,731	\$1,735,744	\$13,009,140	\$14,272,918
Estimated Savings (Acute Care)	(\$2,243,461)	(\$2,437,213)	(\$23,277,919)	(\$24,466,968)
<b>Total</b>	<b>(\$514,730)</b>	<b>(\$701,469)</b>	<b>(\$10,268,779)</b>	<b>(\$10,194,050)</b>

*HB 10-1378 – Concerning Moneys Appropriated in the 2010-11 Fiscal Year for Health Clinics*

HB 10-1378, recommended by the Joint Budget Committee as part of its budget package for FY 2010-11, allows \$12,800,000 for Medical Services Premiums from the Primary Care Fund Cash fund to be used to offset General Fund expenditures in FY 2010-11. This bill has a net effect on Total Funds of \$0..

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*HB 10-1379 – Concerning a Reduction in the General Fund Portion of the Per Diem Rates Paid to Nursing Facilities for the 2010-11 Fiscal Year*

HB 10-1379 initiated a Nursing Facilities rate reduction of 1%, in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. The rate reductions apply to all days incurred under the effective periods of each bill. This bill reduces Department expenditure \$5,591,531 in FY 2010-11. Due to issues related with claims runout, the Department has also estimated an FY 2011-12 impact to this bill which was not incorporated in the fiscal note. See Exhibit H, footnote 10 for further details.

*HB 10-1380 – Concerning the Use of Moneys in the Supplemental Old Age Pension Health And Medical Care Fund to Pay for Services Received by Certain Persons in the State Medicaid Program*

HB 10-1380, recommended by the Joint Budget Committee as part of its budget package for FY 2010-11, allows moneys in the Supplemental Old Age Pension and Medical Care Fund to be used to offset General Fund expenditures for Medicaid for persons 65 years of age and older. A General Fund offset from the cash fund of up to \$4,850,000 is allowed in FY 2010-11 and up to \$3,000,000 in FY 2011-12. The provisions of the bill are repealed on July 1, 2012.

*HB 10-1381 – Concerning the Use of Tobacco Revenues for Health-related Purposes during a State Fiscal Emergency*

This bill allows certain Tobacco Tax Cash Funds to be used in FY 2010-11 to offset expenditures for persons enrolled in Medicaid or the Children's Basic Health Plan (CBHP). The bill appropriates \$25.7 million to the Department, \$15,521,625 from the Tobacco Education Programs Fund, \$5,679,358 from the Prevention, Early Detection and Treatment Fund, \$4,490,435 from and the Health Disparities Grant Program Fund under the Colorado Department of Public Health and Environment (CDPHE). The bill's provisions are repealed as of July 1, 2012.

*HB 10-1382 – Concerning the Repeal of the Delay of Certain Payments made under Public Medical Assistance Programs*

This bill, recommended by the Joint Budget Committee as a budget package bill, repeals provisions of SB 09-265. SB 09-265 authorized the Department to delay the last normal fee-for-service payment cycle to managed care organizations (MCO's) for FY 2009-10 until after July 1, 2010. Another provisions specified that after June 1, 2010, capitation payments to MCO's are to be made on the first of day of the month following a client's enrollment. The effect of these provisions was to allow for 51 weeks of fee-for-service and 11 months of MCO payments to be made in FY 2009-10. This bill allows the normal payment cycle to be followed in FY 2010-11.

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The Department does not make any adjustments in its estimates for HB 10 1382. The appropriation in the Long Bill was for 53 weeks of payments, and the appropriation from HB 10-1382 reduced the number of weeks appropriated to 52. Because the Department uses a 52 week base for FY 2009-10 for its projections, no further adjustment is necessary to maintain the 52 week base for FY 2010-11 and FY 2011-12.

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

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below, The bill reduces Department expenditure \$2,390,570 in FY 2010-11, annualizing to \$3,699,827 in FY 2011-12 by requiring the Department to;

- Appoint an internal auditor and to ensure that duplicate benefits are not being paid by other states to clients enrolled in DHCPF programs through creating access to the Public Assistance Reporting Information System (PARIS) which will allow the Department to identify and eliminate clients receiving medical services premiums in other states.
- Implement an automated, pre-payment review system to reduce medical services coding errors in Medicaid claims using the National Correct Coding Initiative.
- Purchase private health insurance coverage through the Health Insurance Buy-In Program for and additional 1,500 eligible clients to create cost savings for the state by enrolling clients into individual insurance plans where enrollment is deemed cost effective. This initiative has been delayed to implement in April 2011 to allow for contract negotiations. The Department anticipates 250 clients will be enrolled per month until the maximum of 2,000 clients is reached. The payment methodology for the program expansion has been altered from a contingency based payment plan to PMPM payment.

While the Department has been able to partially implement the components of SB 10-167, full implementation is not anticipated until August 2011. Consequently, a portion of the savings anticipated in FY 2010-11 has been shifted to FY 2011-12.

Colorado Medicaid False Claims Act:

Anyone who knowingly submits a false claim or intends to defraud the state or a political subdivision is liable for up to three times the amount of damages, the costs of civil action, and a civil penalty of between \$5,000 and \$10,000. Persons ineligible to receive state funds and who report to the Attorney General within 30 days of receiving such funds may be liable for two times the amount of damages and no civil penalty, provided certain conditions are met. The bill specifies certain investigative, notification, and court procedures for false claims and requires the Attorney General to prepare an annual report for certain legislative committees.

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*SB 10-169 –Concerning Authority for Moneys in the Hospital Provider Fee Cash Fund Generated by an Enhanced Federal Match through the 2010-11 Fiscal Year to be used to Offset General Fund Expenditures in the Medicaid Program*

The bill allows funds in the Hospital Provider Fee Cash Fund to offset General Fund appropriations to the Medicaid program in FY 2009-10 and FY 2010-11. Under HB 09-1293 funds generated by the hospital provider fee were prohibited from use to offset the General Fund. However, SB 10-169 amends this clause and allows the General Fund to be offset by hospital provider fees equal only to the enhanced federal funds match, or 9.71%, for Medicaid received under the American Reinvestment and Recovery Act (ARRA). The following table illustrates SB 10-169 FY 2010-11 request and spending authority.

<b>SB 10-169 Request and Authority</b>	
Total Request	(\$53,223,690)
Spending Authority <sup>(1)</sup>	(\$46,329,388)
Difference Between Request and Spending Authority	(\$6,894,302)

<sup>(1)</sup>Per SB 10-169 Appropriation Clause

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

This section describes the impact from legislation passed during legislative sessions prior to 2010, and also includes any relevant impacts from the Department’s budget requests prior to the FY 2010-11 budget cycle. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

***Estimated Impact of Increasing PACE Enrollment***

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department’s health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider – the in instance of a PACE provider, the payment covers acute care and long term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing

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providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

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

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost-per-enrollee attributable to those services (based on the actuarially-certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as 1/12<sup>th</sup> of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

<b>Estimated Savings due to PACE Enrollments</b>				
<b>FY 2010-11</b>	<b>Adults 65 and Older (OAP-A)</b>	<b>Disabled Adults 60 to 64 (OAP-B)</b>	<b>Disabled Individuals to 59 (AND/AB)</b>	<b>Total</b>
Acute Care	(\$536,193)	(\$199,611)	(\$145,213)	(\$881,017)
CBLTC	(\$812,508)	(\$78,313)	(\$37,890)	(\$928,711)
<b>Total</b>	<b>(\$1,348,701)</b>	<b>(\$277,924)</b>	<b>(\$183,103)</b>	<b>(\$1,809,728)</b>
<b>FY 2011-12</b>	<b>Adults 65 and Older (OAP-A)</b>	<b>Disabled Adults 60 to 64 (OAP-B)</b>	<b>Disabled Individuals to 59 (AND/AB)</b>	<b>Total</b>
Acute Care	(\$548,312)	(\$188,676)	(\$124,798)	(\$861,786)
CBLTC	(\$830,870)	(\$74,023)	(\$32,564)	(\$937,457)
<b>Total</b>	<b>(\$1,379,182)</b>	<b>(\$262,699)</b>	<b>(\$157,362)</b>	<b>(\$1,799,243)</b>

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### *Colorado Access Contract for CRICC*

The Colorado Access Contract for the Colorado Regional Integrated Care Collaborative (CRICC) was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. The reimbursement rates for the ASO have been set such that the ASO reimbursement for the expected life of the program (through June 2011) do not exceed the estimate cash flow savings from shifting clients from risk-based managed care to non-risk based care. The Department has accounted for this change with bottom line impacts in Acute Care and PIHP Administration.

### *Remove Manual Pricing of DME, Injectibles, and Medical Services*

In an effort to continuously find efficiencies within the Medicaid programs, the Department identified a number of antiquated, manual price setting methodologies around Durable Medical Equipment (DME), injectibles, and medical services. The Department initiated adjustments to these methodologies so that reimbursement rates would automatically be set to a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists, rates were set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate.

This effort ensures that rates will be adjusted on medical goods and services as prices fluctuate, often downwards, over time.

### *Benefits Limits on Echocardiograms*

Through the Department's community-involved Benefits Collaborative, the Department and its stakeholders identified appropriate limits to set on the use of echocardiograms. The Benefits Limits on Echocardiograms limits the number of echocardiograms taken and the number of echocardiogram readings available without prior authorization. The Department set these policies in consultation with physicians and clients, and adhered to best practices in diagnosis requirements. The limitations should reduce the number of unnecessary echocardiograms received, and in greater volume, the number of unnecessary readings when readings by certified professionals are already available and recorded in patient records.

### *NEMT Supplemental Payments*

The Department provided additional funds to be expended on its fixed price contract to provide Non-Emergency Transportation Services in the 8 metro counties. The contractor had recently informed the Department that it would need to cease to provide services,

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as the fixed price contract did not accommodate the unprecedented caseload growth facing the Department and the provider. Through contract negotiations, the Department was able to adjust the fixed price on the contract in order to ensure vital services continued.

In the long-term, the Department is actively exploring altering the contract from a fixed-price to a Per-Member-Per-Month (PMPM) structure to avoid any similar problems in the future while simultaneously ensuring the Department does not pay an inflated rate when caseload ceases to grow.

*HB 09-1293 Adjustments*

As caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of the expansion populations will be 75% of the per capita rate of traditionally eligible population in the same categories. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population. The following table contains the calculation of adjustments for each eligibility category.

<b>HB 09-1293 Expansion Population Adjustments</b>				
<b>Eligibility Category</b>	<b>Per Capita</b>	<b>Reduced Utilization</b>	<b>Expansion Caseload</b>	<b>Bottom Line Adjustment</b>
Foster Care	\$3,471.27	25%	380	\$329,771
Eligible Children (AFDC-C/BC)	\$1,676.51	25%	7,966	\$3,338,770
Disabled Individuals to 59 (AND/AB)	\$9,366.03	25%	4,329	\$10,136,386

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*HB 08-1114 -- "Reimbursement of Nursing Facilities Under Medicaid"*

HB 08-1114 had a retroactive impact on FY 2008-09 Hospice Rates. Since hospice rates are a function of the reimbursement rate for Class I Nursing Facilities, the reimbursement methodology changes directed by HB 08-1114 have a fiscal impact on hospice expenditure. This impact was not anticipated in the original fiscal note and was included as an adjustment in FY 2009-10, annualized as a corresponding reduction in FY 2010-11.

*FY 2009-10 BRI-1 Pharmacy Technical and Pricing Efficiencies*

This budget reduction item reduced FY 2009-10 expenditure by an estimated \$1,022,887, with an expected additional \$1,848,763 reduction in FY 2010-11, as the result of an automated prior authorization system for pharmacy claims as well as through changing the reimbursement rates for drugs using a state maximum allowable cost structure. Delay in the implementation of the automated prior authorization system results in a shift of \$1,623,080 in estimated FY 2010-11 savings to FY 2011-12.

*FY 2009-10 BA-33 Provider Volume and Rate Reductions*

This budget reduction item requested funding to add anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses in coordination with the FY 2009-10 BRI-1, Pharmacy Efficiencies. In addition, the Department requested, and was appropriated, a 2% provider volume and rate reduction effective July 1, 2009. This impact is fully annualized in the Department's base. Delays in the implementation of the automated prior authorization system have prevented the Department from moving forward with the prior authorization requirements/limits on non-seizure utilization of anti-convulsants. FY 2010-11 savings associated with this initiative have been shifted to FY 2011-12 as a result.

The Department's veteran outreach efforts have provided insight into the VA/Medicaid dynamic which have caused the Department to reevaluate the potential savings stemming from this initiative. The Department has found the vast majority of eligible veterans are already enrolled in veterans' benefits. Because not all veterans are fully aware of what specialty services are available to them through VA benefits, potential to enhance the level of care of veterans enrolled in Medicaid exists. Further, veterans seeking specialty care from the VA that would otherwise be provided by a Medicaid provider will result in Department savings. FY 2010-11 savings for the enhanced VA enrollment initiative have been significantly reduced as the Department explores alternative means of achieving savings.

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*FY 2009-10 BA-15 Community Transitions Services for Mental Illness Waiver Clients*

This request, after being delayed in FY 2009-10, was to be implemented by the Department in FY 2010-11. However, the Department will not implement this program in anticipation of the receipt of the Money Follows the Person federal grant. This grant aims to offer transition services to help clients move from nursing facilities and institutions into community based services. One of the target populations of the grant are those Medicaid clients with Mental Illness. Grant funds are anticipated in April 2011 with the first clients being enrolled in the program in January 2012. Therefore, to avoid overlapping efforts, the Department will not implement this request.

*FY 2009-10 ES-2, Medicaid Program Reductions*

This request reduces expenditure through a combination of rate reductions, service restrictions, elimination of certain programs, increased cost-sharing, and financial efficiencies. Included in the request are three initiatives which have an annualized impact in this request:

- Provider Rate Reductions: A 1.5% reduction in the reimbursement rate paid for providers of Acute Care and Community Based Long Term Care services as well as payments to Single Entry Points effective September 1, 2009. Rates paid to managed care organizations, including PACE, decreased by approximately 1.2%; effective October 1, 2009. The annualized impacts of these rate reductions are bottom line adjustments for FY 2010-11.
- Pharmacy Reimbursements: the Department reduced rates paid to pharmacies to average wholesale price (AWP) minus 14.5% for brand-name medications and AWP minus 45% for generic medication, beginning September 2009. The annualized impact of this rate change is a bottom line impact for FY 2010-11 in Acute Care.
- Non-Medical Transportation Cap: the Department imposed a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients are limited to two roundtrips per week. Trips to adult day programs are not to be subject to the cap included limitations on the HCBS waiver transportation benefit. This impact is annualized for FY 2010-11 as bottom line adjustments in Community Based Long Term Care.

*FY 2009-10 ES-6, Provider Rate Reductions*

This request included a permanent 1.0% reduction in the reimbursement rate paid to providers for Acute Care Services and Community Based Long Term Care services for the remainder of FY 2009-10, effective December 1, 2009. The impact of this rate reduction is annualized for FY 2010-11.

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*NP-ES#5, a Department of Human Services budget reduction initiative*

This initiative requested to close 59 beds at the Colorado Mental Health Institute at Fort Logan. This impacts Medicaid as former residents of the Fort Logan institute relocate to an appropriate nursing facility; it is annualized as a bottom line impact for Class I Nursing Facilities in FY 2010-11.

*NP-ES#8, a Department of Human Services budget reduction initiative*

This initiative requested to close a 32-bed Nursing Facility at Grand Junction Regional Center. This impacts Medicaid as former residents at the Regional Center relocate to an appropriate nursing facility; it is annualized as a bottom line impact for Class I Nursing Facilities in FY 2010-11.

*FY 2010-11 Reconciliation for Payments prior to FY 2009-10 Q1*

The Department will pay one of its PACE providers a one-time reconciliation of \$3,000,000. This settlement adjusts for rates which were paid below the true cost of providing services due to erroneous patient payment reporting.

*FY 2010-11 Reconciliation for Payments between FY 2009-10 Q2 - Q4*

The Department will pay one of its PACE providers a one-time settlement of \$3,014,310. This settlement adjusts for rates which were paid below the true cost of providing services due to erroneous patient payment reporting in FY 2009-10, quarters two through four.

### **(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS**

The following is a description of the budget projection for the Medicaid Mental 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 granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide mental health services through a managed care program.

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

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible Adults 65 and Older, Disabled Adults 60-64 and Disabled Individuals to 59, Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, and Baby Care Program - 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 and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Medicaid Mental 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

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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 Medicaid Mental 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 Medicaid Mental Health Community Programs expenditures are addressed in this section.

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

- HB 02-1420 also provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.
- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.
- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 and the entire FY 2003-04 to 52.95% (up from 50%), while the State’s share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

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- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately \$70 million in Medical Services Premiums and \$7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's prospective per capita budget methodology did not require the use of historical data prior to FY 2002-03.
- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of \$1,000,000 in FY 2003-04, wherein \$500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. (2005) and the remaining \$500,000 was from federal funds for mental health capitation and performance incentive awards.
- Within the appropriation for Medicaid Mental Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered that the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005 began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.
- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group into the following sections:
  1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 2005-06.
  2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement

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Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from the Centers for Medicare and Medicaid Services to cease making Child Placement Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the current year and the out-year requests and are elaborated below.
- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately.

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

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

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.
- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds, and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

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- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designates funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; b) for FY 2009-10 through FY 2013-14, 50% of State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.
- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund, effective until FY 2011-12. Beginning FY 2012-13, state funding for the Breast and Cervical Cancer Program will be shifted to 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund.
- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates above the actuarial midpoint of the rate setting range. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from the Centers for Medicare and Medicaid Services, the Department has gradually put more weight on the encounter data PMPM. FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found that the estimated service expenditures were generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes that there are two primary reasons for this discrepancy. First, the non-traditional, federally waived (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices cause some difficulties in the encounter pricing methodology. To offset the discrepancy the Department paid its mental health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.
- HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans. The bill was implemented in April 2010 when the Department began collecting the hospital provider fee. Mental health services were subsequently expanded to parents up to 100% of the federal poverty line using the Hospital Provider Fee cash fund to cover the additional expenses. Mental health services will be expanded further in FY 2011-12 by extending guaranteed eligibility for children and foster care children to twelve months. In addition, disabled individuals with income up to 450% of the federal poverty level will become eligible to purchase Medicaid benefits beginning in July 2011. For more detail, please see Exhibit J in Medical Services Premiums.

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- The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department’s mental health programs in the following ways:
  1. As a part of FY 2010-11 ES-2 “Medicaid Program Reductions” the Department reduced the reimbursement rate for the mental health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years’ mental health capitation payments.
  2. As a part of NP-ES-5 “Close Beds at the Mental Health Institutes” the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients of the capitated mental health program. While treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the “payer of last resort.” Displacing these clients allowed them to be eligible to receive Medicaid funded benefits and increased expenditure for mental health services.
- Effective January 1, 2010, the Department calculated a new set of mental health rates and set them below the actuarial midpoint. Three of the Behavioral Health Organizations (BHOs) were paid 2.5% below the actuarially set midpoint of the new set of rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). These rates remained in effect through CY 2010. See the description of Exhibit GG for additional information.
- Effective January 1, 2011, the Department calculated a new set of mental health rates for calendar year 2011. The new rates implicitly include the 2.5% reductions taken by the BHOs as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of \$2,170,355. The Department worked with the BHOs in order to ensure that they were able to certify the rates and continue to provide quality services to their clients, even while their rates were being reduced. The result of that negotiation process was to begin a series of rate reforms, the first of which was to include a new component in the rate called a “case rate” adjustment that was applied to the CY 2011 rates. The case rate is the BHO statewide average cost by diagnosis category. The case rate allows the Department to comply with CMS’s direction by increasing the weight of the encounter data in the rate-setting process. The BHOs can accept the increased weight of encounter data because the case rate allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department’s goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients.

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***Program Administration***

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

***Medicaid Anti-Psychotic Pharmaceuticals***

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

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

**(A) MENTAL HEALTH CAPITATION PAYMENTS**

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental 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 Mental Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

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

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The Medicaid populations that are eligible for mental health services covered by capitation rates are combined into six categories, as indicated in the table below. Partial Dual Eligibles and Non-citizens are ineligible for Medicaid mental health services.

***Eligible Medicaid Mental Health Populations***

Adults 65 and Older (OAP-A)
Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB)
Categorically Eligible Low-Income Adults (AFDC-A), Expansion Adults, and Baby Care Program – Adults
Eligible Children (AFDC-C/BC)
Foster Care
Breast and Cervical Cancer

***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. Monthly payments were paid based on eligibility categories. The Medicaid Management Information System provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System. The drawback was the Colorado Financial Reporting System 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 Colorado Financial Reporting System. 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 Medicaid Management Information System eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total Medicaid Management Information System 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 Colorado Financial Reporting System. This calculation estimated actual Colorado Financial Reporting System expenditures across each eligibility category. Variance between the two systems was less than 0.3%.

***Description of Transition to New Methodology***

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

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

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

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g. Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some mental 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.

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The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year for Medicaid Mental Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted. The exhibits being referenced can be found in the Department's November 2, 2010 Budget Request, Section F.

**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 Medicaid Mental Health Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

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

Exhibit AA includes one early supplemental, which is factored into the total FY 2010-11 estimate of need. Since this request has not been passed, it is not reflected in the appropriations shown in the Schedule 13. An additional page in exhibit AA is presented with the spending authority prior to early supplementals for FY 2010-11, in which the spending authority matches the Schedule 13 appropriations.

**EXHIBIT BB - CALCULATION OF FUND SPLITS**

Exhibit BB details fund splits for all Mental Health Community Programs budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% state funds and 50% federal funds (prior to ARRA impacts, see the description of Exhibit AA, above). Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately, below. Capitation expenditures have

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been split between traditional clients and expansion clients funded from Tobacco Tax Funds or from Hospital Provider Fee funds. Finally, the recoupments from prior years for mental health capitation overpayments and retractions for capitations paid for clients later determined to be deceased are also presented (see Exhibit II for recoupment calculations), as well as an adjustment for a CMS disallowance that the Department was required to pay in FY 2010-11 (see below for more information on the disallowance).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Health Care Expansion Fund clients are paid for with 50% cash funds from the Health Care Expansion Fund and 50% federal funds. Clients enrolled in the Breast and Cervical Cancer Prevention and Treatment Program (BCCP) are paid for with 35% state funds and 65% federal funds. State funding for 70% of the BCCP program comes from the Breast and Cervical Cancer Prevention and Treatment fund, and the remaining 30% of state funding comes from the Prevention, Early Detection, and Treatment fund (as reappropriated funds from the Department of Public Health and Environment). Expansion clients funded through HB 09-1293 receive state share funding from either the Hospital Provider Fee Cash Fund or (in future years) the Medicaid Buy-in Fund, and are discussed in more detail, below. These clients also receive a 50% federal match.

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

The federal match rate is adjusted for the American Recovery and Reinvestment Act (ARRA), which will be phased out in FY 2010-11. For that fiscal year, those populations of clients not already receiving an enhanced federal match (e.g. Breast and Cervical Cancer Clients) receive an increased federal match of 61.59% (from the established 50% match) for the first two quarters of that fiscal year, as well as an increased match of 58.77% for the third quarter and an increased match of 56.88% for the fourth quarter. The weighted average over the whole year is 59.71%, which is applied to all populations that receive the enhanced match. ARRA has the effect of decreasing state-share responsibility for the entirety of the Medicaid Mental Health Programs, shifting expenditure from General Fund or various cash funds to federal funds. There is no ARRA impact in FY 2011-12.

*Mental 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 Medicaid Mental Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Mental health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the mental health caseload that includes the Breast and Cervical Cancer Program Adults eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

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Annual designations of General Fund contributions to program costs are specified in Section 25.5-5-308 (8), (9), and (10) C.R.S. (2009). Exhibit BB details funds splits for Mental Health Community Programs Capitations lines. In addition to clients already enrolled in the program, also called “traditional clients”, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the “expansion clients”, are funded by the Prevention, Early Detection and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients is 35% cash funds and 65% federal funds. For traditional clients, the source for cash funds is the Breast and Cervical Cancer Prevention and Treatment Fund; for expansion clients, the Department receives a transfer from the Department of Public Health and Environment from the Prevention, Early Detection and Treatment Fund. The Department is requesting a change to the allocation of traditional and expansion clients in FY 2011-12 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment’s appropriation for the Breast and Cervical Cancer Treatment program is \$1,215,340. The Department is requesting \$1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request DI-1, “Request for Medical Services Premiums.” As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill group with the Breast and Cervical Cancer Prevention and Treatment Fund.

### *Mental Health Services for Hospital Provider Fee Expansion Clients*

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients to be funded is parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients will be funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other adult expansion clients, and expenditure for these clients are therefore calculated using the same per capita rate as other adult clients (see exhibit JJ). Starting in FY 2011-12, additional expansion populations will receive funding through the Hospital Provider Fee Cash Fund, including continuously eligible children, continuously eligible foster care children, and disabled individuals with income limits up to 450% of the federal poverty line.

### *CMS Disallowance for Supplemental Payments*

The Department’s request includes an increase of \$3,329,551 General Fund and a corresponding decrease in federal funds in FY 2010-11 in order to pay a disallowance in Medicaid federal financial participation (FFP) as directed by the Centers for Medicare & Medicaid Services (CMS). On August 3, 2009, CMS determined that supplemental payments made to Mental Health Assessment and Services Agencies (MHASAs) for the period August 13, 2003 through September 30, 2004 were not made pursuant to contracts that had been reviewed and approved by CMS. The Department of Health and Human Services Departmental Appeals Board (DAB) upheld the disallowance on November 10, 2010.

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MHASAs were the managed care organizations in the Colorado Medicaid Mental Health Capitation and Managed Care Program prior to the inception of Behavioral Health Organizations (BHOs). When the capitation program began in 1995, the capitation rates were set using data on mental health fee-for-service payments made during FY 1994-95. At the time, child placement agencies (CPAs) provided mental health services to foster care children but services were paid by the agencies' counties; thus, the payments for these services were not part of the FY 1994-95 fee-for-service data and were not included in the capitation rates set in 1995. The Department of Human Services, which administered the mental health program prior to 2003, incorporated the payments into the capitation rates in 1998. The counties stopped making payments to the CPAs and began paying the Department instead. The Department used the county funds to pay for the increase in the capitation rates attributable to the newly-incorporated CPA services.

The payments to the Department were fixed amounts based on the county funding to the CPAs as of 1998. In the following three years, MHASA enrollment grew at an unexpected rate, and the fixed amounts provided by the counties were insufficient to cover the payments to the CPAs under the per-member per-month capitation rate methodology. The Department and the MHASAs orally agreed at that time to amend the contracts to remove the cost of the CPA services from the capitation rates and instead to make supplemental payments to the MHASAs using the fixed county funds, effective April 2001. This would save money for both the state and the federal government as the amount spent on these services would not be able to exceed the fixed, predetermined amounts from the counties, instead of increasing as caseload continued to grow. The Department paid \$24,000,947 total funds, \$12,227,602 federal funds, in supplemental payments over the period April 2001 through November 2004. During that time, CMS approved contracts for the MHASAs, including the actuarial certification of their capitation rates. The contracts did not specifically address the supplemental payments, however, and CMS did not learn of them until a site review of the Colorado Medicaid Community Mental Health Services Program in April 2004.

The Department sent a letter to CMS confirming that it was making the supplemental payments on October 8, 2004. In November 2004, CMS required the Department to stop making the payments. The following November, CMS issued a notice of disallowance for \$487,390 in FFP to Colorado for CPA-related supplemental payments claimed by the Department during October and November of 2004. This disallowance was upheld by the DAB in May 2007 based on the grounds that the supplemental payments were not part of any contract reviewed and approved by CMS, as required under 42 C.F.R. § 438.6.

CMS then asked the HHS Office of Inspector General (OIG) to analyze the payments made before October 2004 to determine whether these were made pursuant to contracts that had been reviewed and approved by CMS. The OIG released its final report in October 2008, "Review of Colorado Medicaid Mental Health Capitation and Managed Care Program," No. A-07-06-04067. The OIG stated in the report that the supplemental payments made between August 13, 2003 and September 30, 2004 "were not fully consistent with Federal and State requirements," and therefore, \$3,324,269 in FFP was unallowable. On August 3, 2009, CMS issued a notice of disallowance for this amount. Supplemental payments made prior to August 13, 2003 did not contradict CMS' requirements for capitation contracts as 42 C.F.R. § 438.6 did not take effect until that date.

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Colorado appealed this determination, citing the DAB's decision in Iowa Dept. of Human Services, DAB No. 1340 (1992). In this decision, the DAB maintained that CMS could use discretion in whether or not to retroactively review contract ratifications, but "may not deny retroactive approval based on unsubstantiated conclusions or on bases so insubstantial that the decision fairly can be described as capricious." The DAB upheld the disallowance for FFP paid to Colorado, noting, "...in the absence of approved contract amendments addressing the supplemental payments, we conclude that CMS properly determined that FFP is not available for the supplemental payments made for the period August 13, 2003 through September 30, 2004."<sup>5</sup> Further, the DAB determined that CMS did not abuse its discretion by denying Colorado the opportunity for a retroactive review and approval of contract ratifications containing the supplemental payments or a retrospective actuarial certification. They decided this on the following basis, as listed in the DAB's Decision:

1. Colorado failed to timely disclose the alleged oral agreements it had with the MHASAs and unreasonably delayed the submission of written contract amendments necessary to support the supplemental payments; and
2. Colorado has failed to show that the supplemental payments did not duplicate payments for the CPA services under the approved capitation rates.

As a result of the disallowance, CMS directed the Department to repay the federal share of the disallowed amount and interest charged in quarter 1 of FFY 2010-11 (quarter 2 of SFY 2010-11). The amount requested to repay the disallowance includes \$3,324,269 in FFP claimed by the Department for the supplemental payments for the period August 13, 2003 through September 30, 2004, as well as \$5,282 in interest charged on the disallowance, for a total of \$3,329,551.

The Department's supplemental payments for CPA services were discontinued in December of 2004 and the line item for the payments has been removed from the mental health long bill group in the Department's budget. Currently, CPAs provide some services that are covered benefits within the BHO contracts, and BHOs can refer clients to CPAs for those services. Those encounters then become part of the rates paid to the BHOs.

**EXHIBIT CC - MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS SUMMARY**

Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 2.5%, as well as caseload driven impacts such as the various recoupsments

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<sup>5</sup> Department of Health and Human Services Departmental Appeals Board, Appellate Division. Colorado Department of Health Care Policy and Financing, Docket No. A-09-121, Decision No. 2343. November 10, 2010.

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and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

**EXHIBIT DD - MENTAL HEALTH CASELOAD AND PER CAPITA HISTORY AND PROJECTIONS, EXPENDITURE HISTORY, AND CALCULATIONS FOR GOEBEL ADJUSTMENTS**

Exhibit DD contains per capita history and projections that provide information on each of the nine eligibility categories. The same is true for per capita projections and historical expenditures. The calculations include the Goebel lawsuit expenditures as incorporated into the expenditure history for FY 2003-04 through FY 2005-06. Each of the tables that comprise Exhibit DD is described below.

*Medicaid Mental Health Community Programs Caseload*

Medicaid Mental Health Community Programs caseload is displayed in two tables. The first table shows total caseload for the combined disabled categories as well as the combined Adult categories. The second table displays caseload by all Mental Health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The mental health caseload excludes the caseload for Partial Dual Eligibles 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 Medicaid Mental Health Community Programs Exhibits and narrative.

*Medicaid Mental Health Community Programs Per Capita Historical Summary*

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

*Medicaid Mental 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.

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Actual expenditures are only available from the Colorado Financial Reporting System. Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the Colorado Financial Reporting System. The Medicaid Management Information System 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 Colorado Financial Reporting System as fiscal periods close. Because the variance is minor, data from the Medicaid Management Information System can be used to distribute total expenditures from the Colorado Financial Reporting System across eligibility categories.

A ratio is calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures by the total Medicaid Management Information System expenditures. The ratio is multiplied by the total expenditures from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

*Adjustments to Medicaid Mental Health Community Programs Expenditures for Inclusion of Goebel Expenditures*

For comparative purposes, expenditures for all years must contain the same primary components. However, expenditures for Goebel enhanced services were not included in the capitation payments for the years shown prior to FY 2006-07. Therefore, an adjustment was made for those years. The table sets forth actual expenditures including the Goebel expenditures. Actual expenditures were distributed by an average percentage from available years since actual percentages were not available for every year. These are the capitation expenditures used in the previous sections of this exhibit.

**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.

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The forecasted capitation rate is derived from exhibits FF through HH, and will be presented in more detail, below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting Partial Dual Eligibles and Non-Citizens, as discussed, above).

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

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

### ***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 eleven 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 that the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages F.EE-3 through F.EE-4 presents the percentage of claims paid in a six month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except Disabled Adults 60 to 64 and Disabled Individuals to 59, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the Disabled Adults and Individuals, it has taken approximately three years for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting

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disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exists for this category of clients.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

On pages F.EE-5 through F.EE-6, 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 EE-1 and EE-2.

*Actuarially Certified Capitation Rates*

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by the Centers for Medicare and Medicaid Services, 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 - MEDICAID MENTAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER**

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

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

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

### ***Retroactivity Adjustment***

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest that the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and has determined that the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories except Disabled. For this reason, the Department assumes that the most recent period is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years. The Disabled category has the longest incurred but not reported series due to the time it can take to determine whether a disabled individual is Medicaid eligible. The most recent period is not the best representation of the claims-to-caseload ratio for this eligibility category. Instead, the Department uses the average of the previous two fiscal years (in this case, FY 2007-08 and FY 2008-09) to estimate the retroactivity adjustment for the Disabled population.

### ***Partial Month Adjustment Multiplier***

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

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating that the claims-based trends are matching capitation trends. In order to capture any potential variance between the trends, the forecasted capitation rate was multiplied by the difference of the average relationship percentage, from 100%.

**EXHIBIT GG - MEDICAID MENTAL HEALTH CAPITATION RATE TRENDS AND FORECASTS**

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

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

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

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

It is important to note that the overall weighted point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Mental 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.

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From January 1, 2009 to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year, set 2.5% below their certified midpoint rates. However, the Department's rate setting process and federal regulation require that both the Department and the BHOs actuarially certify that they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates. These two BHOs continued to be paid their September 1, 2009 rates through CY 2010. The 2.5% reductions to the BHOs' rates will continue to be in effect through FY 2010-11 and FY 2011-12, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates will be reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011, and appropriated it as a savings of \$2,170,355 to be achieved in FY 2010-11. The Department determined that it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%.

The following table presents the estimated paid rates (as opposed to midpoint rates) across eligibility categories beginning with the January 1, 2009 rates with their plus 3% adjustment.

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Fiscal Year	Adults 65 and Older	Disabled Adults 60 to 64 and Disabled Individuals to 59	Categorically Eligible Low Income Adults, Expansion Adults, and Baby Care Program Adults	Eligible Children	Foster Care
January 2009 Midpoint Rate	\$13.15	\$124.52	\$18.25	\$14.25	\$232.64
% Change in the Rate Range	3.00%	3.00%	3.00%	3.00%	3.00%
Paid Rate, January 2009 to June 2009	\$13.54	\$128.26	\$18.80	\$14.68	\$239.61
July 2009 Midpoint Rate	\$13.37	\$126.68	\$18.57	\$14.50	\$237.60
% Change in the Rate Range	0.00%	0.00%	0.00%	0.00%	0.00%
Paid Rate, July 2009 to August 31 2009	\$13.37	\$126.68	\$18.57	\$14.50	\$237.60
September 2009 Midpoint Rate	\$13.37	\$126.68	\$18.57	\$14.50	\$237.60
% Change in the Rate Range	-2.50%	-2.50%	-2.50%	-2.50%	-2.50%
Paid Rate, September 2009 to December 2009	\$13.04	\$123.51	\$18.11	\$14.14	\$231.66
January 2010 Midpoint Rate	\$13.43	\$136.37	\$20.01	\$14.90	\$204.05
% Change in the Rate Range	0.00%	-4.22%	-3.50%	-3.96%	8.49%
Paid Rate, January 2010 to June 2010	13.43	130.62	19.31	14.31	221.37
July 2010 Midpoint Rate	\$13.43	\$136.37	\$20.01	\$14.90	\$204.05
% Change in the Rate Range	-1.41%	-1.37%	-0.90%	-1.07%	-1.34%
Paid Rate, July 2010 to December 2010	13.24	134.50	19.83	14.74	201.31

Note: Rates for each eligibility category are weighted by the proportion of claims incurred by each BHO within that category. The weighted average midpoint rates and weighted average paid rates are determined by the Department every six months based on the rates certified by the actuaries. The paid rate from January 1, 2010 to December 31, 2010 is the result of two of the BHOs having their previous rates carried forward; the blend of those rates with the new rates for three BHOs yields unique weighted average rates, as presented.

**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. Page F.HH-2 presents the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

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

***Final Forecasts***

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-2 (see below). For Decision Items, the first rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. Finally, the rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

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

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

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims are impacted by payments made for partial months of eligibility as well as payments made for clients determined to be eligible retroactively; neither of these

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types of payments will be for a “whole” capitation payment at the current fiscal period’s capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

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

### *Capitation Trend Models*

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-2 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 that 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 that the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

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

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the mental health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models’ reliance on historical performance for predicting future

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performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes that the most recent years' experience is the most predictive of the likely current year and future year experiences.

For Q3 and Q4 of FY 2011-12:

- The rate of change from FY 2009-10 to FY 2010-11 was applied for 1) Adults 65 and Older and 2) Eligible Children eligibility categories. The rate for Adults 65 and Older has been increasing slowly over the past two years, but increased moderately in FY 2010-11. It is likely to continue to increase, but at a slower rate than the other eligibility categories. The rate for the Children category has been steadily increasing, and the Department expects it to increase again to a similar degree in CY 2012.
- The linear growth model was selected for the Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB) as well as the Low Income Adult populations. The rate for the Disabled population has increased along a linear trend since the incorporation of the Goebel settlement into the rate methodology. The Department used the historical rates since the Goebel settlement to trend the rate for the disabled population in CY 2012. The Low Income Adults category has also seen steady increases in its rate, and that growth has followed closely to a linear trend since FY 2002-03. The Department divided the percentage change produced by this model by two as it anticipates that this growth will begin to decline, especially as the case rate methodology is given increasing weight in the rate-setting process.
- The percentage change from FY 2010-11 to FY 2011-12 as predicted by the average growth model was chosen for the Foster Care population. The rate for this eligibility category has decreased over the last several years; the Department expects that this will continue, but will begin to level off. The trend selected is negative but lower in magnitude than the decline experienced over the last two years.

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

**EXHIBIT II - RECOUPMENT OF PAYMENTS MADE FOR CLIENTS FOUND TO BE INELIGIBLE FOR MEDICAID**

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid

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benefits retroactively, a recoupment of the capitation payments is completed separately. Exhibit II summarizes the expected fiscal impacts.

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

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community mental health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments will be collected for FYs 2004-05 and 2008-09. The recoupments in FY 2010-11 from incurred expenses in FY 2008-09 will be altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Starting in FY 2011-12, all historical recoupments will be collected. Each fiscal year recoupments will be made for ineligible clients from two years prior to it. Recoupments from FY 2009-10 will be collected in FY 2011-12 and will be altered by the enhanced federal match from the year the claims were processed.

**EXHIBIT JJ - CASH FUNDED EXPANSION POPULATIONS**

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Tobacco Tax Bill (HB 05-1262) and related bills as well as the Colorado Health Care Affordability Act (HB 09-1293) to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note that the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

**Tobacco Tax Bill:**

HB 05-1262 established a number of funds, two of which provide funding to the Medicaid Mental Health Community Programs line: the Health Care Expansion Fund administered by the Department; and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provides capitated mental health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, Optional Legal Immigrants

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eligible for services as a result of HB 05-1086, and Foster Care clients eligible for services up to the age of 21 as a result of beginning SB 07-002.

The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program, and historically 30% of the Breast and Cervical Cancer Program caseload is paid for out of this fund. The Department is requesting a change to the allocation of traditional and expansion clients in FY 2011-12 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is \$1,215,340. The Department requested \$1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request DI-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill Group from the Breast and Cervical Cancer Prevention and Treatment Fund.

With the passage of HB 05-1262, the Department received funding to provide services to the 478 individuals on the Children's Home and Community Based Services waiver program waiting list. In addition, the Joint Budget Committee decided to add an additional 200 expansion slots during FY 2006-07 Figure Setting (see the March 13, 2006 Figure Setting Document, page 145). In total, there are 678 expansion slots in the Children's Home and Community Based Services waiver program FY 2008-09 and subsequent fiscal years. Please see Exhibit JJ for the Department's projected Health Care Expansion Fund expenditures for the Children's Home and Community Based Services.

HB 05-1262 also provided funding to pay for 148 individuals on the Children's Extensive Support wait list. However, since 99 of these clients were already Medicaid eligible, expenditures associated with these clients cannot be billed to the Health Care Expansion Fund. Therefore, only 49 of the original 148 expansion slots are funded with Health Care Expansion Fund money. During FY 2006-07 Figure Setting, the Joint Budget Committee approved an additional 30 expansion slots (March 13, 2006 Figure Setting Document, page 145), of which 10 were paid for through the Health Care Expansion Fund due to the other 20 clients not being Medicaid eligible at the time these slots were approved. Based on the consistently increasing number of individuals on the waitlist for the Children's Extensive Support waiver, the Department requested that the remaining 20 slots approved for FY 2006-07 be paid out of the Health Care Expansion Fund as well. In total, the Department expects to pay for 79 Children's Extensive Support expansion slots. Exhibit JJ provides additional detail regarding the Department's projections of expenditures for the Children's Extensive Support expansion population.

In addition, the Health Care Expansion Fund provides funding for capitated mental health services to Expansion Adults. This population consists of individuals that meet the following requirements: 1) they are parents of children that are eligible for either Medicaid or the Children's Basic Health Plan, 2) their income is less than 60% of the federal poverty level, and 3) they are not

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otherwise eligible for Medicaid. The estimated caseloads were taken from the Department's caseload projections provided in this Budget Request (see Exhibit B in Medical Services Premiums). Costs for each expansion population are assumed to be the same as for the traditional populations as the vast majority of mental health services payments are made via the capitation, and do not change based on client utilization.

SB 07-002 and SB 08-099 provided for appropriations to support Medicaid clients from the Foster Care system who are between the ages of 18 and 21. The Department's caseload projections are provided in this Budget Request (see Exhibit B in Medical Services Premiums). As with Expansion Adults, the per capita costs and rate of per capita growth for this expanded Foster Care population is assumed to be the same as for the traditional Foster Care population.

The Health Care Expansion Fund also pays for individuals that are eligible for Medicaid as a result of the removal of the asset test, as required by HB 05-1262. Due to the fact that many Medicaid recipients are no longer required to submit information for the asset test, the Department has found it difficult to track expenditures for this population. To project expenditures in the Medicaid Mental Health Community Programs line for the asset test removal population, the Department has built its estimated caseload and per capita growth rates from the last completed fiscal year by applying the last known changes to the current year as well as the growth rates from the estimated current year to the request year.

The Department is proposing a substantial change to its methodology for allocating expenditure to the Health Care Expansion Fund for clients who gain eligibility as a result of the removal of the Medicaid Asset test. See the narrative for Medical Services Premiums, Exhibit J for details. The Department would apply the same methodology to the Medicaid Mental Health Community Programs Long Bill group.

The Optional Legal Immigrants program is also funded out of the Health Care Expansion Fund. The caseload for this program is spread across all of the eligibility categories, and funds are matched by the federal government at 50% to the State's 50% contribution. See the Tobacco Tax Report in this Budget Request for the Department's caseload projections for this group.

### *Colorado Health Care Affordability Act*

HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

The first expansion population to be affected by HB 09-1293 is the expansion adult population described, above, but now with income limits up to 100% of the federal poverty level. The Department also assumes that the costs for this population will be the same as for

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the traditional population, as the vast majority of mental health services payments are made via capitation, and do not change based on client utilization. Additional populations will be added in FY 2011-12. These include continuously eligible children, continuously eligible foster care children, and disabled individuals with income limits up to 450% of the federal poverty line. As with adults, the Department assumes that the costs for these populations will be the same as for their corresponding traditional populations. The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see Exhibit B in Medical Services Premiums).

**(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS**

All Medicaid Mental Health Community Programs payments which are not part of the capitation payments are under this Long Bill group as Mental Health Fee-For-Service Payments.

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

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

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

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

*History and Background Information*

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation.

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

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

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

In FY 2005-06 there was a one-time recoupment of \$303,492 in the inpatient services area for disallowed payments going back to FY 2001-02. The recoupment was added back to get an accurate base for trending forward. The recoupment was then deducted to arrive at a bottom-line expenditure which matches data from the Colorado Financial Reporting System. The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

### *Current Calculations*

The current fiscal year's total estimated expenditure is based on the actual expenditures made in the first six months of the year, trended forward based upon the expected change in caseload from the first half of the year to the second half. The actual year-to-date expenditures exclude the amount that was paid at the beginning of the fiscal year as a result of the two-week payment delay in FY 2009-10. This expenditure is subtracted from the totals in order to forecast from a 26-week base instead of a 28-week base, thereby

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preventing the forecasts for the current and request years (both of which are assumed to be 52-week years) from being artificially inflated. The request year estimate is the result of a forward trend of the current year estimate by the factor of the anticipated change in caseload.

No rate or utilization increases are forecast, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Mental health fee-for-service expenditure has increased drastically over previous years. The Department is currently performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. In the interim and until data analysis can prove or disprove any theories, the Department takes the conservative view for forecasting purposes, assuming the increase fee-for-service expenditure will continue into the foreseeable future.

*Mental Health Anti-Psychotic Pharmaceuticals*

This line was included in the Other Medicaid Mental Health Payments appropriation section within the Long Bill for informational purposes only. Original funding is in the Medical Services Premiums Long Bill group of the Department's budget. For calculations of the requested amount, see Calculation of Anti-psychotic Drugs under the Medical Services Premiums section, Exhibit F. Through implementation of the Medicare Modernization Act, the costs to the State for providing prescription drugs, including anti-psychotic medications, were expected to decline. However, the rate of increase for anti-psychotic medications has been approximately the same, and is projected to continue.

For FY 2008-09, the Department requested and received approval on the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This change did not impact the Department's ability to pay for these drugs, as they are still part of the Medicaid physical health benefit (as are all other pharmaceuticals related to the treatment of mental health conditions, such as anti-depressants). The Department will continue to report expenditure for anti-psychotics in its Budget Request in future years (such as in Exhibit F of the exhibits for Medical Services Premiums), and so no information will be lost from the Budget Request.

By removing the double-count, the Department's Budget more accurately reflects the total funds appropriated to the Department, and the actual expenditure for Medicaid services.

**EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR MENTAL HEALTH CAPITATION PAYMENTS**

The Global Reasonableness Test presented in Exhibit LL compares the percent change between mental health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2010-11 appropriation is 9.26% higher than FY 2009-10 actual expenditures, primarily due to caseload growth. The FY 2010-11 estimate incorporates increased caseload projections along with

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various rate adjustments for budget cutting initiatives and results in a 8.98% increase from FY 2009-10 actual expenditures and a 0.26% decrease from the current appropriation. The FY 2011-12 Budget Request is built on the FY 2010-11 estimate, and presents a 15.62% expenditure increase. This increase is primarily due to 1) increased caseload projections for traditional clients and 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations. The FY 2011-12 Request represents a 15.32% increase over the current FY 2010-11 appropriation.