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

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

Request Title: Children's Basic Health Plan Medical Premium and Dental Benefit Costs
Department: Health Care Policy and Financing **Dept. Approval by:** John Bartholomew **Date:** November 1, 2010 10/20
Priority Number: DI-3, S-3 **OSPB Approval:** **Date:** 10-22-10

	Fund	1 Prior-Year Actual FY 2009-10	2 Appropriation FY 2010-11	3 Supplemental Request FY 2010-11	4 Total Revised Request FY 2010-11	5 Base Request FY 2011-12	6 Decision/ Base Reduction FY 2011-12	7 November 1 Request FY 2011-12	8 Budget Amendment FY 2011-12	9 Total Revised Request FY 2011-12	10 Change from Base (Column 5) FY 2012-13
Total of All Line Items	Total	178 495 021	216 400 036	9 069 508	225 469 544	216 400 036	57 635.124	274 035.160	0	274 035.160	57 635 124
	FTE	0 0	0 0	0 0	0 0	0.0	0 0	0 0	0 0	0 0	0 0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	62 675 659	69 209 967	3 118 350	72 328.317	76 066 847	20 165 441	96 232 288	0	96.232.288	20.165.441
	CFE/RF	0	6 856 880	0	6.856 880	0	0	0	0	0	0
	FF	115 819.362	140.333 189	5 951 158	146.284 347	140.333 189	37 469.683	177 802.872	0	177.802.872	37.469.683
(4) Indigent Care Program; Children's Basic Health Plan Premium Costs	Total	167 729 257	202 521 966	11 258 390	213.780.356	202 521.966	58.063.417	260 585.383	0	260.585 383	58.063.417
	FTE	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	58 910 116	64 352.642	3.884.459	68.237 101	71 209 522	20 315 343	91.524 865	0	91.524 865	20.315.343
	CFE/RF	0	6.856.880	0	6 856 880	0	0	0	0	0	0
	FF	108 819 141	131 312 444	7 373 931	138 686 375	131 312 444	37 748 074	169 060 518	0	169.060.518	37 748.074

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Decision Item FY 2011-12 ☑	Base Reduction Item FY 2011-12 ☐	Supplemental FY 2010-11 ☑	Budget Amendment FY 2011-12 ☐
Request Title:	Children's Basic Health Plan Medical Premium and Dental Benefit Costs		
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew	**Date:** November 1, 2010
Priority Number:	DI-3, S-3	**OSPB Approval:**	**Date:**

	Fund	1 Prior-Year Actual FY 2009-10	2 Appropriation FY 2010-11	3 Supplemental Request FY 2010-11	4 Total Revised Request FY 2010-11	5 Base Request FY 2011-12	6 Decision/ Base Reduction FY 2011-12	7 November 1 Request FY 2011-12	8 Budget Amendment FY 2011-12	9 Total Revised Request FY 2011-12	10 Change from Base (Column 5) FY 2012-13
(4) Indigent Care Program; Children's Basic Health Plan Dental Benefits Costs	Total	10,765,764	13,878,070	(2,188,882)	11,689,188	13,878,070	(428,293)	13,449,777	0	13,449,777	(428,293)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	3,765,543	4,857,325	(766,109)	4,091,216	4,857,325	(149,902)	4,707,423	0	4,707,423	(149,902)
	CFE/RF	0	0	0	0	0	0	0	0	0	0
	FF	7,000,221	9,020,745	(1,422,773)	7,597,972	9,020,745	(278,391)	8,742,354	0	8,742,354	(278,391)

Non-Line Item Request: None.

Letternote Revised Text:

FY 2010-11: a Of this amount, $29,240,783 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $28,388,860 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; $10,047,855 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.; and $559,603 shall be from the Colorado Immunization Fund created in 25-4-2301, C.R.S. Reappropriated Funds shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.

FY 2010-11: b Of this amount, $2,307,876 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $1,417,620 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; and $365,720 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.

FY 2011-12: c Of this amount, $37,862,340 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $32,439,876 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; $20,639,550 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.; and $583,099 shall be from the Colorado Immunization Fund created in 25-4-2301, C.R.S. Reappropriated Funds shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.

FY 2011-12: d Of this amount, $2,365,627 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $1,627,651 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; and $714,145 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.

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

Reappropriated Funds Source, by Department and Line Item Name: Children's Basic Health Plan Trust Fund 11G

Approval by OIT? Yes: ☐ No: ☐ N/A: ☑

Schedule 13s from Affected Departments: N/A

CHANGE REQUEST for FY 2011-12 BUDGET REQUEST CYCLE

Department:	Health Care Policy and Financing
Priority Number:	DI-3, S-3
Change Request Title:	Children's Basic Health Plan Medical Premium and Dental Benefit Costs

SELECT ONE (click on box):

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

SELECT ONE (click on box):

Supplemental or Budget Request Amendment Criterion:

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

Short Summary of Request:

This request is to increase the FY 2010-11 appropriation for the Children's Basic Health Plan Premium Costs by $11,258,390, of which $3,884,459 is cash funds and $7,373,931 is federal funds. The FY 2011-12 request for the Children's Basic Health Plan Premium Costs is an increase of $58,063,417 from the FY 2011-12 Base Request, and includes $20,315,343 cash funds and $37,748,074 federal funds. This request also seeks to decrease the FY 2010-11 Children's Basic Health Plan Dental Benefit Costs appropriation by $2,188,882, consisting of $766,109 cash funds and $1,422,773 federal funds. The FY 2011-12 request for the Children's Basic Health Plan Dental Benefit Costs is a reduction of $428,293 from the FY 2011-12 Base Request, and includes $149,902 cash funds and $278,391 federal funds. The adjustments requested for FY 2010-11 are the result of reduced caseload estimates and higher medical and dental costs.

General Description of Request:

The Children's Basic Health Plan, marketed as the Child Health Plan Plus or CHP+, is a program that provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 250% of the federal poverty level) who do

not qualify for Medicaid and do not have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration. The federal government implemented this program in 1997, giving states an enhanced match on State expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. The Plan also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization. All pregnant women enrolled in the Plan receive services through the State's self-funded network.

This request seeks:

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

I. Description of Request Related to Children's Premiums

Caseload Projections (Exhibit C.6)

Many factors have caused volatility in the traditional children's caseload (up to 185% of the federal poverty level) since FY 2006-07. These factors include:

- Marketing and outreach for the Children's Basic Health Plan began in April 1, 2006. The marketing campaign has been successful, and the Department believes that it has had a positive effect on caseload in both the children and prenatal programs. The Department's outreach efforts were expanded in FY 2008-09 through many initiatives, including trainings, enrollment fairs, issuance of community grants, and Spanish translation of brochures. In addition to efforts funded by the Department, there has been an increase in community-based outreach activities in the last three years;

- The Medicaid asset test was removed on July 1, 2006, which increased the number of low-income children moving from CHP+ to Medicaid; and,
- The Deficit Reduction Act of 2005 (DRA) imposed citizenship and identification requirements on individuals applying for or receiving Medicaid benefits, which may have had a positive impact on CHP+ caseload. Children who did not provide proper proof of citizenship may not gain Medicaid eligibility, but would still be eligible for CHP+, which was not subject to the Deficit Reduction Act. With the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the DRA citizenship documentation requirements for Medicaid are now required for children in CHP+.

Net of the effects of policy changes, it is reasonable to expect the caseloads in Medicaid Eligible Children and CHP+ to partially move in opposite directions. In times of economic growth or stability, Medicaid caseload is expected to drop with employment or income increases. Some children whose family income is now too high for Medicaid eligibility may be within CHP+ income guidelines. Similarly, in times of economic decline, Medicaid caseload is expected to increase, with some children entering Medicaid rather than CHP+. So as Medicaid caseload increases, CHP+ caseload may increase at a slower rate. As seen in the Department's November 1, 2010 Budget Request, Exhibit B, page EB-1, Medicaid Eligible Children caseload increased by 40,543 in FY 2009-10, a 17.24% increase from FY 2008-09. Children's caseload in CHP+ increased by 7,143 in FY 2009-10, or 11.60%. The base Medicaid Eligible Children caseload is projected to grow by a further 21,668 children, or 5.61%, in FY 2010-11 and 2.77% in FY 2011-12.

The final FY 2009-10 caseload for traditional children was 62,786, which was lower than the Department's February 16, 2010 forecast of 63,776. The Department believes that the major reason for this was the implementation of the expansion in CHP+ to 250% FPL in May 2010, which resulted in movement within income categories. The Department anticipates that the traditional children caseload will continue to experience moderate increases in FY 2010-11. Growth in FY 2010-11 and FY 2011-12 should be due to community outreach and natural growth, owing to factors such as the economic conditions and general population growth.

The Department believes that there is now sufficient data to project caseload for traditional children using econometric models, similar to those used to forecast Medicaid caseload. The selected trend for FY 2010-11 for traditional children is in line with the Department's February 2010 forecast, and would result in average growth of 304 children, or 0.48% per month. The forecasted annual average caseload for traditional children in FY 2010-11 is 64,014. This forecast reflects the moderating monthly growth seen since FY 2007-08. However, because the economy is believed to be largely responsible for this change, the Department believes that projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2010-11. Similar to the pattern seen in low-income Medicaid categories, the out-year trend is expected to temper with moderating monthly growth, reflective of projected moderating economic conditions beginning in FY 2010-11. The Department forecasts that the traditional children caseload will increase by 0.36% per month in FY 2011-12 to 68,035. This revised caseload estimates for both FY 2010-11 and FY 2011-12 are lower than the current FY 2010-11 appropriated caseload of 70,906. See Exhibit C.10 for details on the models used to project trends for the traditional children.

After accounting for policy changes that affected traditional and expansion populations over the last three years, monthly growth in the Expansion to 200% FPL Children caseload has been approximately equal to that for the traditional children since FY 2006-07. The Department believes that the converging of growth rates is reflective of a maturing population that is approaching a stable long-term growth rate. As such, the Department anticipates that growth in Expansion to 200% FPL Children will mirror that in traditional children in both FY 2010-11 and FY 2011-12. This forecast results in average monthly growth of 21 children, or 0.47% per month in FY 2010-11 and 0.35% per month in FY 2011-12. The FY 2010-11 revised caseload forecast is 4,363 and the projection for FY 2011-12 is 4,637. Both the FY 2010-11 and FY 2011-12 forecasts are much lower than the current FY 2010-11 appropriated caseload of 4,859.

Eligibility in CHP+ was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Expansion to 205% FPL Children), and was implemented

beginning March 1, 2008. Growth in this population in FY 2007-08 was significantly higher than the forecast included in the fiscal note for SB 07-097. The Department believes that this higher than anticipated growth is due largely to the number of children that moved within CHP+ from lower income groupings.

Growth in Expansion to 205% FPL children in FY 2009-10 was lower than the Department's February 16, 2010 forecast, in which annual caseload was projected to be 1,698. The selected trend for FY 2010-11 for Expansion to 205% FPL children is lower than the Department's February 2010 forecast, and would result in average growth of 18 children per month. This is based on the average monthly growth of 1.19% that was experienced between August 2008 and April 2010. May and June 2010 are omitted because the Department believes that the large declines seen in these months are due to the expansion to 250% FPL in CHP+, which resulted in movement within income categories. Out-year trends for this population remain positive, with forecasted monthly increases of 0.83% in FY 2011-12, as current forecasts indicate that economic conditions should begin to improve in FY 2010-11. The FY 2010-11 revised caseload forecast of 1,504 and the FY 2011-12 projection is 1,691, both of which are much lower than the current FY 2010-11 appropriated caseload of 2,168.

Eligibility in CHP+ was again expanded from 205% to 250% of the federal poverty level through HB 09-1293 (known as Expansion to 250% FPL Children), and was implemented beginning May 1, 2010. Growth in FY 2009-10 was slightly lower than the Department's February 16, 2010 estimates. However, the Department believes that caseload will grow as was originally forecasted due to children undergoing annual redeterminations throughout FY 2010-11 and moderating economic conditions, which may increase caseload in the higher income groups. The forecast would result in average growth of 897 per month in FY 2010-11 and 205 per month in FY 2011-12.

Caseload Adjustments

In addition to the base caseload outlined above, there is a small bottom line adjustment to the children's caseload for the forecast period from the passage of the Health Care

Affordability Act, HB 09-1293. Effective February 2012, a 12-month guaranteed eligibility will be granted to children in Medicaid, which is anticipated to decrease the length of stay in CHP+ as fewer children move between the two programs and result in a caseload decrease beginning in FY 2011-12. This adjustment has been updated from the HB 09-1293 estimate to account for the revised caseload forecasts, and is being included in the Traditional Children population as this group is closest to Medicaid in terms of income, and is therefore the group that such children would most likely move to.

Total Children's Caseload Projection

The FY 2010-11 children's caseload forecast is 76,741, an 11.66% increase over the FY 2009-10 caseload of 68,725. This forecast results in average increases of 1,239 (1.26%) per month, and is much lower than the current FY 2010-11 appropriated caseload of 84,793. The FY 2011-12 caseload is projected to increase by 12.74% to 86,516, with forecasted increases of 474 clients, or 0.55% per month in FY 2011-12. Caseload growth in CHP+ may accelerate as the caseload increases in Medicaid children moderate.

Children's Caseload Summary	FY 2010-11 Appropriated Caseload	FY 2010-11 Revised Caseload	FY 2011-12 Requested Caseload
Traditional Children (up to 185% FPL)	70,906	64,014	67,063
Expansion to 200% FPL Children	4,859	4,363	4,637
Expansion to 205% FPL Children	2,168	1,504	1,691
Expansion to 250% FPL Children	6,860	6,860	13,125
Final Requested Caseload	**84,793**	**76,741**	**86,516**

Children's Per Capita (Exhibit C.5)

CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. The

CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor. Effective January 2009, the schedule of claims reconciliations has changed from annually to monthly. This will reduce the large year-end payments that have occurred in past years, and should help the Department identify changes in utilization trends sooner.

Beginning with FY 2009-10, the Department and its contracted actuary have changed the schedule for developing capitation rates. Previously, rates were calculated one year in advance, which required the actuary to rely on utilization data from at least two years prior to the year in question. For example, the original FY 2008-09 HMO rates were developed in July 2007 and were based on claims costs incurred in 2005 and 2006. The rate development now begins 6 months later, which allows the actuaries to use the entire prior fiscal year of utilization data in its calculation. This change should decrease the variation in rates between years, as well as making the rates more accurate.

In the development of the FY 2009-10 CHP+ rates (using data from FY 2006-07 and FY 2007-08), the contracted actuary found large increases in costs in both the SMCN and the HMOs. The following have been identified as possible causes of these increased costs:

- Children's enrollment has increased significantly since the base capitation rates were set. The highest growth was seen in children age 0 through 2 years old, which is the age group with the highest cost;
- Utilization of services (such as number of doctor visits, prescriptions filled, etc) has been increasing. There were also increases in the number of high cost children enrolled in the CHP+;
- Both the self-funded network and the HMOs have experienced large increases in unit cost, which measures the mix of services obtained as well as the underlying fee schedule and billed charges where applicable, and;
- In addition to these identifiable impacts, the Department implemented presumptive eligibility for children effective January 1, 2008. Although the Department cannot quantify the impact of this policy change at this time, the contracted actuary believes that this may be partially responsible for the increased utilization seen for emergent type services.

In addition, historic capitation rates for the self-funded network have been too low, resulting in significant year-end claims reconciliations. The Department believes that by trending these rates forward, there has been a compounding effect on the inadequacy of the rates. With the move to cash accounting and the switch in TPA vendors, the Department has been reconciling claims incurred in both FY 2007-08 and FY 2008-09 in FY 2009-10. These factors resulted in larger than anticipated reconciliation payments in FY 2009-10, and thus a higher per member per month cost than projected.

The Department has been working on revising its facility reimbursement methodology for two years, and the plan was effective July 1, 2009. Previously, the Department reimbursed inpatient hospitals at an approximate average of 65% of billed charges for the Children's Basic Health Plan self-funded network, whereas Medicaid reimburses at a much lower rate. During negotiations with the hospitals regarding the change in reimbursement methodology, the Department gave notice of its intent to move to a diagnosis-related group (DRG) methodology based on that used in Medicaid. At that time, Medicaid was scheduled to begin moving to a new DRG platform in FY 2009-10 to be fully implemented in FY 2010-11, and the Department proposed that hospital reimbursement for CHP+ move at the same time. However, the hospitals were reluctant to change to a CHP+ DRG system in FY 2009-10 and change again in FY 2010-11 to the Medicaid DRG system, and agreed that the savings could be achieved through a reduction to 44% of billed charges in FY 2009-10. In addition to the reduction to 44% of billed charges, the hospital charge masters were supposed to be frozen as of July 1, 2009 to ensure that the State was not seeing increased charges. However, the Department was not able to execute contracts with the hospitals due to limited resources in the Procurement Division, which allowed the billed charges to increase.

As discussed in the Department’s June 21, 2010 1331 Emergency Supplemental Request for FY 2009-10, the anticipated savings from this reimbursement change were not realized. The year-to-date actual PMPM (data through March 2010 with an estimate for incurred but not reported (IBNR) claims) for hospital services is 6.5% higher than that included in the FY 2009-10 rate development (blended for the relative share of children

and prenatal women). This is a combination of both utilization and unit costs being higher than estimated in the rate development. Due to lags in billing and retroactivity, the Department and the contracted actuary were not able to confirm that hospital charge masters had indeed been increased until May 2010. In response to the continuing rise in hospital costs, the Department is again changing its facility reimbursement methodology. Effective July 1, 2010, CHP+ will reimburse both inpatient and outpatient hospital services at 135% of the Medicaid DRG. This change will result in predictable hospital reimbursements, and will result in more equitable reimbursement across hospitals (i.e., hospitals with relatively low cost-to-charge ratios will no longer receive lower reimbursement due to their charges being lower).

For the development of the FY 2010-11 CHP+ rates, the contracted actuary again found an annual cost trend above 15%. The actuary has opted to use the FY 2008-09 costs as the base, but assumes normal trends going forward as the FY 2008-09 base cost reflects the increases in utilization and unit costs that have caused the large increases in the past two years. For projecting to FY 2010-11, the contracted actuary reviewed published studies to determine industry norms for current and projected health care cost trends. Based on surveys reporting trends ranging from 4.40% to 10.80%, the contracted actuary estimates a trend of 9.50% for the average unit cost increase across service types. Utilization trend is projected to average 5.30% across service types, with relatively higher trends in inpatient and outpatient hospital due to long-term utilization patterns being high in these services. The total per member per month base trend is 15.30%.

As discussed above, effective July 1, 2010, the Department will implement a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they will be paid 135% of the Colorado Medicaid DRGs for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program will essentially adopt the Medicaid reimbursement methodologies. Actuarial analysis shows a 28% savings in outpatient claims and a 35% savings for inpatient claims, or a total decrease of 21.62% in the base monthly rate for children in the SMCN.

The final FY 2010-11 SMCN children's per member per month rate is $174.93, which includes administrative costs of $24.19 for claims administration and case management and $3.23 for stop loss coverage. This is a 12.42% increase from the final FY 2009-10 blended rate.

For projecting the FY 2010-11 HMO capitation rate, the contracted actuary used actual HMO experience through FY 2008-09 combined with published studies of health care cost trends. The average trends across service types are 3.0% for utilization and 6.9% for unit cost, with higher trends for both utilization and cost in both inpatient and outpatient hospital services due to long-term utilization patterns being high in these services. This includes $12.11 in administrative costs, which are estimated to be 8.4% of total costs based on expenses reported by the four HMOs. To estimate this cost, the contracted actuary calculated the average per member per month cost of the two HMOs with mid-range reported administrative expenses. An annual trend of -0.6% is applied, based on the most recent Denver-Boulder-Greeley consumer price index for all items.

For FY 2010-11, the Department estimates that approximately 32% of children will be served in the self-funded network and the remaining 68% will be enrolled in an HMO. This is based on historical experience as well as the expectation that the percentage of children in an HMO will continue to increase as the Plan adds HMO service to geographic areas that were previously served only by the SMCN. Applying these weights to the actuarial rates yields a blended rate of $154.47 for all children in FY 2010-11. This is an increase of 6.28% over the final FY 2009-10 blended rate of $145.34 (calculated based on actual caseload shares between HMOs and the self-funded network). See Exhibit C.5, page C.5-2 for calculations.

The Department's FY 2010-11 forecasted per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that the capitation rate for the self-funded network is indeed in line with the costs incurred for these children, and that other factors that may affect per capita costs remain constant from FY 2008-09. Examples of other factors that may affect per capita costs include the length of stay in the program,

enrollment mix between the more expensive self-funded network and HMOs, and the average length of time taken for a child to enroll in an HMO.

The growth in the FY 2010-11 blended capitation rate is used to project the FY 2010-11 per capita. The base growth of 6.28% is applied to the calculated FY 2009-10 per capita to estimate a base per capita of $2,324.41. There are no bottom line adjustments to the FY 2010-11 per capita at this time.

The Department has used the ten-year average Consumer Price Index for medical care for the Denver-Boulder-Greeley area to project the FY 2011-12 HMO and self-funded rates separately. The blended rate is then calculated assuming that 30.0% of children will be served in the self-funded network in FY 2011-12 and the remaining 70.0% will be enrolled in an HMO. This results in an increase of 4.20% for FY 2011-12 from the FY 2010-11 base rate.

Similar to the FY 2010-11 per capita, the projected growth in the FY 2011-12 blended capitation rate is used to project the FY 2011-12 per capita. The Department applies the projected 4.20% growth to the FY 2010-11 estimated per capita of $2,324.41 for a projected FY 2011-12 per capita of $2,422.04. There are currently no adjustments to the FY 2011-12 per capita for programmatic changes.

II. Description of Request Related to the Prenatal Program

Caseload Projections (Exhibit C.7)

In FY 2006-07 and FY 2007-08, the Children's Basic Health Plan prenatal population did not experience the volatility in caseload that was seen in the children's population. The removal of the Medicaid asset test did not affect this population, as pregnant women were never subject to asset limitations to qualify for the Medicaid Baby and Kid Care Program. In addition, the prenatal population was subject to the identification requirements of HB 06S-1023. With the passage of SB 07-211, the prenatal population is exempted from the

HB 06S-1023 identification requirements beginning July 1, 2007, which may be partially responsible for some of the strong growth in FY 2007-08.

Similarly to the Medicaid Baby and Kid Care Program Adults, the traditional prenatal population experienced unusually strong growth in FY 2007-08 and a negative trend in the first half of FY 2008-09. Traditional prenatal in CHP+, however, has continued to exhibit declines. Pregnant women in Medicaid are required to provide proof of citizenship and identification under the Deficit Reduction Act. Strong growth in the Medicaid population and the negative trend in FY 2008-09 indicate that the exemption of the prenatal population in the Children's Basic Health Plan from similar requirements under HB 06S-1023 was not the sole driver behind the large increases in FY 2007-08. Prior to January 2008, all functions for presumptive eligibility for pregnant women in the Children's Basic Health Plan were performed by an external contractor. Presumptive eligibility is now processed in the Colorado Benefits Management System, which may impact the growth trends by moving clients from presumptive eligibility into the Plan immediately upon full eligibility determination.

The Department has modeled the FY 2009-10 projection for the traditional prenatal on the monthly growth experienced between January 2008 and June 2010, during which caseload declined by an average of 0.02% per month. This forecast is lower than that from the Department’s February 16, 2010 forecast, reflecting the lower than anticipated growth since FY 2008-09. The Department’s forecast assumes that the FY 2010-11 trend will continue in out years, with zero growth on average

The Colorado Department of Public Health & Environment Family Planning Initiative was awarded a grant for approximately $3.5 million to address the issue of unintended pregnancy. This funding will provide local Title X Family Planning clinics with money to purchase long acting methods of contraception, funding for sterilizations and funding to expand clinic capacity to see more Title X clients, the vast majority of which are under 200% of the federal poverty level. These initiatives may reduce future trends. This Family Planning initiative as well as the Family Planning waiver that was submitted by the

Department in accordance with SB 08-003, and assuming a stable economy, support moderate trends in the traditional prenatal population.

While the Expansion to 200% FPL Prenatal population has been in place for the same amount of time as the Expansion to 200% FPL children, its growth rate is not converging with the traditional prenatal population, as is occurring with the child populations. As with the children's populations, it appears that the expansion to 205% of the federal poverty level (known as Expansion to 205% FPL Prenatal) is partially responsible for the caseload decline in March 2008. This effect is expected to be mitigated in the prenatal population, as there is no period of guaranteed eligibility that would allow for movement within the program.

Unlike the traditional prenatal population, this income group has seen growth throughout FY 2009-10. The Department's forecast for FY 2010-11 is based on the growth experienced between May 2008 and June 2010, during which monthly increases averaged 0. 60%. The Department projects that this moderate growth will continue in FY 2010-11. The selected trend is higher than that from the Department's February 2010 forecast, and results in average growth of approximately 1 client per month.

Eligibility in the Children's Basic Health Plan was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Expansion to 205% FPL Prenatal), and was implemented beginning March 1, 2008. Growth in this population in FY 2007-08 was significantly higher than the forecast included in the fiscal note for SB 07-097. The Department believes that this higher than anticipated growth is partially due to the women moving within the Children's Basic Health Plan from lower income groupings. The Department's forecast for this population for is based on the average monthly growth slightly less than 1 client per month that was experienced between June 2008 and June 2010, and results in average growth of 0.67% per month. The Department assumes that this moderate growth will continue in FY 2011-12.

Eligibility in CHP+ was again expanded from 205% to 250% of the federal poverty level through HB 09-1293 (known as Expansion to 250% FPL Prenatal), and was implemented

beginning May 1, 2010. Growth in FY 2009-10 was lower than the Department's February 16, 2010 estimates. However, the Department believes that caseload will grow as was originally forecasted due to moderating economic conditions, which may increase caseload in the higher income groups. The forecast would result in average growth of 119 per month in FY 2010-11 and 36 per month in FY 2011-12.

Total Prenatal Caseload Projection

The FY 2010-11 total prenatal caseload forecast is 2,393, a 53.30% increase over the FY 2009-10 caseload of 1,561. This forecast includes average increases of 121 (6.06%) per month. The FY 2011-12 caseload is projected to increase 38.03% to 3,303, with average growth of 2.26% (66 clients) per month.

Prenatal Caseload Summary	FY 2010-11 Appropriated Caseload	FY 2010-11 Revised Caseload	FY 2011-12 Requested Caseload
Traditional Prenatal (up to 185% FPL)	1,307	1,262	1,262
Expansion to 200% FPL Prenatal	192	197	209
Expansion to 205% FPL Prenatal	110	76	82
Expansion to 250% FPL Prenatal	858	858	1,750
Final Requested Caseload	**2,467**	**2,393**	**3,303**

Prenatal Per Capita (Exhibit C.5)

All clients in the prenatal program are served by the self-funded program (now administered by Colorado Access) and the costs of their services are billed in full directly to the State. As discussed in Children's Rates in Section I, the contracted actuary found large increases in costs in the SMCN during the development of the FY 2009-10 CHP+ rates (using data from FY 2006-07 and FY 2007-08). Specifically, inpatient hospital utilization in the prenatal program increased by 27.9% in FY 2007-08.

In addition, historic capitation rates for the self-funded network have been too low, resulting in significant year-end claims reconciliations. The Department believes that by trending these rates forward, there has been a compounding effect on the inadequacy of the rates. With the move to cash accounting and the switch in TPA vendors, the Department has been reconciling claims incurred in both FY 2007-08 and FY 2008-09 in FY 2009-10. These factors resulted in larger than anticipated reconciliation payments in FY 2009-10, and thus a higher per member per month cost than projected.

As discussed in the Children's Rates in Section I, the Department has been working on revising its facility reimbursement methodology for two years, and the plan was effective July 1, 2009. Previously, the Department reimbursed inpatient hospitals at an approximate average of 65% of billed charges for the Children's Basic Health Plan self-funded network, whereas Medicaid reimburses at a much lower rate. During negotiations with the hospitals regarding the change in reimbursement methodology, the Department gave notice of its intent to move to a diagnosis-related group (DRG) methodology based on that used in Medicaid. At that time, Medicaid was scheduled to begin moving to a new DRG platform in FY 2009-10 to be fully implemented in FY 2010-11, and the Department proposed that hospital reimbursement for CHP+ move at the same time. However, the hospitals were reluctant to change to a CHP+ DRG system in FY 2009-10 and change again in FY 2010-11 to the Medicaid DRG system, and agreed that the savings could be achieved through a reduction to 44% of billed charges in FY 2009-10. In addition to the reduction to 44% of billed charges, the hospital charge masters were supposed to be frozen as of July 1, 2009 to ensure that the State was not seeing increased charges.

A discussed in the Department's June 21, 2010 1331 Emergency Supplemental Request for FY 2009-10, the anticipated savings from this reimbursement change were not realized. The year-to-date actual PMPM (data through March 2010 with an estimate for incurred but not reported (IBNR) claims) for hospital services is 6.5% higher than that included in the FY 2009-10 rate development (blended for the relative share of children and prenatal women). This is a combination of both utilization and unit costs being higher than estimated in the rate development. Due to lags in billing and retroactivity, the Department and the contracted actuary were not able to confirm that hospital charge

masters had indeed been increased until May 2010. In response to the continuing rise in hospital costs, the Department is again changing its facility reimbursement methodology. Effective July 1, 2010, CHP+ will reimburse both inpatient and outpatient hospital services at 135% of the Medicaid DRG. This change will result in predictable hospital reimbursements, and will result in more equitable reimbursement across hospitals (i.e., hospitals with relatively low cost-to-charge ratios will no longer receive lower reimbursement due to their charges being lower).

For the development of the FY 2010-11 CHP+ rates, the contracted actuary again found large annual cost trends, with inpatient and outpatient hospital services both exceeding 45%. The actuary has opted to use the FY 2008-09 costs as the base, but assumes normal trends going forward as the FY 2008-09 base cost reflects the increases in utilization and unit costs that have caused the large increases in the past two years. For projecting to FY 2010-11, the contracted actuary reviewed published studies to determine industry norms for current and projected health care cost trends. Based on surveys reporting trends ranging from 4.40% to 10.80%, the contracted actuary estimates a trend of 9.60% for the average unit cost increase across service types. Utilization trend is projected to average 5.70% across service types, with relatively higher trends in inpatient and outpatient hospital due to long-term utilization patterns being high in these services. The total per member per month base trend is 15.80%.

As discussed above, effective July 1, 2010, the Department will implement a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they will be paid 135% of the Colorado Medicaid DRGs for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program will essentially adopt the Medicaid reimbursement methodologies. Actuarial analysis shows a 42% savings in outpatient claims and a 14% savings for inpatient claims, or a total decrease of 15.93% in the base monthly rate for children in the SMCN.

The final FY 2010-11 SMCN prenatal per member per month rate is $1,092.92, which includes administrative costs of $24.19 for claims administration and case management

and $3.23 for stop loss coverage. This is a 33.06% increase from the final FY 2009-10 rate. The single largest factor contributing to the cost trend is a change in the claim handling for certain newborns. Newborns without a state ID number are covered under the prenatal program by the current administrator, while the prior administrator denied claims for newborns without a state ID number. The claims for such newborns were then paid under the children's program under the previous administrator, whereas they are now paid under the prenatal program.

The Department's FY 2010-11 forecasted per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that the capitation rate for the self-funded network is indeed in line with the costs incurred for the women and that length of stay in the program remains constant from FY 2008-09. The base growth of 33.06% is applied to the calculated FY 2009-10 per capita to estimate a base per capita of $14,794.32. There are no bottom line adjustments to the FY 2010-11 per capita at this time.

The Department has used the ten-year average Consumer Price Index for medical care for the Denver-Boulder-Greeley area to project the FY 2011-12 self-funded rate. Similar to the FY 2010-11 per capita, the projected growth in the FY 2011-12 capitation rate is used to project the FY 2011-12 per capita. The Department applies the projected 4.60% growth to the FY 2010-11 estimated per capita of $14,794.32 for a projected FY 2011-12 per capita of $15,452.67. There are currently no adjustments to the FY 2011-12 per capita for programmatic changes.

III. Description of Request Related to the Children's Dental Benefit Costs

Dental Caseload (Exhibit C.6)

Children who qualify for the Children's Basic Health Plan are eligible to receive dental benefits in addition to medical benefits. There are consistently fewer members enrolled in the dental program than in the medical plan, because new members do not receive dental coverage during their pre-HMO enrollment period. Beginning in FY 2007-08, the

Department no longer estimates a separate dental caseload. Rather, the dental caseload will be the same as the medical caseload, and the per capita will incorporate a lower cost per client due to a shorter length of stay in the dental program.

Dental Per Capita (Exhibit C.5)

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

For the development of the FY 2010-11 dental capitation rate, the contracted actuary based the annual trend rate of 3.50%. This is lower than industry trends (between 4.10% and 6.75%) because the trend affects costs only for the portion of children that do not reach the annual cap. The assumed cost trend assumes 1.50% annual utilization trend and 2.00% unit cost trend. Combined with the projected change in the age and income distribution in the Plan, the projected capitation rate of $14.40 is a 2.77% decrease over the FY 2009-10 capitation. The FY 2010-11 monthly rate assumes the continuation of all benefit expansions, as well as an estimated $1.12 in administrative costs. The trend in the capitation rate is negative due largely to decreased utilization in high cost services between FY 2007-08 and FY 2008-09, which is the base period that the FY 2010-11 rate is trended from.

The Department’s FY 2010-11 forecasted per capita growth rates mirrors that of the actuarially developed rate. This forecast assumes that other factors that may affect per capita costs, such as the length of stay in the Children's Basic Health Plan and the average length of time taken for a child to receive dental benefits, remain constant from FY 2008-09 base period. Base growth of -2.77% from the capitation rate is applied to the calculated FY 2009-10 per capita of $156.66, resulting in a projected FY 2010-11 per capita of $152.32.

As discussed in Children's Rates in Section I, beginning with FY 2009-10, the Department and its contracted actuary have changed the schedule for developing capitation rates and the FY 2011-12 rates have not yet been developed.

To estimate the FY 2011-12 per capita trend, the Department analyzed the historical growth in the dental rates. The Department has assumed that the growth rate for FY 2011-12 will approximate the average growth over the last four years, or 2.06%. The projected FY 2011-12 per capita is $155.46. There are no per capita adjustments for the dental program.

IV. Update on Reconciliation of Administrative Expenditures

As discussed in its November 1, 2006 FY 2007-08 DI-3 and February 16, 2009 S-3, the Department described a potential accounting irregularity related to administrative costs in the Children's Basic Health Plan. When the federal government enacted the State Children's Health Insurance Plan, it stipulated that administrative costs up to 10% of total program expenditures would be matched by the federal government on a federal fiscal year basis. While unspent federal funds in a given quarter can be utilized within the same fiscal year, expenditures can not be applied against the 10% cap in any other fiscal year. In the early years of the program, the Department experienced administrative costs that were in excess of the 10% cap and was therefore entitled to claim the entire amount of federal matching funds available. In subsequent years, the Department continued to draw federal matching funds on 10% of its budgeted program expenditures, even though actual administrative costs as a portion of total expenditures decreased considerably.

With large program growth in FY 2005-06, the Department reviewed the procedure for administrative costs and revised its methodology in October 2006. The Department is able to administer the program for less than the allowable 10% of program costs. As a result, since October 2006 the Department has drawn the federal revenue it needs for administration based on the actual expenditures by quarter and no longer rolls expenditures into other quarters.

The review of this issue has been on-going and is a work in progress. The Department has been working with the Centers for Medicare and Medicaid Services since late 2008 to determine which methodology for calculation of the federal draw for administration is most appropriate, as well as to determine whether any federal revenue has in fact been overdrawn. The Office of Inspector General began auditing this issue in early 2009, and the Department has been working with the OIG throughout this process. The Department anticipates that this audit will be finalized in 2010, following the Department's review of the OIG findings.

Consequences if Not Funded:

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

Calculations for Request:

Summary of Request FY 2010-11 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs	**Total Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Total Appropriation	$202,521,966	$64,352,642	$6,856,880	$131,312,444
FY 2010-11 Final Appropriation (Column 2)	$202,521,966	$64,352,642	$6,856,880	$131,312,444
FY 2010-11 Supplemental Request (Column 3)	$11,258,390	$3,884,459	$0	$7,373,931
FY 2010-11 Total Revised Request (Column 4)	**$213,780,356**	**$68,237,101**	**$6,856,880**	**$138,686,375**

Summary of Request FY 2011-12 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs	**Total Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Final Appropriation (Column 2)	$202,521,966	$64,352,642	$6,856,880	$131,312,444
Remove One-time Appropriation from Trust	$0	$6,856,880	($6,856,880)	$0
FY 2011-12 Base Request (Column 5)	$202,521,966	$71,209,522	$0	$131,312,444
FY 2011-12 November 1, 2010 DI-3 (Column 6)	$58,063,417	$20,315,343	$0	$37,748,074
Total FY 2011-12 Revised Request (Column 9)	**$260,585,383**	**$91,524,865**	**$0**	**$169,060,518**

Summary of Request FY 2012-13 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs	**Total Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Final Appropriation (Column 2)	$202,521,966	$64,352,642	$6,856,880	$131,312,444
FY 2011-12 Base Request (Column 5)	$202,521,966	$71,209,522	$0	$131,312,444
FY 2011-12 November 1, 2010 DI-3 (Column 6)	$58,063,417	$20,315,343	$0	$37,748,074
FY 2012-13 Change from Base (Column 10)	**$58,063,417**	**$20,315,343**	**$0**	**$37,748,074**

Summary of Request FY 2010-11 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs	**Total Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Total Appropriation	$13,878,070	$4,857,325	$0	$9,020,745
FY 2010-11 Final Appropriation (Column 2)	$13,878,070	$4,857,325	$0	$9,020,745
FY 2010-11 Supplemental Request (Column 3)	($2,188,882)	($766,109)	$0	($1,422,773)
FY 2010-11 Total Revised Request (Column 4)	**$11,689,188**	**$4,091,216**	**$0**	**$7,597,972**

Summary of Request FY 2011-12 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs	**Total Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Final Appropriation (Column 2)	$13,878,070	$4,857,325	$0	$9,020,745
FY 2011-12 Base Request (Column 5)	$13,878,070	$4,857,325	$0	$9,020,745
FY 2011-12 November 1, 2010 DI-3 (Column 6)	($428,293)	($149,902)	$0	($278,391)
Total FY 2011-12 Revised Request (Column 9)	**$13,449,777**	**$4,707,423**	**$0**	**$8,742,354**

Summary of Request FY 2012-13 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs	**Total Funds**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2010-11 Final Appropriation (Column 2)	$13,878,070	$4,857,325	$0	$9,020,745
FY 2011-12 Base Request (Column 5)	$13,878,070	$4,857,325	$0	$9,020,745
FY 2011-12 November 1, 2010 DI-3 (Column 6)	($428,293)	($149,902)	$0	($278,391)
FY 2012-13 Change from Base (Column 10)	**($428,293)**	**($149,902)**	**$0**	**($278,391)**

Cash Funds Projections:

Cash Fund Name	**Cash Fund Number**	**FY 2009-10 Expenditures**	**FY 2009-10 End of Year Cash Balance**	**FY 2010-11 End of Year Cash Balance Estimate**	**FY 2011-12 End of Year Cash Balance Estimate**	**FY 2012-13 End of Year Cash Balance Estimate**
Children's Basic Health Plan Trust Fund	11G	$35,440,483	$599,735	$54,080	$11,692	$2,398,058
Health Care Expansion Fund	18K	$111,444,298	$79,234,953	$35,822,131	$753,168	$10,456,327
Hospital Provider Fee Cash Fund	24A	$298,055,638	$5,714,436	$5,714,436	$5,714,436	$5,714,436

Please note that this request does not address the insolvency of either the CHP+ Trust Fund or the Health Care Expansion Fund. Please see the Department's FY 2011-12 DI-6 for information on this.

Assumptions for Calculations: All calculations and assumptions are presented in Exhibits C.1 through C.10 included with this request. Detailed caseload and per capita assumptions are outlined below.

Assumptions for Children's Caseload Projections
FY 2010-11 and FY 2011-12 Enrollment Projection: Exhibit C.6

- The Department's FY 2010-11 forecast assumes that the monthly growth rate will increase to 0.48% per month, based on econometric models. This forecast is reflective of the slowing monthly growth seen over the course of FY 2009-10. Because the economy is believed to be partially responsible for this change, the Department believes that projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2010-11
- Current forecasts indicate that economic conditions will begin to improve beginning in FY 2010-12, and growth in Medicaid Eligible Children caseload is projected to moderate from 5.61% in FY 2010-11 to 2.77% in FY 2011-12. These factors may increase the number of children eligible for CHP+ rather than Medicaid. The Department forecasts that the traditional children caseload will increase by 0.36% per month in FY 2011-12.
- After accounting for policy changes that affected traditional and expansion populations over the last three years, monthly growth in the Expansion to 200% FPL Children caseload has been approximately the same as that for the traditional children since FY 2006-07. The Department believes that the converging of growth rates is reflective of a maturing population that is approaching a stable long-term growth rate. As such, the Department anticipates that growth in Expansion to 200% FPL Children will mirror that in traditional children in both FY 2010-11 and FY 2011-12. This forecast results in average monthly growth of 0.47% per month in FY 2010-11 and 0.35% per month in FY 2011-12.
- Eligibility in CHP+ was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Expansion to 205% FPL Children), and was implemented beginning March 1, 2008. The Department's FY 2010-11 forecast for this population is based on growth experienced between August 2008 and April 2010, during which caseload increased by an average of 1.19% per month. Out-year trends are slightly lower, as current forecasts indicate that economic conditions should begin

to improve in 2010. Growth is forecasted to increase to 0.83% per month in FY 2011-12.

- Eligibility in CHP+ was again expanded from 205% to 250% of the federal poverty level through HB 09-1293 (known as Expansion to 250% FPL Children), and was implemented beginning May 1, 2010. Growth in FY 2009-10 was slightly lower than the Department's February 16, 2010 estimates. However, the Department believes that caseload will grow as was originally forecasted due to children undergoing annual redeterminations throughout FY 2010-11 and moderating economic conditions, which may increase caseload in the higher income groups. The forecast would result in average growth of 897 per month in FY 2010-11 and 205 per month in FY 2011-12.

Assumptions for Prenatal Caseload Projections (Exhibit C.7)

- The Department has modeled the FY 2010-11 projection for the traditional prenatal population on monthly growth experienced between January 2008 and June 2010, during which caseload declined by an average of 0.02% per month. The Department assumes that this trend will continue in FY 2011-12.
- While the Expansion to 200% FPL Prenatal population has been in place for the same amount of time as the expansion children, its growth rate is not converging with the traditional prenatal population, as is occurring with the child populations. The Department's forecast for FY 2010-11 for Expansion to 200% FPL Prenatal is based on the growth experienced between May 2008 and June 2010, during which monthly increases averaged 0.60%. The Department projects that this moderate growth will continue in FY 2011-12.
- Eligibility in CHP+ was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Expansion to 205% FPL Prenatal), and was implemented beginning March 1, 2008. The Department's FY 2010-11 forecast for this population is based on the average monthly growth of slightly less than 1 client per month that was experienced between June 2008 and June 2010. The Department assumes that this moderate growth will continue in FY 2011-12.
- Eligibility in CHP+ was again expanded from 205% to 250% of the federal poverty level through HB 09-1293 (known as Expansion to 250% FPL Prenatal), and was

implemented beginning May 1, 2010. Growth in FY 2009-10 was lower than the Department's February 16, 2010 estimates. However, the Department believes that caseload will grow as was originally forecasted due to moderating economic conditions, which may increase caseload in the higher income groups. The forecast would result in average growth of 119 per month in FY 2010-11 and 36 per month in FY 2011-12.

Assumptions for Per Capita Projections (Exhibit C.5)

- The forecasted children's and prenatal per capitas assume that the actuarially developed self-funded program capitation rates are indeed in line with the costs incurred by clients served in the network.
- All forecasted per capitas assume that growth will mirror that in the actuarially developed capitation rates. Thus, the Department assumes that factors other than the capitation rate that may affect the per capita remain constant from the FY 2008-09 base period from which rates are projected. Such factors may include the children's caseload mix between the self-funded network and HMOs, average length of time to enroll in an HMO or to receive dental benefits, and the average length of stay in CHP+.

Impact on Other Government Agencies: Not applicable.

Cost Benefit Analysis: Not applicable. This request is only to update caseload and per capita costs, and does not require a cost benefit analysis.

Implementation Schedule: Not applicable. This request is only to update caseload and per capita costs, and does not have any programmatic changes to implement.

Statutory and Federal Authority:

Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj). SEC. 2101. [42 U.S.C. 1397aa] (a) PURPOSE-*The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage…*

25.5-8-105 C.R.S. (2010) (1) *A fund to be known as the Children's Basic Health Plan Trust is hereby created… all monies deposited in the trust and all interest earned on the moneys in the Trust shall remain in the Trust for the purposes set forth…*

25.5-8-103 (4) C.R.S., (2010) *"Eligible person" means: (a) A person who is less than nineteen years of age, whose family income does not exceed two hundred fifty percent of the federal poverty level, adjusted for family size…; or (b) A pregnant woman whose family income does not exceed two hundred fifty percent of the federal poverty level, adjusted for family size.*

25.5-8-107 (1) (a) (II), C.R.S. (2010) (1) *In addition to any other duties pursuant to this article, the department shall have the following duties: (a) (II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that: (A) An adequate number of dentists are willing to provide services to eligible children; and (B) The financial resources available to the program are sufficient to fund such services.*

24-22-117 (2) (a) (II), C.R.S. (2010) …*moneys in the Health Care Expansion Fund shall be annually appropriated by the general assembly to the Department of Health Care Policy and Financing for the following purposes: (A) To increase eligibility in the Children's Basic Health Plan, Article 19 of Title 25.5, C.R.S., for Children and Pregnant women from one hundred eighty-five percent to two hundred percent of the federal*

poverty level; (B) To remove the asset test under the Medical Assistance program, Article 4 of Title 25.5, C.R.S., for children and families; … (F) To pay for enrollment increases above the average enrollment for state fiscal year 2003-04 in the Children's Basic Health Plan, Article 19 of Title 25.5, C.R.S.

Performance Measures:

The Department believes that avoidance of an enrollment cap can be achieved by providing funding to support natural caseload growth in children and prenatal women in the Children's Basic Health Plan. This would ensure continuity of care, and clients in the program would have better health outcomes and show a high level of satisfaction with their care. As such, the Department believes that this request supports the following Performance Measures:

- Expand coverage in the Children's Basic Health Plan.
- Increase the number of clients served through targeted, integrated care management programs.
- Increase the number of children served through a dedicated medical home service delivery model.