



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

FY 2011-12, FY 2012-13, and FY 2013-14 Budget Request

February 15, 2012

(2) MEDICAL SERVICES PREMIUMS 2

I. BACKGROUND 2

II. MEDICAID CASELOAD..... 4

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS 4

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS 7

Exhibit A - Calculation of Total Request and Fund Splits..... 7

 Summary of Request..... 7

 Calculation of Fund Splits 8

Exhibit B - Medicaid Caseload Projection..... 13

Exhibit C - History and Projections of Per Capita Costs..... 14

Exhibit D - Cash Funds Report 14

Exhibit E - Summary of Premium Request By Service Group..... 14

 Summary of Total Requested Expenditure by Service Group..... 14

 Comparison of Request to Long Bill Appropriation and Special Bills 14

Exhibit F – Acute Care 15

 Calculation of Acute Care Expenditure 15

 Breast and Cervical Cancer Program Per Capita Detail and Fund Splits 23

 Antipsychotic Drugs 25

 Family Planning - Calculation of Enhanced Federal Match..... 26

 Indian Health Service..... 27

 Prior Year Expenditure 28

Exhibit G - Community Based Long Term Care 28

 Calculation of Community Based Long Term Care Expenditure..... 29

 Colorado Choice Transitions 34

 Prior Year Expenditure 35

Exhibit H - Long Term Care And Insurance Services 35

 Summary of Long Term Care and Insurance Request..... 35

 Class I Nursing Facilities 35

 Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category 47

 Class II Nursing Facilities..... 47

 Program of All-Inclusive Care for the Elderly (PACE)..... 47

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

Supplemental Medicare Insurance Benefit (SMIB).....	49
Health Insurance Buy-In (HIBI)	51
Exhibit I – Service Management	52
Summary of Service Management.....	52
Single Entry Points	53
Disease Management	55
Prepaid Inpatient Health Plan Administration	57
Exhibit J - Hospital Provider Fee Funded Populations.....	60
Summary of Cash Funded Expansion Populations.....	60
Hospital Provider Fee Fund	61
Medicaid Buy-in Fund	62
Hospital Provider Fee Supplemental Payments.....	63
Exhibit K - Upper Payment Limit Financing.....	63
Exhibit L – Department Recoveries	64
Exhibit M – Cash-Based Actuals	65
Exhibit N – Expenditure History by Service Category	66
Exhibit O – Comparison Of Budget Requests And Appropriations.....	67
Exhibit P – Global Reasonableness	67
Exhibit Q – Caseload Graphs	67
<i>V. ADDITIONAL CALCULATION CONSIDERATIONS.....</i>	<i>68</i>
New Legislation and Impacts from FY 2011-12 Budget Cycle Requests	68
Federal Legislation.....	75
Prior Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments.....	76
Accountable Care Collaborative.....	87
<i>(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS</i>	<i>91</i>
History and Background Information	91
Program Administration.....	97
Medicaid Anti-Psychotic Pharmaceuticals	97
<i>(A) MENTAL HEALTH CAPITATION PAYMENTS.....</i>	<i>98</i>
Exhibit AA - Calculation of Current Total Long Bill Group Impact	100
Exhibit BB - Calculation of Fund Splits	101

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

Exhibit CC - Medicaid Mental Health Community Programs Summary	103
Exhibit DD - Mental Health Caseload, Per Capita, and Expenditure History	103
Exhibit EE - Estimate and Request by Eligibility Category	105
Incurred but not Reported Estimates.....	106
Exhibit FF - Medicaid Mental Health Retroactivity Adjustment and Partial Month Adjustment Multiplier.....	107
Retroactivity Adjustment Multiplier.....	107
Partial Month Adjustment Multiplier.....	108
Exhibit GG - Medicaid Mental Health Capitation Rate Trends and Forecasts	108
Exhibit HH - Forecast Model Comparisons	110
Final Forecasts	110
Capitation Trend Models	111
Exhibit II - Recoupments and Reconciliations.....	114
Exhibit JJ - Expansion Populations	116
(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS	118
Exhibit KK - Medicaid Mental Health Fee-for-Service Payments.....	118
Exhibit LL - Global Reasonableness Test for Mental Health Capitation Payments.....	120

(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.
2. 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, July 1, 2010 and again on July 1, 2011, 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.

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

3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom line impacts. Bottom line impacts can be found by service category (e.g. Acute Care, Community Based Long Term Care, Long Term Care, Insurance, etc.) in the respective sections of this request. Those bottom line impacts include the identification number of the originally submitted request, so that the bottom line impact in the current year may be traced to 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.
4. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information, and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J
5. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations which gain eligibility as a result of HB 09-1293. This includes the implementation of the Disabled Buy-In program and expansion of eligibility to Adults without Dependent Children in FY 2011-12. These expansions increase Medicaid caseload, and are discussed further in Sections II and III of this narrative.
6. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for administration and case management are included in Exhibit I.
7. The Department's request includes a forecast for FY 2011-12, FY 2012-13 and FY 2013-14. Because previous requests included only forecasts for the current and request years, additional exhibits and changes in formatting to accommodate the additional year are present throughout.
8. Previously "Expansion Adults" encompassed populations funded through multiple cash fund sources. However, effective with this request, the eligibility category has been bifurcated. "Expansion Adults to 60%" and "Expansion Adults to 100%" are now separate eligibility types. As a result, the calculations in Exhibit F which calculated the aggregate per capita growth for all expansion adults is no longer included as part of the Department's request.
9. Due to changes in how the Department is appropriated funds from the Health Care Expansion Fund, adjustments for Expansion Adults to 60% are no longer made at the service category level. This is reflected in both exhibits A and J.
10. The Department has added a new calculation for its Money Follows the Person grant program, known as Colorado Choice Transitions, to exhibit G. Please see the narrative for Exhibit G, and section V, for additional information.

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

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

II. MEDICAID CASELOAD

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

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 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.

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

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
- 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

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

Long Term Care:

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

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

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

Financing:

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

Note that for services in the Long Term Care, Insurance, and Service Management categories and Financing, 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.¹ 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-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

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

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

Federal Medical Assistance Percentages

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

The FMAP was impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA was an enhanced FMAP for specified Medicaid programs; the effective period of this enhanced rate was originally October 1, 2008 through December 31, 2010. However, federal legislation (HR 1586) extended the effective period of ARRA to June 30, 2011. The enhanced

¹ 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.

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

FMAP from ARRA beyond December 31, 2010 underwent a staged phase out. Additional relief was available for states which experience increased unemployment; there were three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA included a ‘hold harmless period’; if the FMAP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 was less than the FMAP for the preceding quarter, the higher percent continued to be 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. ARRA continues to be a relevant component of the Department’s request as certified public expenditure receives the enhanced FMAP associated with the period of time during which the expenditure was initially included. This specifically impacts upper payment limit financing. See Exhibit K for additional details.

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 was a weighted average of the multiple FMAPs available during the fiscal year, totaling 59.71%.

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.

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

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

of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

- **Breast and Cervical Cancer Program:** This program receives a 65% federal financial participation rate. To determine state funding, the population is separated into two groups: traditional clients, and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308 (9), C.R.S. (2009). For FY 2011-12, 100% of state funding for traditional clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 2012-13 and FY 2013-14, 50% of state funding for traditional clients comes from the Breast and Cervical Prevention and Treatment Fund and 50% comes from the General Fund. 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.
- **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.
- **Home Health Telemedicine Services:** In HB 10-1005, the Department received authority to use gifts, grants, and donations to fund home health telemedicine services. The Department has been informed by CMS that these funds are not eligible for a federal match. Therefore, the Department assumes that the grant funding will be used as state only funds, and that the remainder of the expenditure will be funded with General Fund and federal funds. See section V for 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.
- **Affordable Care Act Drug Rebate Offset:** The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the state. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in exhibit A, as the increased drug rebate will offset total federal funds expenditure.

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

- SB 11-008: “Aligning Medicaid Eligibility for Children”: This bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). The Department assumes that the FMAP for clients these clients will remain at the same level it would have had the clients enrolled in the Children’s Basic Health Plan instead of Medicaid, or 65%. The Department estimates that the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.
- SB 11-250: “Eligibility for Pregnant Women in Medicaid”: This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan (CBHP) to Medicaid. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients. The Department estimates that the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare reimbursement. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP) of 100%. Additional details are provided in sections IV and V.
- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.
- 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 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 2011-12 and FY 2012-13, the Department is requesting to use a portion of the funding for the adult medical home pilot program;

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

see Exhibit I for further details. In accordance with SB 08-118 - Money Transfer for Medicaid Programs, FY 2012-13 is the last year in which this transfer will occur.

- **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. 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.
- **Disabled Buy-in:** Funds for this population come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.
- **Adults Without Dependent Children:** This population is anticipated to begin participation in Medicaid in FY 2011-12. The population is funded with a combination of federal funds and Hospital Provider Fee. Calculations and information regarding this population can be found in Exhibit J.
- **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.
- **Expansion Adults to 100% Adjustment:** 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. These adjustments allocate Hospital Provider Fee to each applicable service categories. See Exhibit J for additional information and detailed calculations.
- **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.

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

- **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 which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations. The state funding for this program comes from the Coordinated Care for People with Disabilities Fund, which was created by SB 06-128 and is generated by interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund.
- **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 2011-12 and FY 2012-13, and FY 2013-14 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2010-11 inflated annually by four percent.
- **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.
- **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 2011-12, FY 2012-13, and FY 2013-14

Cash Funds	FY 2011-12	FY 2012-13	FY 2013-14
Tobacco Tax Cash Fund (SB 11-210)	\$2,230,500	\$2,230,500	\$2,230,500
Prevention, Early Detection, and Treatment Fund (SB 11-211)	\$11,955,055	\$0	\$0
Hospital Provider Fee Cash Fund(SB 11-212)	\$50,000,000	\$25,000,000	\$0
Primary Care Fund (SB 11-219)	\$15,775,670	\$0	\$0
Tobacco Education Program Fund (SB 11-219)	\$17,758,594	\$0	\$0
Old Age Pension Adult Transfer (10-1380)	\$3,000,000	\$0	\$0
Total	\$100,719,819	\$27,230,500	\$2,230,500

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

In addition, the Department's appropriation includes a \$5,036,351 transfer of reappropriated funds for FY 2011-12 from the Prevention, Early Detection and Treatment fund. This amount is reduced to \$1,750,000 in FY 2012-13 and \$0 in FY 2013-14. Of this amount, \$1,750,000 in FY 2011-12 and a like amount in FY 2012-13 is funding associated with the Department's Disease Management program and is funded through the Department of Public Health and Environment's Prevention Programs line. \$3,286,351 is a one-time transfer for medical services funded through CDPHE's Health Disparities Program line as provided for by SB 11-211.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund is insolvent and no longer covers the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.
- Old Age Pension Adult Transfer Adjustment: In FY 2011-12, the Department is appropriated \$3,000,000 from the Supplemental OAP Health and Medical Care Fund to offset General Fund.

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

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2013-14. Adjustments for HB 09-1293 funded populations such as Disabled Buy-In and Adults Without Dependent Children, and children and women that gain eligibility through SB 11-08 and SB 11-250 are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3

Pages EB-4 and EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2010-11.

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

A description of the forecasting methodology for Medicaid caseload is located in a separate section of this request.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

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

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

EXHIBIT D - CASH FUNDS REPORT

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

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

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

Comparison of Request to Long Bill Appropriation and Special Bills

This exhibit contains a detailed summary of the Department's Budget Request, by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation as well as compares the current request to the Department's most recent prior requests for Medical Services Premiums. The Department has isolated

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

individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. This exhibit includes all bottom-line impacts and financing, but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

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

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2010-11. 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-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in the three most recent historical years. 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. In light of changes resulting from the Medicare Modernization Act of 2003, trends that incorporate historical data from FY 2005-06 or earlier have been omitted for the following eligibility types: ‘Adults 65 and Older’, ‘Disabled Adults 60 to 64’, and ‘Disabled Individuals to 59’. For these categories, pharmaceutical expenditure was drastically reduced in FY 2006-07 for these eligibility types resulting in artificially deflated trends.

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

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

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 2011-12, FY 2012-13, and FY 2013-14. In some cases, though not all, the Department has held the trend constant between the three years. On Exhibit F, the selected trend factors have been bolded for clarification. 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 2011-12, FY 2012-13, and FY 2013-14, with the rationale for selection, are as follows:

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Adults 65 and Older (OAP-A)	-1.15% The per capita growth from FY 2003-04 to FY 2004-05	0.70% One half the per capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per capita growth from FY 2009-10 to FY 2010-11	While primary cost drivers in FY 2010-11 saw low to modest levels of growth, a portion of this growth is attributed to a one-time level shift in expenditure associated with restating third party liability recoveries as revenue instead of as a direct offset to expenditure. Half year expenditure support this conclusion and indicates a mild decline in per capita expenditure in FY 2011-12. The Department has selected a trend that captures the underlying stability in the per capita growth pattern for this population for FY 2012-13 and FY 2013-14.
Disabled Adults 60 to 64 (OAP-B)	2.06% The average per capita growth from FY 2007-08 through FY 2009-10	2.06% The average per capita growth from FY 2007-08 through FY 2009-10	2.06% The average per capita growth from FY 2007-08 through FY 2009-10	This eligibility type displayed growth despite rate reductions and other bottom line impacts which put downward pressure on per capita growth. The Department anticipates continued per capita growth over the next three years similar to what was experienced between FY 2009-10 and FY 2010-11.

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

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	2.38% The per capita growth from FY 2009-10 to FY 2010-11	2.38% The per capita growth from FY 2009-10 to FY 2010-11	2.38% The per capita growth from FY 2009-10 to FY 2010-11	Similar to OAP-B, this eligibility category experienced modest growth in FY 2010-11. Primary cost drivers for this eligibility type (Physician, Inpatient Hospital, Outpatient Hospital, Pharmacy, and Home Health) increased by approximately 4% in per capita expenditure in the last fiscal year. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns.
Categorically Eligible Low-Income Adults (AFDC-A)	-0.41% The average per capita growth from FY 2007-08 through FY 2009-10	-0.41% One half the FY 2011-12 per capita growth rate	-0.41% One half the FY 2011-12 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 aggressively over the next three years. However, most recent expenditure data indicates the rate of decline has slowed dramatically. The Department has selected a trend that accounts for the recent stabilization of per capita growth for this population.
Expansion Adults to 60%	2.18%	2.18%	2.18%	This population is showing signs of reaching maturity as per capita growth is beginning to slow. While FY 2010-11 growth was still aggressive, the Department anticipates the rate of growth to continue to decrease in FY 2011-12 as the per capita costs get closer to that of other non disabled adults in Medicaid. The trend selected for this population allows for a modest amount of continued growth over the next three years.

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

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Expansion Adults to 100%	12.73%	5.92%	0.75%	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. For FY 2011-12, the selected trend is the percent change required to bring the per capita costs to 90% of the per capita costs of expansion adults to 60% The trends for the request year and out year are set at levels that allow the per capita cost of Expansion Adults to 100% to continue to converge to the Expansion Adults to 60% per capita cost.
Breast & Cervical Cancer Program (Page EF-7)	-1.08%	-1.08%	-1.08%	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)	-1.02% One half the per capita growth from FY 2009-10 to FY 2010-11	-1.02% One half the per capita growth from FY 2009-10 to FY 2010-11	-1.02% One half the per capita growth from FY 2009-10 to FY 2010-11	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.
Foster Care	1.97% One half the average per capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per capita growth from FY 2007-08 through FY 2010-11	Historically, this eligibility category has had significant variation in per capita growth from year to year; on average, growth is moderate to strongly positive. FY 2010-11 growth reflected this trend of moderate positive growth. The Department expects FY 2011-12 growth to follow this trend.

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

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Baby Care Program - Adults (BCKC-A)	1.22% One half the average per capita growth from FY 2006-07 through FY 2009-10	1.22% One half the average per capita growth from FY 2006-07 through FY 2009-10	1.22% One half the average per capita growth from FY 2006-07 through 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	14.60% The average per capita growth from FY 2005-06 through FY 2008-09	7.30% One half the FY 2011-12 trend	7.30% One half the FY 2011-12 trend	The Department has selected a per capita trend for these clients that reflects the most recent years aggressive per capita growth while maintaining consideration for the volatile history of the population.
Partial Dual Eligibles	10.74%	5.37% One half the FY 2011-12 trend	5.37% One half the FY 2011-12 trend	This population consistently experiences a strong growth in per capita expenditure growth from the first part of the year to the second. This is primarily due to coinsurance maximums resetting January 1 st each year. Given the level of expenditure in the first half of FY 2011-12, the Department has selected a trend that allows for the level of expected growth in the second half of the year. For the out years, the trend is halved, still allowing for continued growth in per capita 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. These impacts are described briefly below, and in detail in section V, Additional Calculation Considerations:

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

- BRI-1 (FY 2011-12), Client Overutilization, expanded the Department's Client Over Utilization Program (COUP). The program reduced expenditure by identifying clients that over utilize ER, pharmaceutical, or physician services and assisting them in managing their care in a more cost effective manner.
- BRI-5 (FY 2011-12), State Maximum Allowable Cost Expansion, expands the list of drugs reimbursed under the State Maximum Allowable Cost (SMAC) pricing methodology. Savings results as drugs reimbursed under this methodology typically have lower levels of reimbursement than other pricing methodologies.
- BRI-5 (FY 2011-12), Reduce Rates for Diabetes Supplies, reduced reimbursement for diabetic test strips. Prices were reduced to reflect the current median market price for the product, \$18.00 per box of 50.
- BRI-5 (FY 2011-12), Reduce Payment for Uncomplicated C-Sections, set reimbursement for uncomplicated c-sections equal to the rate paid for complicated vaginal deliveries.
- BRI-5 (FY 2011-12), Reduce Payments for Renal Dialysis, reduced the amount paid for inpatient renal dialysis from 185 percent of cost to 100 percent of cost. The Department agreed to reduce payment to 129.42 percent rather than 100 percent after negotiations with affected providers.
- BRI-5 (FY 2011-12), Deny Payment of Hospital Readmissions within 48 hours, stopped payment to hospitals for clients readmitted to the same hospital within 48 hours of the original discharge for a condition related to the original admission.
- BRI-5 (FY 2011-12), Prior Authorize Certain Radiology, requires prior authorization for MRI, CT, PET, and SPECT scans in the outpatient setting except in the case of emergency.
- BRI-5 (FY 2011-12), Limit Acute Home Health Services, requires enforcement of the Department's policy to require prior authorization for acute home health services beyond 60 days.
- BRI-5 (FY 2011-12), HMO Impact to Rates, accounts for the impact to HMO rates that results when fee-for-service rates are reduced.
- BA-9 (FY 2011-12), 0.75% Provider Rate Reduction, reduced reimbursement for most acute care services by 0.75%. The Department's original request was for a 0.50% rate reduction.
- BA-9 (FY 2011-12), Expand the Accountable Care Collaborative (ACC), increased the volume of clients to be enrolled in the ACC in FY 2011-12.
- BA-9 (FY 2011-12), Limit Fluoride Application Benefit, restricts the fluoride application benefit to three applications per year.
- BA-9 (FY 2011-12), Limit Dental Prophylaxis Benefit, limits the routine dental cleaning benefit to two per year.
- BA-9 (FY 2011-12), Eliminate Reimbursement for Oral Hygiene Instruction, terminated the oral hygiene instruction benefit.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year regardless of prior authorization.
- BA-9 (FY 2011-12), Home Health Billing Changes, requires providers to utilize a brief visit billing code for services that should require only a brief home health visit.

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

- Estimated Impact of Increasing PACE Enrollment – 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.
- Eliminate Circumcision Benefit – as part of budget balancing measures for FY 2011-12, the Joint Budget Committee eliminated the circumcision benefit of the Medicaid program.
- Wound Therapy DME Reduction – as part of budget balancing measures for FY 2011-12, the General Assembly specified in footnote 11a of the Long Bill that their intent was that the Department should reduce reimbursement for negative pressure wound to \$88.50 per day. The Department complied with the footnote.
- SB 11-177: “Sunset of Pregnancy Prevention Program”, provides for the continuation and expansion of the Department’s teen pregnancy and dropout prevention program. Through the program, teens receive vocational, health and educational counseling.
- Managed Care Organization Reconciliations account for recoupment payments that the Department will receive from ,managed care organizations in FY 2011-12. The Department does not know when future reconciliations will occur and therefore annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.
- 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-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. 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.

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

- Increased Drug Rebates due to the Affordable Care Act: The minimum level of drug rebates collected from manufactures by Medicaid agencies increased. The Department estimates the impact of this change in Exhibit F.
- 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 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 four 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 third components is a systems change that allows for coordination of the Department’s pharmacy benefit with other payers. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid that are eligible to enroll in the Medicaid programs of other states.
- 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).
- 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. 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.
- BRI-2 (FY 2009-10), Oxygen Restriction, reduced expenditure on Oxygen by an estimated 2% by bringing on an FTE to evaluate billing practices and assessing national best practices. As a result of this action, restrictions were put in place in FY 2010-11. Figures listed in exhibit F represent an annualization of savings from this initiative.
- ACA 4107 Smoking Cessation Counseling for Pregnant Women – Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit the Department has restricted services by allowing a maximum of 5 counseling sessions up to 10 minutes and 3 counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.

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

Initiatives that impact FY 2012-13 or FY 2013-14 only:

- Implementation of SB 10-117: “Over the Counter Medications” accounts for savings incurred through the implementation of SB 10-117. This bill allows pharmacists to directly prescribe certain over the counter medication to Medicaid clients without prior authorization or a prescription from the client’s primary care physician. The Department anticipates initial implementation by July 1, 2012.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- Colorado Choice Transitions: this adjustment accounts for increased home health service expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.
- In its previous request, the Department included an adjustment for its approved 1331 supplemental request to not apply the BA-9 0.75% rate reduction to pharmacies. The funding for that request was included in the Department’s FY 2011-12 supplemental bill. To prevent double-counting, the Department has removed the impact from that request from this calculation.

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.

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

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 affected caseload is very small and changes to total expenditure, therefore, have a large impact on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as -32.73%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per capita expenditures. The Department assumes 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. In the past twelve months, the per capita expenditure has decreased more slowly than in previous periods, indicating that the negative growth is beginning to moderate. For the current and request years, 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 0.9972. The Department calculated the average of the percent changes of the predicted values produced by the regression model for the current year and annualized the average for a full-year effect. The resulting trend factor is -1.08%. The Department kept this trend constant for the request and out years – the regression model produces much larger negative trends for those years, but as discussed above, the Department believes that per capita expenditure will not continue to decline as quickly as it has in the past. The trend factor for each year is 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. (2011), 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.

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

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. (2011), 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.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is \$1,215,340. On a go-forward basis, the Department will continue to limit the amount paid from this fund source for this program to this amount. Any expenditure beyond this amount will be allocated to the Breast and Cervical Cancer Prevention and Treatment Fund and the General Fund, in accordance with statute.

All Breast and Cervical Cancer Program expenditures have a 65% federal medical assistance percentage.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-8 through EF-9, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The 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.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after

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

the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on FY 2010-11 and two quarters of FY 2011-12 data.

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 reporting to 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. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

The total estimate for FY 2011-12 and the out-years are based on a linear regression analysis of FY 2000-01 to FY 2010-11. The Department trended FY 2010-11 expenditure forward using the percent change between the forecasted estimates, 5.99%. This trend was carried forward and the addition of SB 11-177 "Sunset Teen Pregnancy and Dropout Program" were added separately.

Due to recent expenditure increases beginning in FY 2009-10, the Department controlled for a level shift in expenditure in the regression model. The Department believes this level shift is a result of the Departments considered effort to educate providers as to which services are billable as family planning services. Research by the Department had indicated that only a fraction of allowable services were being appropriately billed.

In FY 2010-11 the Department submitted BA-16 "Implementation of Family Planning Waiver" which was to add \$1,903,500 in FY 2012-13 to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. The state share

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

of the funding was to be transferred from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds. However, after further discussion between the two agencies, the Department has removed its application for federal waiver approval. Populations that would have been served under the waiver would be eligible by July 2014 for services either through Medicaid or through a subsidized plan under the Colorado Health Benefit Exchange. In addition, system changes necessary to implement the program would be delayed due to federally mandated changes that could not be done concurrently with the changes necessary to implement the family planning waiver. The Department has removed all impacts of the family planning waiver from this request.

SB 11-177 “Sunset Teen Pregnancy and Dropout Program” adds \$19,763 local funds, annualizing to \$40,869 in FY 2012-13 and \$69,819 in FY 2013-14 to operate and expand the program. This estimate varies from the projection the Department submitted in the November request for several reasons. First, the Montrose County Department of Health and Human Services had to discontinue the program as a result of limited budget funding available. In addition, the Department is currently working with the Center for Medicare and Medicaid Services to assure an appropriate payment methodology for the services. The Department currently anticipates a proper payment methodology would be established by July 2012. With such approval the Department would move forward expanding the program.

Indian Health Service

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

The Department uses historical expenditure to estimate total expenditure for services to these clients for the current and request years, all of which is federally funded. Expenditure was very low in the first six months of the current year; an inpatient facility in New Mexico that normally serves a few Colorado Medicaid clients has not had any Colorado Medicaid clients need services this year. In FY 2007-08 through FY 2010-11, an average of 50.72% of the total annual expenditure was paid in the first six months of the year (please see table below). The Department assumes that expenditure this year will follow that pattern and estimates total expenditure as the year-to-date expenditure divided by 50.72%. In the request and out years, the Department anticipates enrolling several new facilities into the Indian Health Service program. The Department chose the average growth from FY 2008-09 to FY 2010-11, or 17.82%, to trend expenditure for FY 2012-13 and FY 2013-14.

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

Indian Health Service Cash Flow Analysis		
	Percentage of Total Expenditure Complete in First Half of the Year	Percentage of Total Expenditure Complete in Second Half of the Year
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%
FY 2010-11	61.49%	38.51%
Average of FY 2007-08 through FY 2010-11	50.72%	49.28%

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 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 2010-11, the Department paid HCBS claims for an average of 19,847 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

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

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 2002-03 through FY 2010-11. 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 2008-09, FY 2009-10, and FY 2010-11.

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

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

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 2011-12, FY 2012-13 and FY 2013-14, with the rationale for selection, are below. In all cases, the Department has kept the trend for the out year the same as the request year.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.36% FY 2008-09 through FY 2010-11	2.36% FY 2008-09 through FY 2010-11	The FY 2011-12 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. The growth rate of expenditure for these services has slowed substantially beginning in FY 2007-08. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns, 2.36% for three years of expenditure.
Disabled Adults 60 to 64 (OAP-B)	5.63% Average of FY 2007-08 through FY 2010-11	2.82% Half the FY 2011-12 Trend	Per capita growth has slowed significantly from FY 2009-10 to FY 2010-11. However, half year growth has indicates that expenditure is slow at much lower rate than the Department had previously anticipated. As a result, the trend was increased from the R-1 request to 5.63% for the remainder of the fiscal year. The out year trends were reduced to half of the FY 2011-12 trend to reflect the stabling of growth the Department expects.
Disabled Individuals to 59 (AND/AB)	2.51% Half the Average of FY 2009-10 through FY 2010-11	2.51% Half the average of FY 2009-10 through FY 2010-11	Significant drivers of expenditure in this aid category are the Elderly, Blind and Disabled waiver, Mental Illness waiver and Private Duty Nursing service categories. Growth for these categories over the past four years has been high and positive averaging 14.85%. The FY 2011-12 trend is half the average of FY 2009-10 through FY 2010-11 per capita growth rate. This rate was reduced from the R-1 request to reflect slowing in per capita growth rates as the Department anticipates programmatic changes to slow rapid per capita growth for these clients, as indicated by half year actual expenditure.

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

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	-57.48% FY 2008-09 change in per capita costs	-1.16% Average of FY 2008-09 through FY 2009-10 overall per capita	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 Department selected a trend to reflect actual half year expenditure for these clients. The out year trend factor is based on the average overall CBLTC change in per capita spending between FY 2008-09 through FY 2009-10.
Expansion Adults to 60%	-45.00%	4.12% FY 2008-09 total growth in per capita costs	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. The Department selected a trend in the current year to reflect anticipated expenditure levels based on half year actuals. In the out years the Department trended using the average growth in total per capita for FY 2008-09.
Expansion Adults to 100%	70.00%	5.00% Total average of FY 2006-07 through FY 2010-11	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. The Department selected a trend in the current year to reflect anticipated expenditure levels based on half year actuals. In the out years the Department trended using the average growth in total per capita for FY 2008-09.
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

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

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Eligible Children (AFDC-C/BCKC-C)	2.75% Average of FY 2007-08 through FY 2010-11	1.38% Half the Average of FY 2007-08 through FY 2010-11	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 chose a trend of 2.75% for FY 2011-12 and half that trend for FY 2012-13 and FY 2013-14. This trend appears to be on track with half year expenditure and was not changed from the R-1.
Foster Care	10.11% Average of FY 2005-06 through FY 2009-10	5.06% Half the FY 2011-12 trend	Per capita growth rates in this aid category have been high for the past three years. However, given that half year expenditure was lower than anticipated, the Department has reduced the trend from the R-1 to 10.11%. For the out years the Department took half of the FY 2011-12 trend to reflect stabilizing growth.
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.
Partial Dual Eligibles	100.00%	-25.00% (FY 2012-13), 0.00% (FY 2013-14)	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. However, based on expenditure to date, the Department has selected a trend to reflect an increase in expenditure for this category. For the out years the Department chose trends to reflect a decrease in expenditure for FY 2012-13 and a trend to reflect leveling off in FY 2013-14.

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

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:

- BRI-5: Medicaid Reductions - Cap CDASS Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. The Department has delayed implementation of this proposal to March 2012.
- BA-9: Medicaid Reductions - 0.50% Rate Reduction: Reduce long-term care providers by 0.5%, effective July 1, 2011.
- BA-9: Medicaid Reductions - Clients Moved from Nursing Home: The Department intended to use grant funds from the Money Follows the Person award to provide additional transitional services to move clients from nursing facilities to Community Based Long Term Care. The Department was unable to transition these clients due to receiving significantly less grant funds than anticipated. The clients specified in this initiative would have been moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
- 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.
- Annualization of FY 2010-11 BRI-2: Coordinated Payment and Payment Reform: This request, estimated to be implemented July 2010, requested a reduction in total 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 was slowed and was reflected appropriately in the FY 2011-12 request.
- Annualization of FY 2010-11 BRI-6: Medicaid Program Reductions; included a 1% reduction to Medicaid physical health provider rates effective July 1, 2010.
- Annualization of FY 2009-10 ES-2: HCBS Waiver Transportation Limitations: 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 had been delayed to FY 2011-12 to allow time for necessary rule changes or waiver amendments. Savings derived from the limitation were shifted to FY 2011-12.
- 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

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

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 delayed implementation to FY 2011-12. Therefore, the cost estimate to CBLTC for this bill has been shifted to FY 2011-12.

- HB 09-1047 “Alternative Therapies for Clients with Spinal Cord Injuries” – HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services include massage, acupuncture and chiropractic care. The Department anticipates approval of the waiver and implementation to be delayed to July 2012.
- Colorado Choice Transitions: The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community based services. The program will begin enrolling clients in July 2012.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community Based Long Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services and home health services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. Savings from the enhanced match are required to be used to improve the long term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Department anticipates transitioning will begin in July 2012 and the Department will transition 90 clients in the first year of the program and 100 each year following until the end of the 5 year grant.

The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the 2 types of services the Department will offer through the program, demonstration (new services offered through the program) and qualified services (existing waiver services and home health). These costs are reflected in exhibits F and G, Community Based Long Term Care as a bottom line impact. The exhibit then reports the savings anticipated from transitioning clients from nursing facilities which is reflected in exhibit H, Class I Nursing Facilities as a bottom line impact. Following the net impact of the program, the Department reports on the rebalancing funds the Department anticipates earning. Rebalancing funds are calculated as 25% of total expenditure and are 100% federal funds.

The Department anticipates the program enrollment will begin in July 2012 and approximately 100 clients will transition per calendar year. The Department estimates the total impact to Medical Services Premiums to be a reduction of \$224,911 total funds in in FY 2012-13, and a reduction of \$637,405 in FY 2013-14. These figures do not include any expenditure from the rebalancing fund.

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

Prior Year Expenditure

As an additional reasonableness check, the Department has split FY 2010-11 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 this trend is changing and the Department no longer anticipates a continued decline in patient days.

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

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

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities 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 was further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

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

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

For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows²:

² For clarity, FY 2011-12 is used as an example. The estimates for FY 2012-13 and FY 2013-14 are based on the estimate for FY 2011-12, and follows the same methodology.

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

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2011-12.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment for claims that will be incurred in FY 2011-12. 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 2011-12 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2011-12.
- 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 2011-12.
- Of the estimated total reimbursement for claims incurred in FY 2011-12, only a portion of those claims will be paid in FY 2011-12. The remainder is assumed to be paid in FY 2012-13. The Department estimates that 92.47% of claims incurred in FY 2011-12 will also be paid during FY 2011-12. Footnote 4 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 2010-11 and prior years (“prior year claims”). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2010-11 to calculate an estimate of outstanding claims to be paid in FY 2011-12.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2011-12 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 5 through 9.
- Legislative impacts are added as bottom-line adjustments. For FY 2011-12, this includes run out from HB 10-1324, which introduced a 1.5% rate reduction effective March 1, 2009 and Additionally, HB 10-1379 introduced an additional 1% rate reduction effective July, 1 2010. SB 11-215, which continued the HB 10-1324 rate reduction into FY 2011-12, is also included.
- Once the “non-rate” factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2011-12 expenditure.

For FY 2012-13 and FY 2013-14, the same methodology is applied, taking into account the estimate for 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

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

Calculation Considerations. The following impacts have been included in the FY 2011-12, FY 2012-13, and FY 2013-14 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2011-12 through FY 2013-14. Please refer to Footnote 6 on page EH-8 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 2011-12, FY 2012-13, and FY 2013-14. FY 2010-11 BRI-2: Coordinated Payment and Payment Reform increased the number of Department auditors resulting in additional audits of nursing facilities. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-9 contains additional detail about these recoveries.
- 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 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 9 on page EH-9 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 9 on page EH-9.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non Medicare day increased to \$12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments, but will be unable to fully fund growth beyond the General Fund cap. The Department estimates that approximately 68% of growth beyond the General Fund cap will be supported by the provider fee.
- SB 11-215 continued the 1.5% rate cut of HB 10-1324, effective July 1, 2012.
- The Colorado Choice Transitions adjustment accounts for the reduction in class I nursing facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.

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

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 4 and 5 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 2011-12, and the percentage of claims incurred in FY 2011-12 which will be paid in FY 2011-12 and subsequent years. The Department applies the same factor to the FY 2012-13 and FY 2013-14 estimates.

The Department uses the IBNR adjustment calculation for the November 2011 Budget Request, using paid claims data through April 2011. 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.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%

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

Date of Change Request:	IBNR Factor:
February 2009, November 2009, February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%

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

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

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 statistical analysis software to test for a unit root in the FTE series. The result is summarized in the following table:

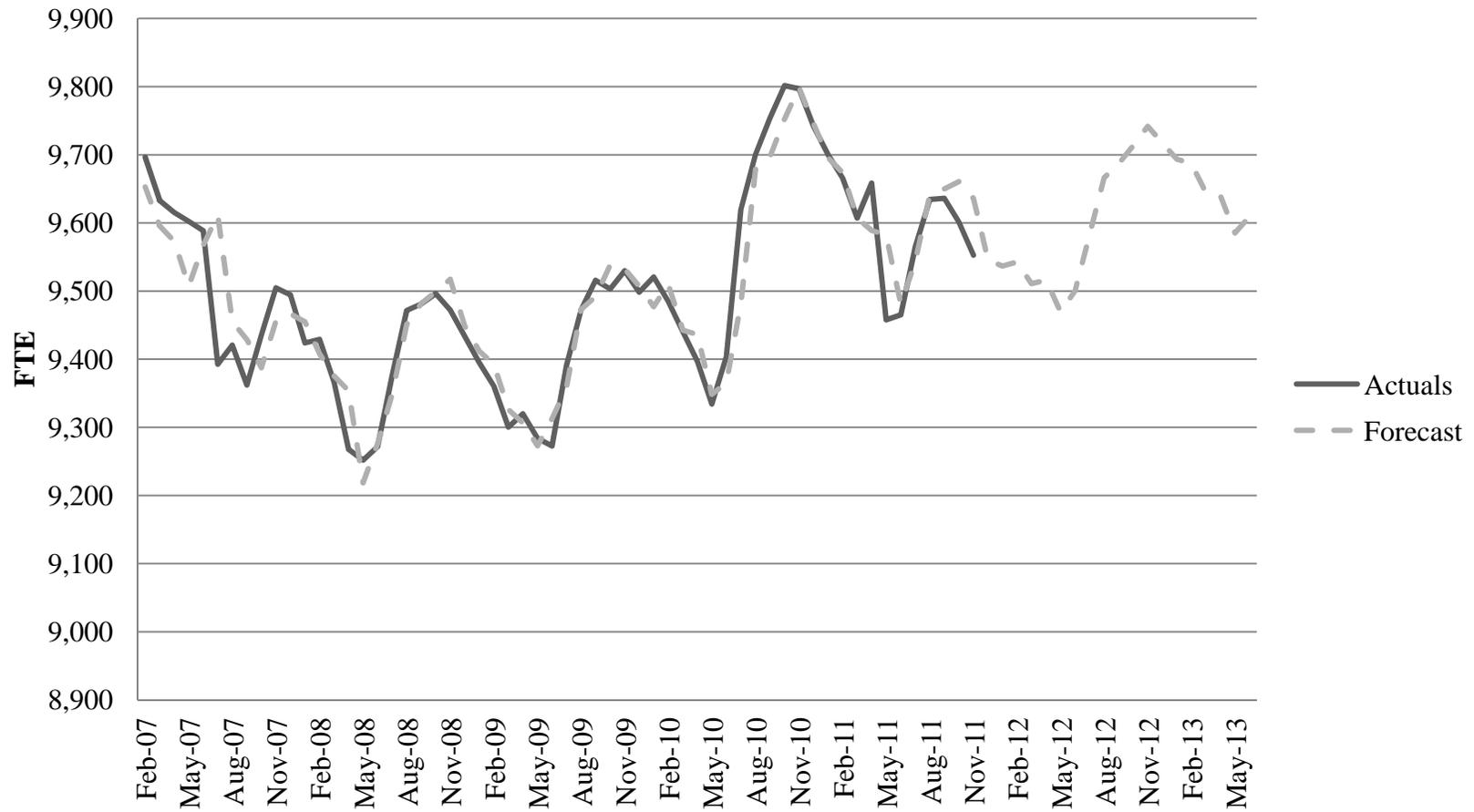
Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	P-Value
Augmented Dickey-Fuller Test Statistic	-3.287	0.0789
Conclusion: Reject that null hypothesis that there is a unit root at the 93 percent confidence level. An auto-regressive model can be used with this series.		

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.

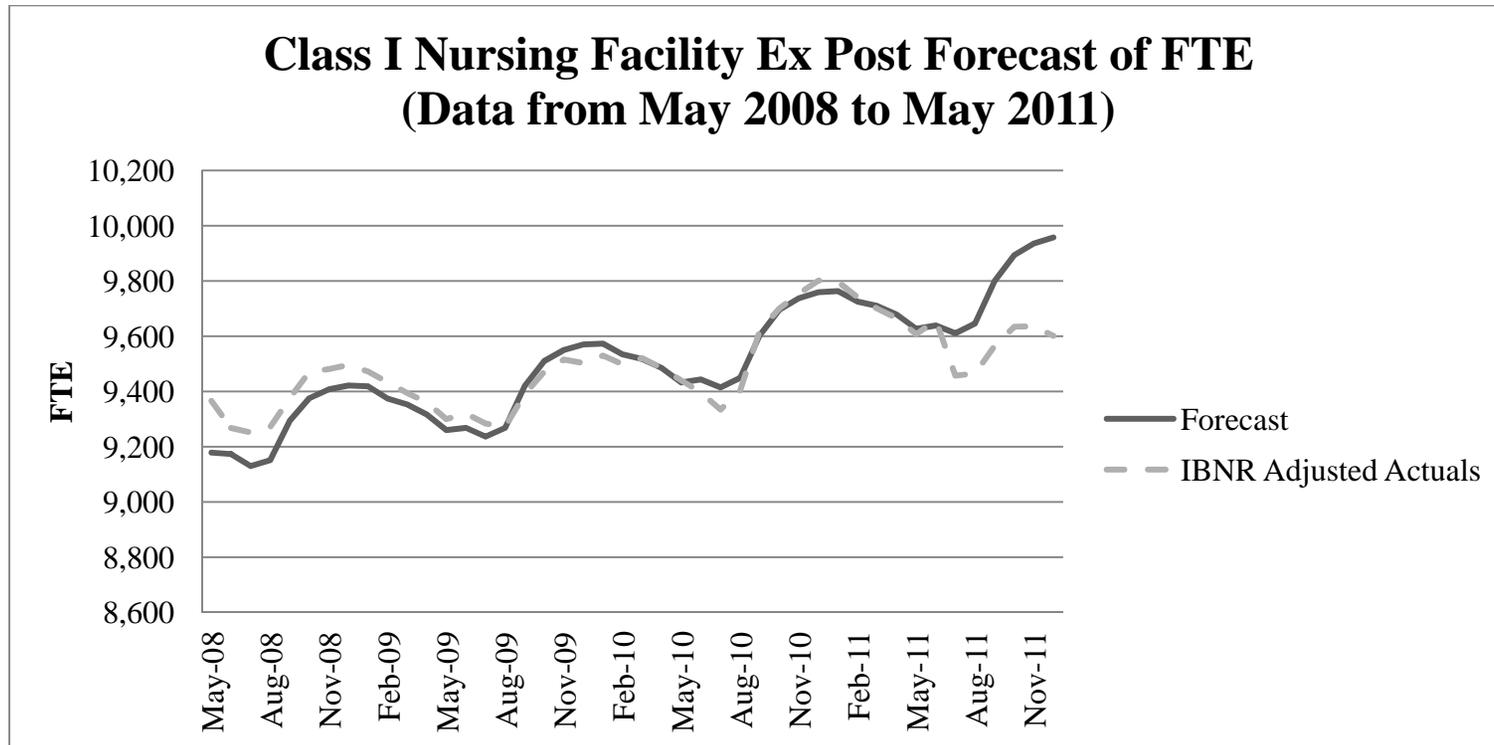
Historically, the Department's efforts toward increasing utilization of home and community based services have resulted in downward pressure on the class one nursing facility days trend. However, in face of an aging population and ever increasing demand for long term care services, the most recent years have displayed a return to marginal annual growth in patient days.

Class I Nursing Facility IBNR Adjusted Adjusted Actuals and FTE Forecast of Patient Days (February 2007 - June 2013)



Ex Post/In-sample Forecasts

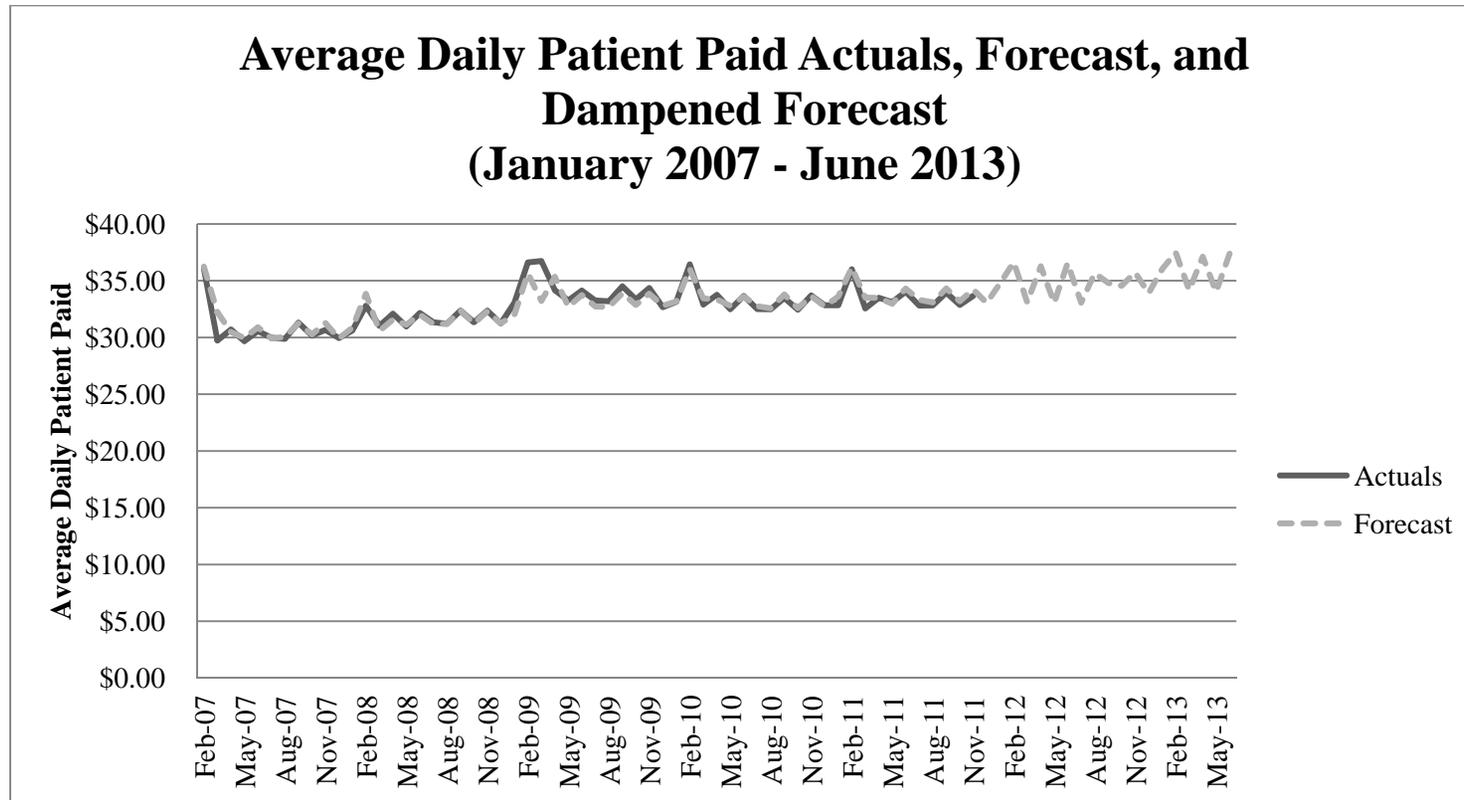
As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from May 2008 through May 2011) and compared the results to actual data reported for June 2011 through November 2011.



It is of note that Ex Post Forecast model significant over estimates FTE in the forecast period from June 2011 to November 2011. This is the direct result of higher than average patient days in the period directly preceding the forecast period. While FY 2010-11 had higher than levels of patient days than the underlying historical trend would predict, actuals from the first half of FY 2011-12 indicate a reversion to the underlying trend of marginal growth over time. By incorporating more data, the Department mitigates the effect of the higher than average patient days in FY 2010-11.

Patient Payment Forecast Model

As with the days forecast, the Department utilizes a seasonally adjusted autoregressive model to forecast patient payment. Inclusion of historical data from the period prior to November 2008 results in a linear trend that greater than would be anticipated given the most recent data. Consequently, the Department has dampened the forecasted values by approximately 1%.



Testing the Stationarity of the Model

To test the stationarity of the patient paid series, the Augmented Dickey-Fuller Unit Root Test of Stationarity is again used. The series is stationary.

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

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	P-Value
Augmented Dickey-Fuller Test Statistic	-5.36	0.0002
Conclusion: Reject that null hypothesis that there is a unit root at the 99 percent confidence level. An auto-regressive model can be used with this series.		

Testing the Overall Predictive Ability of the Model

Again utilizing the F-statistic, an analysis of the model’s overall statistical significance can be done. Like the patient days model, the patient payment model also has a p-value of 0.0000, and is statistically significant at the 99% confidence level. R-squared for the model is 0.976 suggesting that 97.6% of the variation in this series can be explained by the linear trend.

Nursing Facility Rate Methodology Changes

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

- FY 1997-98 8% Health Care Cap and 6% Administrative Cap Implemented
- FY 1998-99 No change
- FY 1999-00 8% Health Care Cap temporarily removed and Case Mix Cap Implemented
- FY 2000-01 No change
- FY 2001-02 8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
- FY 2002-03 Administrative Incentive Allowance removed for three months then reinstated
- FY 2004-05 8% Health Care Cap reinstated
- FY 2005-06 No change
- FY 2006-07 8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility’s current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
- FY 2007-08 Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
- FY 2008-09 New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105%

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

of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.

- FY 2009-10 The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and, made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.
- FY 2010-11 HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010 through June 30, 2011. This bill also reduced the maximum general funds portion of the core per diem rate to 1.9% growth for FY 2010-11.
- FY 2011-12 SB 11-125 increased the level of the provider fee to \$12.00 per non Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
- FY 2011-12 SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2012.

Department Forecast Methodology Change

With the Department's November 2011 request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate setting methodology in statute. To generate the nursing facility forecast using the previous methodology, claims that were 100 percent patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100 percent patient payment impact the next year's rate. To more accurately forecast the per diem rates, the revised forecast methodology, claims with 100 percent patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

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

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. 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, the provider 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 rate for FY 2011-12 reflects changes in per diem rates based on audited cost reports from CY 2010. The estimated growth rate for FY 2012-13 is based on anticipated changes in per diem reimbursement using information from unaudited cost reports for CY 2011. 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.

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.

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

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 2011-12 projection for PACE is computed in several parts: First, the Department estimates the growth in the average enrollment at PACE providers using a linear regression model for each eligibility category. This projection is then added to the exhibit to calculate total expenditure. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2010-11 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2011-12 base expenditure. The Department then 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 2011-12 total expenditure. FY 2012-13 and FY 2013-14 expenditure is calculated in the same fashion.

To estimate the average increase in cost per enrollee in FY 2011-12, the Department selected the estimated growth rate between PACE rates from FY 2010-11 to FY 2011-12. Because the PACE program is capitated, the Department believes the best estimate for cost per enrollee is based on the actual rate that will be paid. For FY 2011-12 the Department selected the estimated growth rate in PACE rates for Total Longterm Care (TLC), the Department's largest PACE provider for all eligibility categories, Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to age 59 aid categories. For FY 2012-13 and FY 2013-14 the Department took the average growth rate in TLC PACE rates from FY 2008-09 to FY 2010-11.

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

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

facility in late 2009 to serve clients in Pueblo. The organization also expanded its current facility in Thornton in 2010 and is looking to expand into Larimer and Weld county in 2012.

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 of this narrative. For FY 2011-12, FY 2012-13 and FY 2013-14 no bottom line adjustments have been added. However, in FY 2010-11 a reconciliation was paid to PACE providers for rates which were paid below the true cost of providing the services due to erroneous patient payment reporting. This was a onetime payment the Department accounted for through a bottom line impact. To account for this payment the Department subtracted it out when calculating per capita and per enrollee costs and trended costs forward using the adjusted amounts.

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.³ 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.

³ 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:⁴

History of Medicare Premiums

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

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.

⁴ 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 2011-12, the Department inflates the actual expenditure from the second half of FY 2010-11 by the increase caseload from FY 2010-11 to FY 2011-12. This generates the anticipated expenditure for the first half of FY 2011-12 as there will be no increases to Medicare premiums during this period. Expenditure for the second half of FY 2011-12 is calculated by inflating the estimated first half of the year's expenditure by the anticipated decrease in Medicare premiums effective January 1, 2012 or -13.43%. This decrease in premiums is based on the change in premiums from CY 2011 to CY 2012 as reported by CMS. The total estimated expenditure for FY 2011-12 is the sum of the first half actual expenditures and the second half estimated expenditures. The Department's February forecast deviates significantly from the November forecast to the unforeseen decrease in Medicare Part B premiums. The decrease represents the first in over a decade.

To forecast FY 2012-13, the Department first inflates the estimated expenditure from the second half of FY 2011-12 by the estimated caseload trend for FY 2012-13 as reported in exhibit B. This figure represents the approximate expenditure for the first half of FY 2012-13. 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 2012-13 is the sum of the first half and second half estimates. The Department does not anticipate a decrease in Part B premiums for a second year in a row. Consequently, the Department has selected a positive premiums trend for CY 2013 and CY 2014 of 6.49% which is equal to the average percentage change in Part B premiums since CY 2004.

The forecast of FY 2013-14 expenditure utilizes the same methodology as the forecast of FY 2012-13.

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

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

process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget, for FY 2011-12 through FY 2013-14 the Department examined total expenditure trends to estimate expenditure. The Department believes this methodology to be more accurate as per capita growth has fluctuated significantly historically because HIBI enrollment does not bear a direct relationship to Medicaid caseload. The Department selected 3.27%, the FY 2010-11 expenditure growth rate for AND/AB clients to trend expenditure in FY 2011-12 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 2011-12 trend selections were held constant for FY 2012-13 and FY 2013-14.

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 2011-12, FY 2012-13 and FY 2013-14 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. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per member per month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline and enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

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

Summary of Service Management

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

Single Entry Points

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to 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 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.

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

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.

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 2011-12, 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

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

Figure Setting), and adds legislative impacts (see below). For FY 2012-13, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2007-08 through FY 2010-11 for the Adults 65 and Older. For Disabled Adults 60 to 64 the Department used the year to date growth rate in paid HCBS utilization. For the Disabled Individuals to 59 aid category the Department trended HCBS paid enrollment using the average percent change in average monthly paid enrollment from FY 2006-07 through FY 2010-11. The overall HCBS utilization growth rate from FY 2006-07 to FY 2010-11 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 2011-12 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2012-13 and FY 2013-14 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. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2011-12 through FY 2013-14.

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.

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

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. (2011) (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's appropriation includes \$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.

FY 2012-13 remains at the same level as FY 2011-12. However, in FY 2013-14, the statutory authorization for this funding expires. Expenditure in the out year and any year following is expected to be zero.

Prepaid Inpatient Health Plan Administration

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

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

Rocky Mountain Health Plans

Because the administrative fees remain the same in FY 2011-12 and FY 2012-13, the Department uses actual enrollment to forecast expenditure in FY 2011-12 and FY 2012-13 for Rocky Mountain Health Plan. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group; for this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

To forecast enrollment in Rocky Mountain Health Plan for the current and request years, the Department assumes that the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its Health Plan. Therefore, the Department estimates that the only growth into the Health Plan in FY 2011-12 will be the base trend from the December 2011 level. In FY 2012-13 and FY 2013-14, the Department assumes that there will be no enrollment growth in the Health Plan.

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

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

The Department included the cost avoidance amount for FY 2009-10 services as a bottom line impact for FY 2011-12 and multiplied it by two, which takes into account the need to pay an additional cost avoidance payment in that fiscal year for FY 2010-11 services. For the FY 2012-13 and FY 2013-14 fiscal years, the Department assumed that the cost avoidance payments would be similar in magnitude to the calculated payment for FY 2009-10 and carried that amount forward for both fiscal years. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

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

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

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

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 in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. To forecast future enrollment, the Department averaged the expected capped enrollment by month for the current and request years. The Department estimates that enrollment will remain around the current level until the end of the program. At the end of FY 2010-11, 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 2011-12. 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 2011-12, including four 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. Due to the lag in payments, it is expected that there will be one additional payment to be made in FY 2012-13. 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)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64, designed to provide a network of services that are high-quality and cost effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. The enrollment forecasts for FY 2011-12 and FY 2012-13 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 2010 to December 2011. The payments to CAHI were lagged by one month at the end of FY 2010-11. The Department assumes that there will be a one-month lag in payment at the end of FY 2011-12, resulting in payments of twelve months in that fiscal year, including one from FY 2010-11 plus eleven from FY 2011-12. Similarly, it is assumed that the Department will make payments for twelve months in FY 2012-13 (one from FY 2011-12 plus eleven from FY 2012-13) and FY 2013-14.

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6, "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5, "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011, and enrollment increased to 60,000 by December 2011. The Department

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

anticipates that enrollment will expand to 123,000 clients by April 2012, which was requested in FY 2011-12 BA-9, “Medicaid Budget Balancing Reductions.” 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 2011-12 include \$2,700,000 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, and a \$2.00 monthly incentive payment divided between the providers and the RCCOs. The fees in FY 2012-13 are the same, except the SDAC costs will increase to \$3,000,000. In FY 2011-12, the SDAC will not have as much data to analyze as the ACC is still ramping up; by FY 2012-13, however, the SDAC will have a full year’s data to analyze and will be assisting the Department in integrating more information to evaluate the program. The contract will increase by \$300,000 in that year, and the Department anticipates that it will remain at that level for future years. In the current and request year, the Department assumes that the full \$2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members. This is the case for the current year, but starting in FY 2012-13, the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in FY 2012-13 and may request a lower PMPM depending on the average percentage of the incentive payments paid to providers. The FY 2013-14 estimate incorporates the same PMPM amounts and enrollment levels as FY 2012-13.

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. The Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

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

Hospital Provider Fee Fund

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

Expansion Adults to 100%

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 29% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level. 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. Per capita cost estimates for this population have been updated to reflect the most recent projection of per capita costs for the Expansion Adults population.

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

Adults without Dependent Children

This expansion allows Adults without Dependent Children to be eligible for Medicaid benefits. Eligibility for this population is scheduled for May 2012. The Department is pursuing a Section 1115 Demonstration Waiver in order to implement the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012.

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

The Department assumes the per capita costs for this population will be a blend of the historical per capitas trended forward for the Low-Income Adults from 29% to 60% of the FPL and the Disabled Individuals to 59 (AND/AB). The experiences from other states and a literature review on this population confirm this assumption. As the Department is only implementing up to 10% FPL, the Department assumes that these clients will be the most high-need clients, with a lot of pent-up demand. With these assumptions, the Department assumed a blended per capita with 25% resembling the Low-Income Adults from 29% to 60% of the FPL, with the other

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

75% resembling the Disabled Individuals to 59 (AND/AB) population. These proportions were applied to the per capitas for the Low-Income Adults and the Disabled Individuals to 59 calculated by the Department's contractor using the historical data of both populations. To allow for potentially higher than anticipated costs with the rollout of a new population, the Department is requesting additional funding beyond the amount indicated in the per capita estimates. If expenditure falls short of the requested amount, all funds will remain in the hospital provider fee cash fund.

Medicaid Buy-in Fund

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

Buy-in for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities is scheduled for March 1, 2012, with eligibility to children with disabilities expected to follow four to six months later. The Department does not have an implementation timeframe for non-working adults with disabilities at this time. The Department submitted a state plan amendment to CMS in January 2012, and rules were approved by the Medical Services Board (MSB) by in January 2012.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed penetration rates depending on FPL bracket and adult/child category. The Department assumed that children would have a higher penetration rate than adults, and also that the penetration rate would vary by FPL group due to interactions with other programs. Furthermore, while the Department acknowledges that as individuals' incomes increase they may be more likely to obtain their own insurance, the Department learned many may buy into the program to receive "wraparound" benefits, where they would receive benefits not available through their own plan.

The Department assumes 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:

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

- The Department assumes that most clients in the Buy-In program will have lower utilization of many Home and Community Based Services (HCBS) waivers and other Long Term Care services. The Department assumes 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. In addition, the Department also assumes that 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services. Overall, the Medicaid Disabled Individuals to 59 Acute Care per capita has been adjusted based on all of the above factors, some of which act to increase and some of which act to decrease the per capita. These adjustments were applied to the total per capita rather than at the service category level.

Hospital Provider Fee Supplemental Payments

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

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit 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 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.

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

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

In FY 2005-06, the Department 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.

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

EXHIBIT L – DEPARTMENT RECOVERIES

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

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

Recoveries made for dates of service under periods where the state received an enhanced federal match are given the same federal match as was applicable when the services were rendered. The Department previously assumed a larger percentage of recoveries would fall under periods of enhanced federal match. However, the most recent expenditure data indicates that a smaller percentage of

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

recoveries are from periods with enhanced federal match. Consequently, the Department has revised assumptions regarding federal match on recoveries accordingly.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 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 data obtained from the Department’s Medicaid Management Information System. This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

This exhibit also includes six-month cash-based actuals for July 2011 through December 2011.

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

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

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

Service Group	Old Title	New Title
Community Based Long Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

Effective with the February 15, 2008 Budget Request, the Department 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.

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

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

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2010-11 final actual expenditures are included in this Budget Request for historical purpose and comparison.

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

Effective with the November 1, 2010 Budget Request, the Department has included 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 2010-11 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2010-11 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

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

The Department has adjusted totals in Exhibit O to capture the effect of audit adjustments that occurred since the Department's November 1, 2012 request.

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 2011-12 year-to-date expenditures through September 2011 and the cash flow pattern of actual expenditures for the first quarter of FY 2011-12 to determine a rough estimate of FY 2011-12 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 prior legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

New Legislation and Impacts from FY 2011-12 Budget Cycle Requests

This section describes the impact from legislation passed during the 2011 legislative session, and also includes impacts from the Department's FY 2011-12 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

SB 11-209 – FY 2011-12 Long Bill

The FY 2011-12 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2011 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.

- ***Client Overutilization Program Expansion (BRI-1):*** Increase enrollment by 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication, but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. The Department has been able to expand to more clients in the current year through outreach efforts, but will not reach 200 clients by June 2012 as anticipated. However, as the program expanded to more clients prior to the assumed March 2012 implementation date, the Department believes that it will reach the acute care savings of \$136,000. The Department projects that it will expand to 200 clients by January 2013 through more outreach efforts by its utilization management vendor and by completing the system change that will broaden the pool of providers who can participate. The savings were reduced in FY 2012-13 by one-fourth as a result of the delay for annualized savings of \$823,650. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department will continue to evaluate whether this payment is necessary to maintain at least 200 clients in the program.

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

- *Medicaid Reductions (BRI-5)*: This budget reduction item included a series of initiatives that were proposed to reduce Medicaid expenditure and meeting budget balancing goals. The initiatives imposed a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies, as listed below.
 - Pharmacy State Maximum Allowable Cost Expansion: Add more drugs to be placed on the SMAC list, reducing expenditure by \$1,833,334 in FY 2011-12 and annualized in FY 2012-13 to an additional reduction of \$166,666.
 - Reduce Rates for Specific Diabetes Supplies: Reduce payment for blood glucose/reagent strips from \$31.80 per box of 50 strips to the current median market price of \$18.00. This rate cut reduces expenditure by \$842,728 in FY 2011-12 and an additional \$150,066 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Reduce Payments for Uncomplicated Cesarean Section Deliveries: Reduce the amount paid for uncomplicated cesarean section deliveries to the amount paid for complicated vaginal deliveries, which reduces expenditure by \$6,276,004 in FY 2011-12 and an additional \$811,545 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Reduce Payments for Inpatient Renal Dialysis: Reduce the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers. This results in a reduction of \$1,418,733 in FY 2011-12 and an additional \$183,455 in FY 2012-13. The request amount also includes an adjustment to account for cash accounting.
 - Deny Hospital Readmissions within 48 Hours: Cease making a separate payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition, reducing expenditure by \$2,475,418 in FY 2011-12 and an additional \$320,094 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Prior Authorize Specific Radiology Services at Outpatient Hospitals: Require prior authorization in outpatient hospitals for MRIs, CT scans, PET scans and SPECT scans, except for in emergency situations. This policy reduces expenditure by \$672,136 in FY 2011-12 and an additional \$3,720,409 in FY 2012-13. It is on track to be implemented in April 2012.
 - Normalize Consumer Directed Attendant Support Services Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. This results in a reduction of \$473,564 in FY 2011-12 and an additional reduction of \$1,204,144 in FY 2012-13 to community based long term care. The request amount was adjusted for a delay in the implementation date from July 2011 to March 2011, and it includes an adjustment to account for cash accounting.
 - Enforce Existing Limitations on Acute Home Health Services: Enforce requirement that prior authorization is needed for acute home health services beyond 60 days, reducing expenditure by \$1,131,555 in FY 2011-12 and an additional \$286,551 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Reduction to Managed Care Organization: Incorporate the reductions to Medicaid fee-for-service in the rates paid to the Department's managed care organization, resulting in a reduction of \$1,906,233 in FY 2011-12 and an additional reduction

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

of \$81,968 in FY 2012-13. The Department has adjusted its request to account for initiatives that were not appropriated and will therefore not affect the rates paid to the managed care organization.

- *Medicaid Budget Balancing Reductions (BA-9)*: In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions.
 - Expand the Accountable Care Collaborative: Enroll 63,000 additional clients in the ACC by November 2011, for a total program enrollment of 123,000. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.
 - Money Follows the Person Deinstitutionalization Efforts: Use grant funds to provide additional transitional services to move clients from nursing facilities to Community Based Long Term Care. The Department was unable to transition these clients due to receiving significant less grant funds than anticipated. The clients specified in this initiative would be moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
 - Limit Fluoride Application Benefit: Limit fluoride application benefit to a maximum of three applications per year, reducing expenditure by \$30,982 in FY 2011-12 and an additional \$6,101 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Limit Dental Prophylaxis Benefit: Restrict dental prophylaxis (routine dental cleaning) to two procedures per fiscal year, reducing expenditure by \$161,936 in FY 2011-12 and an additional \$31,892 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Eliminate Reimbursement for Oral Hygiene Instruction: Eliminate reimbursement for oral hygiene instruction. This results in a reduction of \$4,241,026 in FY 2011-12 and an additional \$835,251 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until March 2012 as the Department is awaiting feedback from a new utilization management contractor to appropriately implement the proposal. The Department adjusted its request accordingly; for FY 2011-12, expenditure is reduced by \$154,227 and for FY 2012-13, it is reduced by an additional \$400,840. The request amount also includes an adjustment to account for cash accounting.

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

- Require Specific Billing for Certain Home Health Visits: Require home health providers to specifically bill codes for brief visits in circumstances in which only a short visit is required, reducing expenditure by \$2,511,443 in FY 2011-12 and an additional \$636,809 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Provider Rate Reduction: Reduce acute care physical health provider rates by 0.75% and community based long-term care providers by 0.5%, effective July 1, 2011. This results in a \$12,092,847 reduction in FY 2011-12 and an additional \$2,904,019 in FY 2012-13 to Acute Care, and a \$1,561,829 reduction in FY 2011-12 and an additional \$361,468 in FY 2012-13 to Community Based Long Term Care.

The following table shows the original request amount, FY 2011-12 appropriation, and FY 2012-13 R-1 request amount for each of the FY 2011-12 impacts requested in BRI-5 and BA-9, as detailed above:

FY 2011-12 BRI-5 and BA-9 Request to Appropriation Comparison					
Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount	FY 2012-13 S-1 Request Amount
State Allowable Cost Expansion	BRI-5	(\$1,833,333)	(\$1,833,334)	(\$1,833,334)	(\$1,833,334)
Reduce Rates for Diabetes Supplies	BRI-5	(\$842,727)	(\$919,340)	(\$842,728)	(\$842,728)
Reduce Payment for Uncomplicated C-Section	BRI-5	(\$6,276,004)	(\$6,846,550)	(\$6,276,004)	(\$6,276,004)
Reduce Payments for Renal Dialysis	BRI-5	(\$2,169,701)	(\$2,366,947)	(\$1,418,733)	(\$1,418,733)
Deny Payment of Hospital Readmissions 48 hrs	BRI-5	(\$2,475,418)	(\$2,700,456)	(\$2,475,418)	(\$2,475,418)
Prior Authorize Certain Radiology	BRI-5	(\$672,136)	(\$672,136)	(\$672,136)	(\$672,136)
Cap CDASS Wage Rates	BRI-5	(\$1,420,692)	(\$1,549,846)	(\$1,065,519)	(\$473,564)
Limit Acute Home Health Services	BRI-5	(\$1,131,555)	(\$1,234,424)	(\$1,131,555)	(\$1,131,555)
HMO Impact to Rates	BRI-5	(\$2,945,547)	(\$2,707,680)	(\$1,906,233)	(\$1,906,233)
Estimated ACC Net Savings	BA-9	(\$9,537,806)	(\$4,768,903)	(\$2,753,663)	(\$734,598)
Clients Moved from Nursing Home	BA-9	(\$624,975)	(\$625,704)	\$0	\$0
Limit Fluoride Application Benefit	BA-9	(\$29,898)	(\$33,798)	(\$30,982)	(\$30,982)
Limit Dental Prophylaxis Benefit	BA-9	(\$156,274)	(\$176,658)	(\$161,936)	(\$161,936)
Limit Oral Hygiene Instruction	BA-9	(\$4,092,739)	(\$4,626,574)	(\$4,241,026)	(\$4,241,026)

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

FY 2011-12 BRI-5 and BA-9 Request to Appropriation Comparison					
Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount	FY 2012-13 S-1 Request Amount
Limit Physical and Occupational Therapy	BA-9	(\$446,504)	(\$504,744)	(\$347,012)	(\$154,227)
Home Health Billing Changes	BA-9	(\$2,423,629)	(\$2,739,756)	(\$2,511,443)	(\$2,511,443)
0.75% Acute Care Provider Rate Reduction	BA-9	(\$8,261,265)	(\$11,711,574)	(\$12,092,847)	(\$12,092,847)
0.5% CBLTC Provider Rate Reduction	BA-9	(\$1,507,220)	(\$2,260,830)	(\$1,561,829)	(\$1,561,829)
Total		(\$46,847,423)	(\$48,279,254)	(\$41,322,398)	(\$38,518,593)

In cases where savings estimates have been reduced due to implementation delays, the Department accounts for the full impact in FY 2012-13.

SB 11-209 also included the following reductions that were not part of the Department’s original requests:

- *Wound Therapy Code Reduction:* Reduce payment for negative pressure wound therapy to \$88.50 per day, reducing expenditure by \$100,000 in FY 2011-12.
- *Elimination of Circumcision Benefit:* Eliminate circumcision as a covered benefit. This results in a reduction of \$373,000 in FY 2011-12.

SB 11-008 – Concerning Medicaid Eligibility for Children

This bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). The Department assumes that the federal match for clients these clients will remain at the same level it would have had the clients enrolled in the Children’s Basic Health Plan instead of Medicaid, or 65%. The impact of this bill will not be seen until FY 2012-13 due to needed system changes.

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

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	2,121	\$3,294,614
FY 2013-14	13,431	\$20,766,966

SB 11-125 – Concerning Nursing Home Fees and Order of Payments

This bill alters the hierarchy of the supplemental payment components funded by the Nursing Facility Provider Fee and increases the maximum allowable fee assessed to nursing facilities.

Nursing facility rates are cost-based. However, the General Fund portion of a nursing facility’s rate is limited by statute regardless of the amount of growth seen. Facilities are compensated for cost growth beyond the General Fund cap through supplemental payments from the Nursing Facility Cash Fund. On the aggregate level, nursing facilities typically see approximately 4.25% growth in costs each fiscal year.

As quality and performance incentives were previously funded after growth beyond the General Fund Cap and the provider fee was unable to fully fund all components of the supplemental payments, these quality and performance components were not always funded. Under this statute, quality and performance incentives take priority over growth beyond the General Fund cap. As a result, the provider fee is able to fully fund quality and performance incentives, but can no longer fully fund growth beyond the General Fund cap. The Department estimates that the provider fee is able to fund approximately 68% of growth beyond the General Fund cap in FY 2011-12.

SB 11-177 – Concerning Pregnancy and Dropout Prevention

SB 11-177 extended the sunset deadline and expanded the Teen Pregnancy and Dropout Prevention program for Medicaid clients. In FY 2010-11 the Department offers teen pregnancy prevention services to at-risk teenagers through two providers: Hilltop Community Resources, Incorporated (Hilltop) and the Montrose County Department of Health and Human Services (Montrose). This program provides services such as group and individual counseling, vocational, health and educational guidance, science-based instruction concerning human sexuality and home visits. In FY 2008-09, Hilltop served approximately 150 teens at a cost of \$98,776 total funds. Montrose served approximately 140 teens at a cost of \$125,453 total funds in FY 2008-09. The program receives a 90% federal financial participation match rate which is drawn through local funds paid to the Department.

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

Through this bill the Department is able to hire a FTE to administer this program which was historically absorbed by other Departmental resources. The Department believes the increased administration will allow the program to expand to addition providers at a rate of two to three new providers per year. The Department assumes the cost of the FTE will be offset in Acute Care through avoided births.

In FY 2011-12 the Department anticipates receiving \$19,763 local funds, annualizing to \$40,869 in FY 2012-13 and \$69,819 in FY 2013-14 to operate and expand the program. This estimate varies from the projection the Department submitted in the November request for a few reasons. First, the Montrose County Department of Health and Human Services had to discontinue the program as a result of limited budget funding available. In addition, the Department is currently working with the Center for Medicare and Medicaid Services to assure appropriate payment methodology for the services. The Department anticipates a proper payment methodology would be established by July 2012. With such approval the Department would move forward expanding the program.

SB 11-210 – Concerning the Phase Out of Supplemental Old Age Pension Health Fund

As part of the Joint Budget Committee's budget balancing package, this bill allows for an annual transfer of \$2,230,500 from the Health Care Expansion Fund to be used as a General Fund offset for services in the Medical Service Premiums line beginning FY 2011-12. This statute eliminates the additional step of transferring funds from tobacco tax to the OAP fund and then appropriating funds from the OAP fund to the MSP line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-211 – Concerning Tobacco Revenues Offsetting Medical Services

Also part of the JBC budget balancing package, this bill allows for the use of \$33,000,000 in tobacco tax funds for services in the Medical Services Premiums line. Of this amount, \$17,758,594 is from the Tobacco Education Program Fund, \$11,955,055 is from the Prevention, Early Detection, and Treatment fund, and \$3,286,351 is reappropriated funds from the Department of Public Health and Environment. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-212 – Concerning the Use of Provider Fee to Offset Medicaid Expenditure

This bill authorizes the Department to utilize \$50,000,000 in Hospital Provider Fee funds as a direct offset to General Fund expenditure for services in the Medical Services Premiums line in FY 2011-12 and \$25,000,000 in FY 2012-13.

SB 11-215 – Concerning the 2011 Nursing Facility Rate Reduction

Effective July 1, 2011, SB 11-215 continues the 1.5% reduction to class I nursing facility reimbursement from HB 10-1324 which expired on June 30, 2011. The total fiscal impact of this bill will depend on the number of patient days incurred in FY 2011-12. Exhibit H of the Department's request contains detailed calculations for the fiscal impact of this bill.

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

SB 11-219 – Concerning 2011 Transfers for Health Care Services

This bill authorizes the Department to use \$15,775,670 in funds from the Primary Care fund as offset to General Fund expenditure in the Medical Services Premiums line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-250 – Concerning Eligibility for Pregnant Women

This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan (CBHP) to Medicaid. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients and that the first fiscal impact within the Medical Services Premiums line will occur in FY 2012-13 due to necessary systems changes.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	181	\$1,506,373
FY 2013-14	1,112	\$9,440,092

Federal Legislation

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

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

The Department estimates that the difference in rates between July 1, 2009 and January 1, 2013 will generate an estimated \$4,950,838 total funds in FY 2012-13 and \$12,872,971 total funds in FY 2013-14, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July

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

1, 2009; this gap represents rate cuts that were taken since July 1, 2009 due to budget reduction measures. The Department estimates that increasing rates to the July 1, 2009 level will increase expenditure by \$1,347,828 in FY 2012-13 and \$3,234,787 in FY 2013-14. These amounts will be matched by the federal government at the standard FMAP rates.

Section 4107 of the Affordable Care Act – Providing Smoking Cessation Counseling for Pregnant Women

Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit the Department has restricted services by allowing a maximum of 5 counseling sessions up to 10 minutes and 3 counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.

The Department estimates this initiative will have a net savings of \$46,357 in FY 2012-13 annualizing to \$142,333 savings in FY 2013-14. By reducing the smoking rate of pregnant mothers, the Department anticipates savings through a reduction to low birth rate births (attributed to smoking mothers) which tend to be more costly than a normal birth.

Colorado Choice Transitions (Money Follows the Person Grant)

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community Based Long Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services and home health services. Savings from the enhanced match are required to be used to improve the long term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. The Department anticipates transitioning will begin in July 2012 and the Department will transition 90 clients in the first year of the program and 100 each year following until the end of the 5 year grant.

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

This section describes the impact from legislation passed during the 2009 and 2010 legislative sessions, and also includes impacts from the Department's budget cycle requests prior to FY 2011-12. Information from budget requests has been updated to be consistent with any approval granted by the legislature. Please note that the descriptions in this section only discuss those portions of approved initiatives which have an impact in this budget request. The budget requests, or portions of budget requests, from prior cycles which have been implemented and do not require further adjustment in this request (such as a bottom line impact) are not

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

discussed in this narrative. For information on the Department's complete requests, please consult the narrative for prior years, or the original requests.

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. Budget actions listed in this section are from the FY 2010-11 budget cycle.

- *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. The Department estimates FY 2011-12 savings to be \$764,595 total funds. The revised implementation date for this initiative was November 1, 2011 when the Department began paying a new utilization management contractor.
- *Implementation of Family Planning Waiver (BA-16)*: This funding was to 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 would 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. However, after further discussion between the two agencies, the Department has removed its application. Populations that would have been served under the waiver would be eligible by July 2014 for services either through Medicaid or through a subsidized plan under the Colorado Health Benefit Exchange. In addition, system changes necessary to implement the program would be delayed due to federally mandated changes that could not be done concurrently with the changes necessary to implement the family planning waiver. Therefore, the Department has removed the estimate from the request.
- *Coordinated Payment and Payment Reform (BRI-2)*: This budget reduction item reduces expenditure in FY 2011-12 and FY 2012-13 for both Acute Care Services and Community Based Long Term Care Services. The table below demonstrates these reductions by service category.

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

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. Savings in FY 2011-12 and FY 2012-13 are associated with the enrollment of Medicare eligible clients in Medicare. The Department has enlisted the services of a contractor to perform outreach to clients and to assist clients with the Medicare application project. The Department has revised savings estimates based on lower per capita savings assumptions and lower than anticipated initiative participation rates as well as a adjustments for partial delays in implementation.

FY 2010-11 BRI -2 Coordinated Payment and Payment Reform Request			
Service Category	FY 2011-12 Estimate (November 2011 Request)	FY 2011-12 Estimate (February 2012 Request)	FY 2012-13 Estimate Annualization Values (February 2012 Request)
Acute Care	(\$5,060,838)	(\$1,555,000)	(\$275,000)
Community Based Long Term Care	(\$616,405)	(\$310,000)	(\$55,000)
Total	(\$5,122,243)	(\$1,866,000)	(\$330,000)

- *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) Implemented in FY 2010-11, this Budget Reduction Item is expected to reduce Acute Care services expenditure by an additional \$125,098 in FY 2011-12.

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

- 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. 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 in FY 2010-11. For this request, the Department limited enrollment to 60,000 clients with the anticipation of enrolling more clients as the program becomes established. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.

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.

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 2011-12 and FY 2012-13. The bill increases Department expenditure \$130,240 in FY 2011-12, with an additional \$182,336 in FY 2012-13.

As of December 2010 the Department has received donations to implement the telemedicine program. However, after review by the Centers for Medicare and Medicaid Services the donated funds will not receive a federal match. Within this bill the Department is given authority to request General Fund to continue operating the program after donated funds are completely utilized. The Department believes this authority grants the Department an exemption from requirements in HB 10-1178 which prohibits agencies from requesting General Fund to continue grant and donated fund programs.

The Department anticipates client enrollment will begin in February 2012 as program implementation has been delayed due to rule change requirements and completion of the documented quote for the vendor.

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

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 for clients 12 and older. 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 statewide. 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 10-1379 – 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. Due to issues related with claims run out, the Department has also estimated an FY 2011-12 impact. See Exhibit H, footnote 9 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 \$3,000,000 in FY 2011-12. The provisions of the bill are repealed on July 1, 2012.

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

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below, The bill originally reduced Department expenditure \$2,390,570 in FY 2010-11, annualizing to \$3,699,827 in FY 2011-12 by requiring the Department to implement a number of initiatives. While the Department has been able to partially implement the components of SB

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

10-167, full implementation is not anticipated until spring of 2012. Consequently, a portion of the savings originally anticipated in FY 2010-11 has been shifted to FY 2011-12 and FY 2012-13. The initiatives are as follows::

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over three million in total) to achieve savings despite delays in implementation. The FY 2011-12 NCCI impact, \$12,500, reflects both delays in implementation and savings achieved through the manual implementing codes in FY 2010-11.

Rx Coordination of Benefits

The Rx Coordination of benefits program implements system changes that allow the Department to perform prepayment review of pharmacy claims to determine whether another party should be primary payer for the claim. A delay in system change implementation has resulted in a shift of savings from FY 2011-12 to FY 2012-13. Estimated savings for FY 2012-13 total \$351,262 with a like amount in FY 2013-14. Revised implementation is scheduled for July 1, 2012.

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.

Enhanced Internal Audits

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.

Health Insurance Buy-In Program Expansion

Purchase private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the state by enrolling clients into individual insurance plans where enrollment is deemed cost effective. This initiative has been delayed to implement in April 2012 to allow for contract execution. The Department has identified a vendor and is

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

in the process of completing the contract to begin enrollment in April 2012. The vendor anticipates 90 clients will be enrolled per month until the maximum of 2,000 clients is reached.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients’ primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2010-11 per capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2011-12 through FY 2012-13.

FY 2011-12 and FY 2012-13 Total HIBI Impact from SB 10-167		
Item	FY 2011-12	FY 2012-13
Provider Payment	\$54,725	\$369,325
Premiums Payment	\$115,183	\$2,073,287
Savings (Realized in Acute Care)	(\$244,599)	(\$3,340,516)
Total Impact	(\$74,691)	(\$897,904)

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

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

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

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

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

Over the counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the Department believes that as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

The Department anticipates full implementation by July 1, 2012. The Department will continue to evaluate the list of medications to determine any needed changes or additional opportunities for savings.

Benefit Type	FY 2012-13	FY 2013-14
Emergency Contraceptive	(\$186,215)	(\$193,966)
Nicotine Replacement	\$28,585	(\$332)
Children's Over the Counter Medications	\$7,876	\$10,018
Total	(\$149,754)	(\$184,280)

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 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

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

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 1/12th of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

Estimated Savings due to PACE Enrollments				
FY 2011-12	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Total
Acute Care	(\$478,357)	(\$477,194)	(\$362,831)	(\$1,318,382)
CBLTC	(\$712,245)	(\$174,874)	(\$97,387)	(\$984,506)
Total	(\$1,190,602)	(\$652,068)	(\$460,218)	(\$2,302,888)
FY 2012-13	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Total
Acute Care	(\$485,389)	(\$484,208)	(\$368,164)	(\$1,337,761)
CBLTC	(\$722,715)	(\$177,445)	(\$98,820)	(\$998,980)
Total	(\$1,208,104)	(\$661,653)	(\$466,984)	(\$2,336,741)
FY 2013-14	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Total
Acute Care	(\$492,523)	(\$491,327)	(\$373,576)	(\$1,357,426)
CBLTC	(\$733,339)	(\$180,053)	(\$100,273)	(\$1,013,665)
Total	(\$1,225,862)	(\$671,380)	(\$473,849)	(\$2,371,091)

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

Managed Care Organization Reconciliations

This impact accounts for recoupment payments that the Department will receive from Denver Health Medicaid Choice and Colorado Access in FY 2011-12. The recoupment payments include overpayments for clients who were later determined to have third party liability at the time of payment, as well as the amount paid for fee-for-service claims for HMO-covered services on behalf of clients who were later determined to be enrolled in the HMO at the time of service. The Department does not know when future reconciliations will occur and therefore annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.

Colorado Choice Transitions

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

The Department anticipates program enrollment will begin in July 2012 and approximately 100 clients will transition per calendar year. The Department estimates a reduction in expenditure of \$224,911 in FY 2012-13, annualizing to savings of \$637,405 in FY 2013-14.

HB 09-1047 – Concerning a program for providing additional therapies to certain persons with disabilities who are eligible to receive Medicaid

HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services are to include massage, acupuncture and chiropractic care. Programmatic design and budgeting constraints delayed timely implementation of this bill. However, in June 2011 the Department applied to CMS for 1915 (c) waiver authority to run the pilot program. The Department originally anticipated, should the waiver be approved, implementation would occur in January 2012 and serve approximately 60 eligible clients. However, waiver approval has not been granted as of January 2012. The Department anticipates approval and implementation to be delayed to July 2012.

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

The Department estimates increased costs of \$187,440 to Community Based Long Term Care in FY 2012-13, annualizing to savings of \$14,305 in FY 2013-14. The Department estimates a decrease in utilization of alternative therapy services over time because the need for more intensive therapy tends to happen when first beginning services.

FY 2009-10 BA-33: Prior Authorization of Anti-Convulsants

Anticonvulsants can be used to treat a variety of conditions. By ensuring this drug class is used only for the treatment of organically originating conditions, expenditure is reduced. This initiative, originally scheduled for implementation in FY 2009-10, required the auto prior authorization system to be in place prior to implementation. Previous savings estimates were adjusted to account for implementation delays. While the system is now in place, savings estimates have been further adjusted to account for the likely reduced savings potential stemming from the fact that many of the drugs are now available in a generic form. The Department now estimates FY 2011-12 savings of \$180,000 with an additional \$60,000 in FY 2012-13. See FY 2009-10 BRI-1 below for additional information regarding the auto PA.

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. The Department has adjusted savings estimates to reflect a delay in the implementation of the automated prior authorization system. The system came online in October 2011. While the auto PA is now operational, programming needs to be completed to fully implement the initiative. The Department estimates a fiscal impact in FY 2011-12 of \$405,770 and an annualization of \$1,217,310 in FY 2012-13.

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:

- 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. The program was delayed due to necessary system changes and rule changes. The Department anticipates system changes to be

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

complete in FY 2011-12, however, the Single Entry Point agencies have been aware of and compliant with the rule change. Therefore the Department believes it will realize savings in Community Based Long Term Care in FY 2011-12.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 budget request S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 budget request BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefit package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds them accountable for health outcomes. The program began in the spring of 2011 with enrollment expected to reach 123,000 Medicaid clients statewide in FY 2011-12. The central goals of the program are to improve health outcomes through a coordinated, client-centered system, and to control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

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

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

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

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

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

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

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

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. The current savings estimate for the initial phase of 60,000 clients deviates from the appropriated amount as the estimated date of full enrollment to 60,000 clients was delayed from November to December 2011. In addition, the originally assumed eligibility mix of clients varied from the eligibility mix of clients that were actually enrolled in the program. The Department has adjusted cost and savings estimates for the initial phase of 60,000 clients to account for the delayed enrollment and for actual enrolled eligibility types. Similarly, the Department adjusted cost and savings estimates for the expansion phase of 63,000 clients due to an estimated delay in full enrollment from January to April 2012, as well as for the current information regarding the eligibility mix of enrolled clients. The chart below illustrates the difference between the appropriated amounts and the Department's requests by service category for the current year. Note that the request amounts represent the total estimated impact; the savings include the estimated amount saved in FY 2010-11 due to the program, as requested in FY 2011-12 S-1, "Request for Medical Services Premiums," plus the annualized amount estimated in the current request.

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

Accountable Care Collaborative FY 2011-12 Appropriation to Request Comparison			
Pilot Phase of 60,000 Clients (Requested in FY 2010-11 S-6, BA-5)			
Service Category	FY 2011-12 Appropriated Amount	FY 2011-12 S-1 Request November 1, 2011	FY 2012-13 S-1A Request February 15, 2012
Estimated Administration Payments (PIHP Admin)	\$13,009,140	\$11,822,246	\$12,934,476
Estimated Savings (Acute Care)	(\$23,277,919)	(\$20,085,549)	(\$14,426,782)
Total Net Impact	(\$10,268,779)	(\$8,263,303)	(\$1,492,306)
Expansion Phase of 63,000 Clients (Requested in FY 2011-12 BA-9)			
Service Category	FY 2011-12 Appropriated Amount	FY 2011-12 S-1 Request November 1, 2011	FY 2012-13 S-1A Request February 15, 2012
Estimated Administration Payments (PIHP Admin)	\$8,298,555	\$7,497,000	\$5,455,164
Estimated Savings (Acute Care)	(\$13,067,458)	(\$10,250,663)	(\$6,189,762)
Total Net Impact	(\$4,768,903)	(\$2,753,663)	(\$734,598)

The costs and savings will increase in FY 2012-13 as the Department anticipates that the program will maintain full enrollment of 123,000 clients for the fiscal year. The chart below illustrates the estimated administration payments and savings for the current, request, and out years.

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

Accountable Care Collaborative Cost and Savings Estimates by Fiscal Year				
	Service Category	FY 2011-12	FY 2012-13	FY 2013-14
Initial Phase of 60,000 Clients	Estimated Administration Payments (PIHP Admin)	\$12,934,476	\$15,240,000	\$15,240,000
	Estimated Savings (Acute Care)	(\$14,426,782)	(\$17,440,452)	(\$17,440,452)
	Total Net Impact	(\$1,492,306)	(\$2,200,452)	(\$2,200,452)
Expansion Phase of 63,000 Clients	Estimated Administration Payments (PIHP Admin)	\$5,455,164	\$12,852,000	\$12,852,000
	Estimated Savings (Acute Care)	(\$6,189,762)	(\$15,594,660)	(\$15,594,660)
	Total Net Impact	(\$734,598)	(\$2,742,660)	(\$2,742,660)
Total Costs and Savings for the Accountable Care Collaborative	Estimated Administration Payments (PIHP Admin)	\$18,389,640	\$28,092,000	\$28,092,000
	Estimated Savings (Acute Care)	(\$20,616,544)	(\$33,035,112)	(\$33,035,112)
	Total Net Impact	(\$2,226,904)	(\$4,943,112)	(\$4,943,112)

(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 individuals through 64, low income adults, adults without dependent children, eligible children, foster care children, and Breast and Cervical Cancer Program adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to, inpatient hospitalization, psychiatric care, rehabilitation and outpatient care; clinic services, case management, medication management and physician care; and non-hospital residential care as it pertains to 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

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

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.

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

- 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

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

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.

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

- 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 to adults without dependent children and disabled individuals with income up to 450% of the federal poverty level. For more detail, please see Exhibit J in Medical Services Premiums.
- 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:

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

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 included the 2.5% reductions taken by the BHOs as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of \$2,170,355. The Department worked with the BHOs in order to ensure 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.
 - The Department requested to continue to apply the 1.71% reduction to the BHO rates in the current and request years in FY 2011-12 BRI-5 “Medicaid Reductions.” The reduction was appropriated in the FY 2011-12 Long Bill.

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

- The FY 2011-12 Long Bill transferred \$616,044 from the Division of Youth Corrections appropriation, which is administered by the Department of Human Services, to the appropriation for Medicaid Mental Health Community Programs to fund mental health services provided to children living at the Ridge View Youth Services Center. In FY 2009-10, the Ridge View Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridge View to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children. Prior to FY 2011-12, the expenditure for mental health services provided to Ridge View clients was transferred from the appropriation for Medicaid Mental Health Community Programs and into the appropriation for the Division of Youth Corrections. Its appropriation was transferred to the mental health long bill line to streamline the process and avoid manually transferring expenditure. Since the Ridge View clients have been incorporated in the caseload data since FY 2009-10, the Department assumes that the impact of these clients on mental health expenditures will be captured in the caseload forecasts and does not need to be added as a bottom line impact to Exhibit BB.
- SB 11-008, “Aligning Medicaid Eligibility for Children,” will expand Medicaid eligibility from 100% to up to 133% of the federal poverty line for children ages 7 to 18. The bill shifts impacted children from the Children’s Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children’s Basic Health Plan. SB 11-250, “Eligibility for Pregnant Women in Medicaid,” will expand Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children’s Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

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

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

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.

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

The eligible Medicaid mental health populations are:

- Adults 65 and Older (OAP-A)
- Disabled Individuals Through 64 (AND/AB, OAP-B)
- Low Income Adults
- Adults without Dependent Children
- Eligible Children (AFDC-C/BC)

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

- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System. 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 0.1%.

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

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

(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.

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.

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).

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

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 Funding Request in the November Budget Request, and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all 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. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately, below. Capitation expenditures are split between traditional clients and expansion clients funded from Hospital Provider Fee funds. Finally, the recoupments from prior years for mental health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and estimated reconciliations for the adults without dependent children population are also presented (see Exhibit II for recoupment calculations).

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

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

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 eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(8), (9), and (10) C.R.S. (2011). Exhibit BB details funds splits for the Mental Health Community Programs Capitations line. The funding for the clients already enrolled in the program, called "traditional clients," is 35% cash funds from the Breast and Cervical Cancer Prevention and

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

Treatment Fund and 65% federal funds in FY 2011-12. Starting in FY 2012-13, the funding is 17.5% General Fund, 17.5% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds. In addition, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the “expansion clients,” are funded by the Prevention, Early Detection and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients was 35% reappropriated funds and 65% federal funds.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment’s appropriation for the Breast and Cervical Cancer Treatment program is \$1,215,340. The Department is requesting \$1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, “Request for Medical Services Premiums.” As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill group with the Breast and Cervical Cancer Prevention and Treatment Fund and General 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 that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients are funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other adult clients, and expenditure for these clients 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 also receive funding through the Hospital Provider Fee Cash Fund. These include disabled individuals with income limits up to 450% of the federal poverty line and adults without dependent children, both of which will receive services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients are therefore calculated using the same per capita rate as other disabled clients (see exhibit JJ). For the adults without dependent children, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for adults without dependent children and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

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

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

SB 11-008, “Aligning Medicaid Eligibility for Children,” extends Medicaid eligibility to up to 133% of the federal poverty line for all children under the age of 19. Formerly, the eligibility limit for children ages 7 to 18 was 100%, and it was 133% for children 6 and under. The bill shifts impacted children from the Children’s Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children’s Basic Health Plan.

SB 11-250, “Eligibility for Pregnant Women in Medicaid,” extends Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children’s Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

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 1.7%, as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

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

Exhibit DD contains the caseload, per capita, and expenditure history for each of the eleven eligibility categories. 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 eligible clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, exhibit B. Please see the

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

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 four adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates.

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.

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.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

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

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

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

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

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

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a

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

10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

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-4 through F.EE-5 presents the percentage of claims paid in a six month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

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

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

The Department assumes that the adults without dependent children population will follow a similar IBNR trend as low income adults and applied the percentage of claims paid in a six month period for low income adults to the calculation for adults without dependent children expenditure. The rate for the adults without dependent children is also adjusted in Exhibit HH by the same retroactivity and partial month adjustments as are applied to low income adults. In future requests, the Department will use actual cost data available for this new population to determine the true, population-specific IBNR factor and rate adjustments that should be applied.

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

On pages F.EE-6 through F.EE-8, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages F.EE-1, F.EE-2, and F.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by 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. 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 Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest 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

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

steadily changing over time and has trended downward for all eligibility categories except for disabled individuals. For this reason, the Department assumes that the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

Partial Month Adjustment Multiplier

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

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

EXHIBIT GG - 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.

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

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.

From January 1, 2009 to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to a new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year and set 2.5% below their certified midpoint rates. However, the Department's rate setting process and federal regulation require that both the Department and the BHOs actuarially certify 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 future fiscal years, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates were reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011, and appropriated it as a savings of \$2,170,355 to be achieved in FY 2010-11. The Department determined that

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

it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%. This rate reduction will continue to be built into the rates in the current and request years, as requested in FY 2011-12 BRI-5.

The Department is adding a new rate cell in FY 2011-12 for the adults without dependent children expansion population, which will be funded through the Hospital Provider Fee Cash Fund. The rate for CY 2012 for the adults without dependent children has not yet been actuarially certified. For this request, the Department assumes an estimated rate based on the encounter data for disabled individuals through 64 and low income adults. The Department estimates that the adults without dependent children will incur costs at about the average of those two eligibility categories, and calculated expenditure using this estimated rate and the projected caseload in Exhibit EE, in the same way as the other eligibility categories. Since the rate for this expansion is not based on actual encounter data for the specific population, the Department also assumes that it will make retroactive reconciliation payments to the BHOs based on actual costs, as outlined in Exhibit II.

EXHIBIT HH - FORECAST MODEL COMPARISONS

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

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

Final Forecasts

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-3 (see below). For Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

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

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

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

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

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep 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-3 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects 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

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

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 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. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.99% Rate change from FY 2009-10 to FY 2010-11	2.99% Rate change from FY 2009-10 to FY 2010-11	Historical capitation rates for adults 65 and older have increased slowly over time. The percentage change for the most recent calendar year was negative. It is anticipated that the rate will not continue to decline in future years, but grow at a moderate rate. The Department chose the percentage change in weighted fiscal year rates from FY 2009-10 to FY 2010-11 to trend the CY 2013 and CY 2014 rates.

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

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Disabled Individuals Through 64 (AND/AB, OAP-B)	5.66% Rate change from FY 2009-10 to FY 2010-11	5.66% Rate change from FY 2009-10 to FY 2010-11	The rate for the disabled populations has increased along a linear trend since the incorporation of the Goebel settlement into the rate methodology, except for the last calendar year -- the percentage change was negative. The Department expects that the rate will not continue to decline but will grow slowly in future years due to rate reform initiatives that reward BHOs for cost-savings efforts. Therefore, the percentage change in weighted fiscal year rates from FY 2009-10 to FY 2010-11 was selected to trend the CY 2013 and CY 2014 rates.
Low Income Adults	3.44% Rate change from FY 2010-11 to FY 2011-12	3.44% Rate change from FY 2010-11 to FY 2011-12	The low income adults category has also seen steady increases in its rate, and that growth has followed closely to a linear trend since FY 2002-03. The percentage change for the most recent calendar year was negative. As with the Adults 65 and Older and Disabled Individuals Through 64 rates, the Department anticipates that the rate for this category will increase rather than decrease, but at a moderate rate. The most recent percentage change in weighted fiscal year rates was selected to trend the CY 2013 and CY 2014 rates.
Adults without Dependent Children	4.55% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	4.55% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	The adults without dependent children rate was set assuming expenditure would reflect the disabled individuals through 64 and low income adults mental health expenditure. Therefore, the Department assumes that the trend for this rate will be an average of the trends of the two categories.

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

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Eligible Children (AFDC-C/BC)	5.20% Average growth model	5.20% Average growth model	The rate for the children category has been steadily increasing over recent years. The Department expects it to increase again to a similar degree in CY 2013 and CY 2014. The Department chose the average growth over the last six periods to trend the CY 2012 rate forward.
Foster Care	-2.01% One-fourth change from CY 2011 to CY 2012	-1.00% One-eighth of rate change from CY 2011 to CY 2012	The rate for this eligibility category has decreased over the last several years but has begun to level off; the Department expects that this will continue. The Department selected one-fourth of the CY 2012 percentage growth to trend the CY 2013 rate and one-eighth of the CY 2012 percentage growth to trend the CY 2014 rate.

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

EXHIBIT II - RECOUPMENTS AND RECONCILIATIONS

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. 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 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

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

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 were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 will be collected in FY 2012-13 and will be altered by the enhanced federal match from the year the claims were processed. Recoupments from FY 2010-11 will also be collected in FY 2012-13, and those from FY 2011-12 will be collected in FY 2013-14.

The most recent recoupment made by the Department was for FY 2008-09 ineligibles. The methodology used to calculate the recoupment for that year differs slightly from previous years. The data for that fiscal year is also more reliable than past fiscal years due to data standardization and verification efforts undertaken by the BHOs and the Department. For those reasons, the Department estimated future recoupments using the FY 2008-09 actual amount as a base and inflating it by the growth rate in caseload for that fiscal year.

Reconciliations

In FY 2011-12, the Department will enroll a maximum of 10,000 adults without dependent children into Medicaid as an expansion population under the Hospital Provider Fee. Since there is no previous encounter data to set a rate for this population, the Department must make assumptions in setting the rate about the clients' expected utilization of and expenditure on mental health services. The Department will not know whether this rate is sufficient to reimburse the BHOs for this population until actual cost data is available. Due to this uncertainty, the Department assumes that it will pay the BHOs a reconciliation amount on a regular basis based on actual costs. The Department is considering using a stop-loss methodology to determine the reconciliation amounts; under this methodology, the Department would pay the BHOs for those clients who incur costs greater than a certain threshold amount through a retroactive reconciliation. This would give the BHOs less risk in serving a population for which the expenditure pattern is uncertain at this time.

To estimate the amount paid in reconciliations, the Department assumes that it would pay 27.62% of the adults without dependent children capitation rate in retroactive reconciliation payments, and that it will make those payments every half year. This percentage was calculated using actual encounter data for disabled individuals through 64 and low income adults, since the Department assumes that the costs of the adults without dependent children will reflect incurred by these two eligibility categories. The Department analyzed current encounter data to estimate the amount of expenditure over the threshold amount that would be incurred by the new population. This amount was then averaged over the 10,000 adults without dependent children to determine the percentage of the capitation rate that would be paid retroactively.

EXHIBIT JJ - EXPANSION POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293) and other bills to the 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 provided 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 eligible for services as a result of HB 05-1086, and foster care clients eligible for services up to the age of 21 as a result of beginning SB 07-002. The Health Care Expansion Fund became insolvent in FY 2010-11. Any additional revenue that comes into the fund will be used to offset General Fund expenditure in Medical Services Premiums; effective in FY 2011-12, there are no longer any mental health services funded by the Health Care Expansion Fund.

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

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided 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.

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

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

The Department is also expanding eligibility to cover adults without dependent children in FY 2011-12. The program will initially be limited to 10,000 clients. This population will receive the full range of mental health services provided by the BHOs, and the BHOs will be paid at a different capitation rate for these members than any of its other eligibility categories. The Department anticipates that it will also make reconciliation payments periodically to ensure that the BHOs are reimbursed for the true costs of this population, as there is no encounter data with which to set the initial rate. This methodology is described in Exhibit II.

The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

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

SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the federal poverty line for all children under the age of 19. Formerly, the eligibility limit for children ages 7 to 18 was 100%, and it was 133% for children 6 and under. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan. As with most of the Hospital Provider Fee populations, the Department assumes that the per capita costs for this expansion population will be the same as for the traditional population since the majority of mental health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate and that the per capita costs will be the same as for the traditional population.

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

(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. 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.

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

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.

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

Current Calculations

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

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

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

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

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR 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 2011-12 appropriation is 8.50% higher than FY 2010-11 actual expenditures, primarily due to caseload growth. The FY 2011-12 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 9.56% increase from FY 2010-11 actual expenditures and a 0.98% increase from the current appropriation. The FY 2012-13 estimate is built on the FY 2011-12 estimate and presents a 13.60% expenditure increase. This increase is primarily due to 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) adding adults without dependent children mental health expenditure to the Mental Health Community Programs request. The FY 2012-13 request represents a 14.71% increase over the current FY 2011-12 appropriation. The FY 2013-14 Budget Request is built on the FY 2012-13 estimate and presents an 12.15% expenditure increase over the FY 2012-13 request and a 28.65% increase over the FY 2011-12 appropriation.