



DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

FY 2013-14 Funding Request
February 15, 2013

Susan E. Birch
Executive Director

Signature

2/13/13
Date

Department Priority: S-3.A, B.1-3
Children's Basic Health Plan Medical Premium and Dental Benefit Costs

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Children's Basic Health Plan Medical and Dental Costs	\$1,550,087	\$106,630	0.0

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Children's Basic Health Plan Medical and Dental Costs	\$2,260,009	(\$573,970)	0.0

Request Summary:

The Department is requesting to adjust the Children's Basic Health Plan Medical and Dental Costs line item to account for updated caseload and expenditure estimates. The FY 2012-13 request is an increase of \$1,550,087 total funds from the Department's January 2, 2013 request S-3, and includes \$106,630 General Fund, \$475,028 cash funds and \$968,429 federal funds. The FY 2013-14 request is an increase of \$2,260,009 total funds from the Department's November 1, 2012 request R-3, and includes a decrease of \$573,970 General Fund, and an increase of \$1,296,429 cash funds and \$1,537,550 federal funds.

The Department is not requesting any change to appropriations for the Children's Basic Health Plan Administration line item, though updated appropriations for internal administration (Personal Services, Operating Costs, Medicaid Management Information System, etc.) are incorporated in the Department's analysis of the Children's Basic Health Plan Trust Fund.

The Department's increased estimate for funding for the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+), for FY 2012-

13 is due to greater than anticipated growth in children's caseload during the first half of FY 2012-13, which shifted caseload estimates upwards for FY 2012-13. This is partially offset by decreases in actual prenatal caseload during the first half of FY 2012-13, which the Department has used to revise its caseload estimates downward for the remainder of the year.

The Department's FY 2012-13 caseload estimate includes bottom line adjustments from SB 11-008 and SB 11-250. SB 11-008 increases eligibility for children aged 6 through 18 in Medicaid to 133% of the Federal Poverty Level (FPL). SB 11-250 implements a federal mandate to increase eligibility for pregnant women in Medicaid to 185% FPL. These changes were effective January 1, 2013, reducing CHP+ caseload as these clients became eligible for and enrolled in Medicaid.

These two bottom line adjustments have been updated from the Department's previous estimates to account for the revised caseload forecast. As a result, the updated SB 11-008 adjustment is a larger reduction relative to the

Department's November 2012 forecast, while the SB 11-250 adjustment is a smaller reduction.

The Department is requesting an increased appropriation in FY 2013-14 from its November 1, 2012 request. This is mainly due to a bottom line adjustment to expenditures for the on-going implementation of the federally mandated Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) participating in CHP+. Please see Attachment A for more details. This increase is slightly offset by minor adjustments to the caseload forecast in FY 2013-14. Although changes in total caseload are relatively small, they include shifts between different caseload groups with different funding sources, which are mostly responsible for changes in funding in this request. The Department's final caseload also includes two bottom line adjustments from SB 11-008 and SB 11-250.

In FY 2013-14, there is an additional bottom line adjustment to the Department's caseload estimate to account for the implementation of the Modified Adjusted Gross Income (MAGI) required by the Affordable Care Act of 2010 (ACA). The Department anticipates this will reduce CHP+ caseload. Please see Attachment A for details.

Problem or Opportunity:

The current appropriation and the Department's November 1, 2012 request for FY 2012-13, as well as its January 2, 2013 supplemental request for FY 2013-14 are insufficient to fully fund the CHP+ program during these two years. Under the ACA, there are maintenance of effort (MOE) provisions on eligibility for pregnant women in CHP+ until December 31, 2013 and for children in CHP+ until September 30, 2019. As such, CHP+ resembles an entitlement program like Medicaid. The Department cannot limit enrollment or eliminate the program until after these MOE provisions expire.

Brief Background:

CHP+ provides affordable health insurance to children under the age of 19 and pregnant women

in low-income families (up to 250% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. CHP+ offers a defined benefit package that uses privatized administration.

The federal government implemented this program in 1997, giving states an enhanced match on State expenditures for the program. Colorado began serving children in April 1998. Where available, children enroll in a health maintenance organization. CHP+ also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization. All pregnant women enrolled in CHP+ receive services through the State's self-funded network.

For the last two years, the Department has not submitted a request to re-estimate caseload and per capita costs for CHP+ in its February 15 Budget Request as it does for the Medicaid program at the request of the Joint Budget Committee staff. Due to the recent volatility in both caseload and expenditures experienced over the last two years, the Department is submitting revised estimates in order to ensure that the Joint Budget Committee staff has the most recent data available before Figure Setting. These include updated caseload and expenditure forecasts that account for experience from the first half of FY 2012-13.

Proposed Solution:

The Department is requesting an increase of \$1,550,087 total funds in FY 2012-13 from its January 1, 2013 request and an increase of \$2,260,009 total funds in FY 2013-14 from its November 1, 2012 request for the Children's Basic Health Plan Medical and Dental Costs to true up its latest expenditures forecast.

Anticipated Outcomes:

Approval of this request would fully fund the Children's Basic Health Plan Medical and Dental

Costs line item in accordance with the Department's latest expenditure forecast.

Assumptions for Calculations:

Please see Attachment A and Exhibits C.1 through C.8 for detailed descriptions of the assumptions and calculations for this request.

Consequences if not Funded:

Not applicable. Under the ACA, there are MOE provisions on CHP+ eligibility until September 30, 2019. As such, CHP+ resembles an entitlement program like Medicaid. The Department cannot limit enrollment or eliminate the program until after these MOE provisions expire.

Cash Fund Projections:

This request includes Cash Funds from the Children's Basic Health Plan Trust and the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balances, please see the Schedule 9

"Cash Funds Report" in Section O of the Department's November 1, 2012 budget request.

Relation to Performance Measures:

Federal mandate.

Current Statutory Authority or Needed Statutory Change:

Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj).

The Children's Basic Health Plan Trust fund is created by 25.5-8-105 C.R.S. (2012).

An "eligible person" for the program is defined in 25.5-8-103 (4) C.R.S. (2012).

25.5-8-107 (1) (a) (II), C.R.S. (2012) allows the Department to provide dental benefits through the Children's Basic Health Plan.

Attachment A

Children's Basic Health Plan Medical and Dental Costs

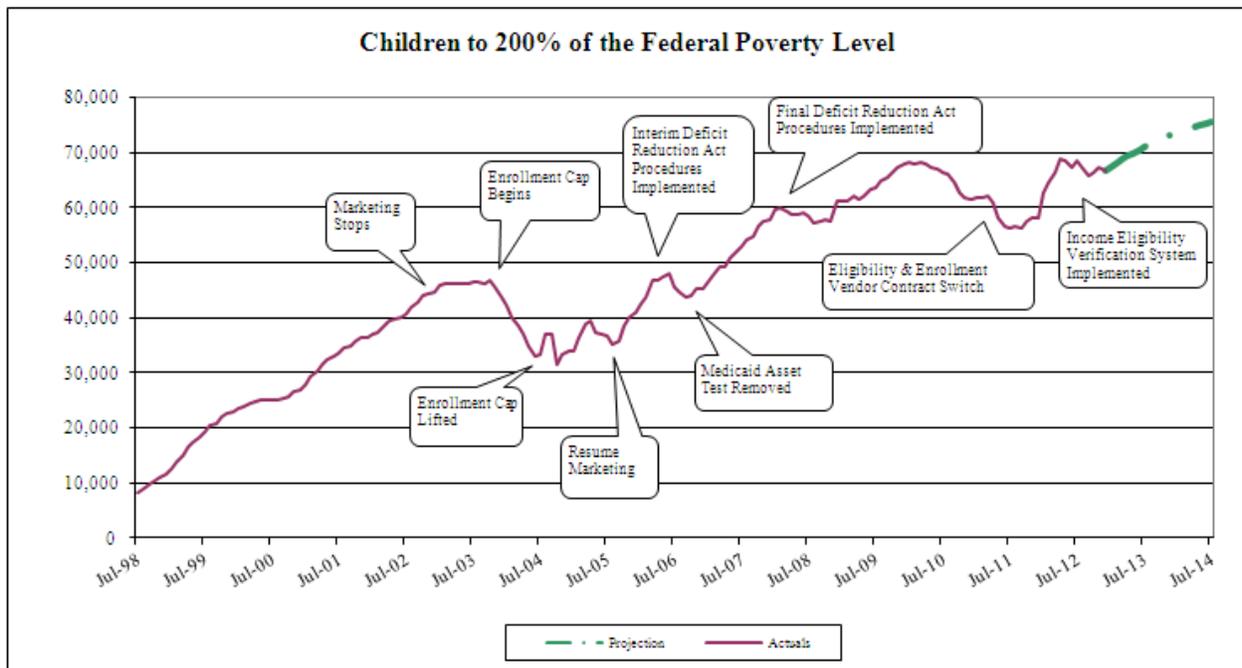
Purpose of Request

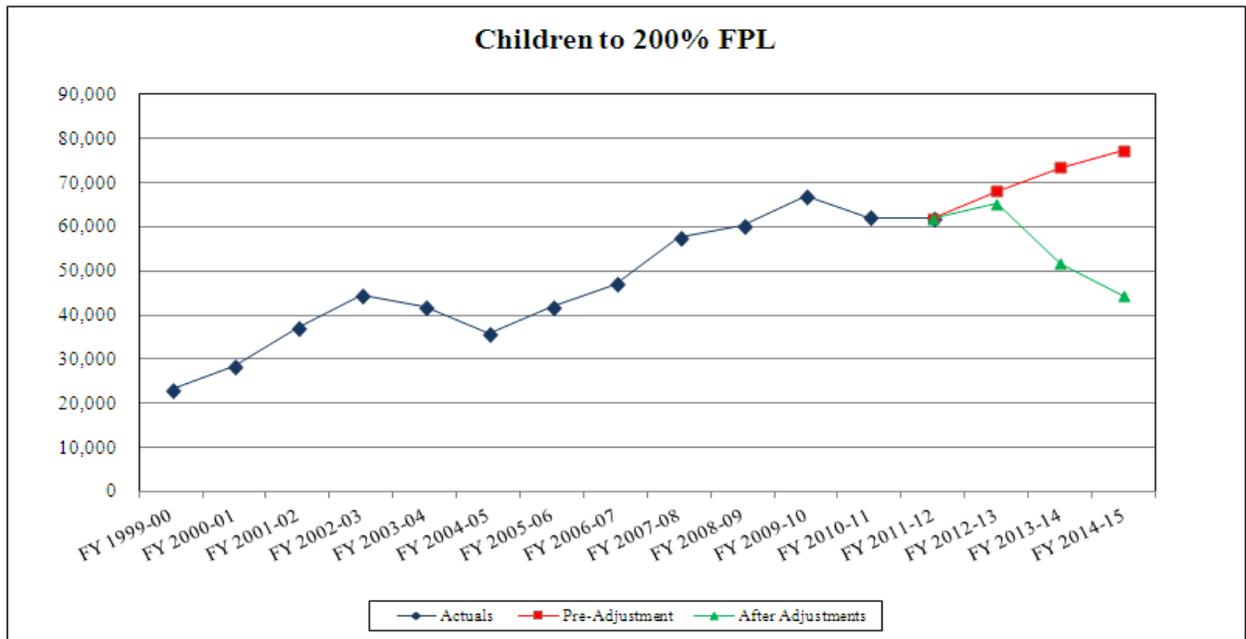
- To adjust the projected enrollment for children and pregnant women in the Plan; and,
- As the capitation rates are set on a fiscal year basis, and no new information is available, the estimated per capita costs for medical and dental services have not been changed from the Department's November 1, 2012 estimates. Total expenditures include a bottom line adjustment for the on-going implementation of the federally mandated Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) participating in CHP+

I. Description of Request Related to Children's Premiums

Children's Caseload Projections (Exhibit C.6)

Children to 200% FPL





- Growth in children to 200% FPL during the first half of FY 2012-13 was slightly higher than the Department’s November 2012 forecast, in which December 2012 caseload was projected to be 66,258 and average monthly growth was projected to be 373. Monthly caseload changes during the first half of FY 2012-13, however, were lower than the long-term average. This eligibility category has experienced volatile monthly growth since 2011. The Department believes the relative increase in volatility may be related to the implementation the federally required Income Eligibility Verification System (IEVS) in August 2011. Per Section 1137 of the Social Security Act, States must use IEVS to request information from other federal and state agencies to verify applicants’ income and resources. IEVS extracts wage information reported by employers to the Colorado Department of Labor and Employment each month to update family incomes for the previous quarter. Since individual and family incomes may vary frequently, even from month to month, the implementation of IEVS has resulted in an increased number of children in low-income FPL categories moving between Medicaid and CHP+ each month.
- The selected trend for FY 2012-13 for Children to 200% FPL is lower than the Department’s November 2012 forecast, which included higher growth trends for the second half of FY 2012-13, and would result in annual average growth of 258 per month. Despite the lower monthly trend, the annual average forecast for FY 2012-13 is higher than the Department’s November 2012 forecast due to lower than anticipated declines experienced in the first half of FY 2012-13. Growth is forecasted to average 0.38% per month in FY 2012-13. The Department believes that caseload will continue to grow, but at a lower rate as economic conditions are projected to continue to show slow improvement over the next few years.
- The Department’s section 1115 waiver, which covered the Premium Assistance Program and pregnant women in CHP+, expired on December 31, 2012. Any eligible CHP+ at Work clients transitioned to direct coverage in the CHP+ program in January 2013.
- The FY 2013-14 forecast for the Children to 200% FPL assumes that growth rates will return to averages experienced over the last 18 months, while economic conditions continue to improve in out years. This results in higher caseload growth compared to FY 2012-13, with average growth projected at 406 (0.47%) per month in FY 2013-14.

- There is a bottom-line adjustment to the Children to 200% FPL caseload from SB 11-008, which increased Medicaid eligibility for children from six through 18 years of age to 133% FPL in January 2013. This is expected to have a negative impact on caseload as children that are currently in CHP+ become eligible for and enroll in Medicaid.
- Another bottom-line adjustment to the Children to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of a new income definition, the Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) beginning in January 2014. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in health care Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with reported household incomes that appear to be within the official Medicaid eligibility range are actually eligible for CHP+. In FY 2011-12, 22.8% of children in the Children to 200% FPL category reported family incomes under 100% FPL and 51.8% reported family incomes under 133% FPL. Due to the number of children under existing Medicaid income limits, the Department believes the potential impact of MAGI is significant. The Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+, thus negatively impacting the caseload for children whose incomes are currently documented at or below 133% FPL in CHP+. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has included a negative adjustment to its caseload forecast for FY 2013-14 forward.

Children to 200% FPL

	Actuals	Monthly Change	% Change
Dec-10	61,662	-	-
Jan-11	61,925	263	0.43%
Feb-11	61,822	(103)	-0.17%
Mar-11	62,097	275	0.44%
Apr-11	60,829	(1,268)	-2.04%
May-11	58,089	(2,740)	-4.50%
Jun-11	56,754	(1,335)	-2.30%
Jul-11	56,237	(517)	-0.91%
Aug-11	56,495	258	0.46%
Sep-11	56,349	(146)	-0.26%
Oct-11	57,549	1,200	2.13%
Nov-11	58,238	689	1.20%
Dec-11	58,258	20	0.03%
Jan-12	62,736	4,478	7.69%
Feb-12	64,579	1,843	2.94%
Mar-12	66,466	1,887	2.92%
Apr-12	69,001	2,535	3.81%
May-12	68,520	(481)	-0.70%
Jun-12	67,346	(1,174)	-1.71%
Jul-12	68,486	1,140	1.69%
Aug-12	67,368	(1,118)	-1.63%
Sep-12	65,667	(1,701)	-2.52%
Oct-12	66,552	885	1.35%
Nov-12	67,410	858	1.29%
Dec-12	66,797	(613)	-0.91%

	Caseload	% Change	Level Change
FY 1999-00	22,935	-	-
FY 2000-01	28,321	23.48%	5,386
FY 2001-02	37,042	30.79%	8,721
FY 2002-03	44,600	20.40%	7,558
FY 2003-04	41,786	-6.31%	(2,814)
FY 2004-05	35,800	-14.33%	(5,986)
FY 2005-06	41,946	17.17%	6,146
FY 2006-07	47,047	12.16%	5,101
FY 2007-08	57,465	22.14%	10,418
FY 2008-09	60,137	4.65%	2,672
FY 2009-10	66,939	11.31%	6,802
FY 2010-11	62,080	-7.26%	(4,859)
FY 2011-12	61,815	-0.43%	(265)
FY 2012-13	68,022	10.04%	6,207
FY 2013-14	73,378	7.87%	5,356
FY 2014-15	77,272	5.31%	3,894

Monthly Average Growth Comparisons

FY 2011-12 Actuals	883	1.47%
FY 2012-13 1st Half Actuals	(92)	-0.12%
FY 2012-13 2nd Half Forecast	608	0.40%
FY 2012-13 Forecast	258	0.38%
November 2012 Forecast	373	0.54%
FY 2013-14 Forecast	406	0.47%
November 2012 Forecast	374	0.51%

Actuals

	Monthly Change	% Change
6-month average	(92)	-0.12%
12-month average	712	1.18%
18-month average	558	0.94%
24-month average	214	0.36%

Base trend from December 2012 level

FY 2012-13	66,922	8.26%	5,107
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November 2012 Trend Selections

FY 2012-13	67,311	8.89%	5,496
FY 2013-14	74,907	11.28%	7,596
FY 2014-15	77,812	3.88%	2,905

SB 11-008 Adjustment

FY 2012-13	(2,630)
FY 2013-14	(17,106)
FY 2014-15	(20,054)

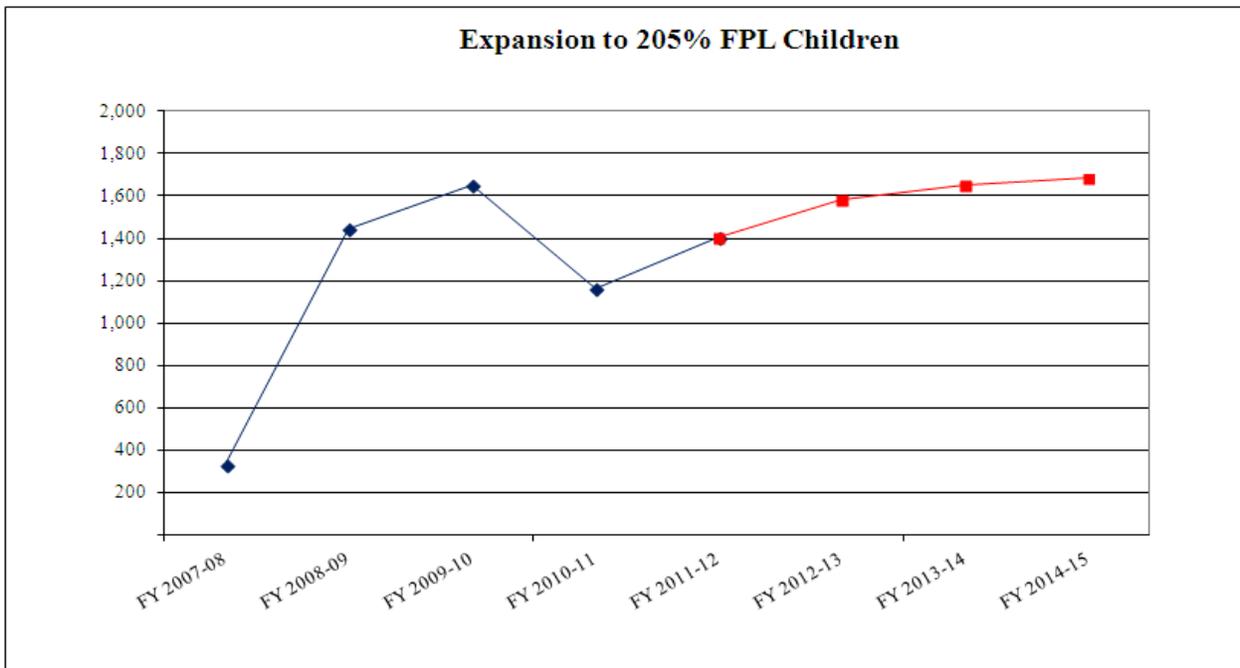
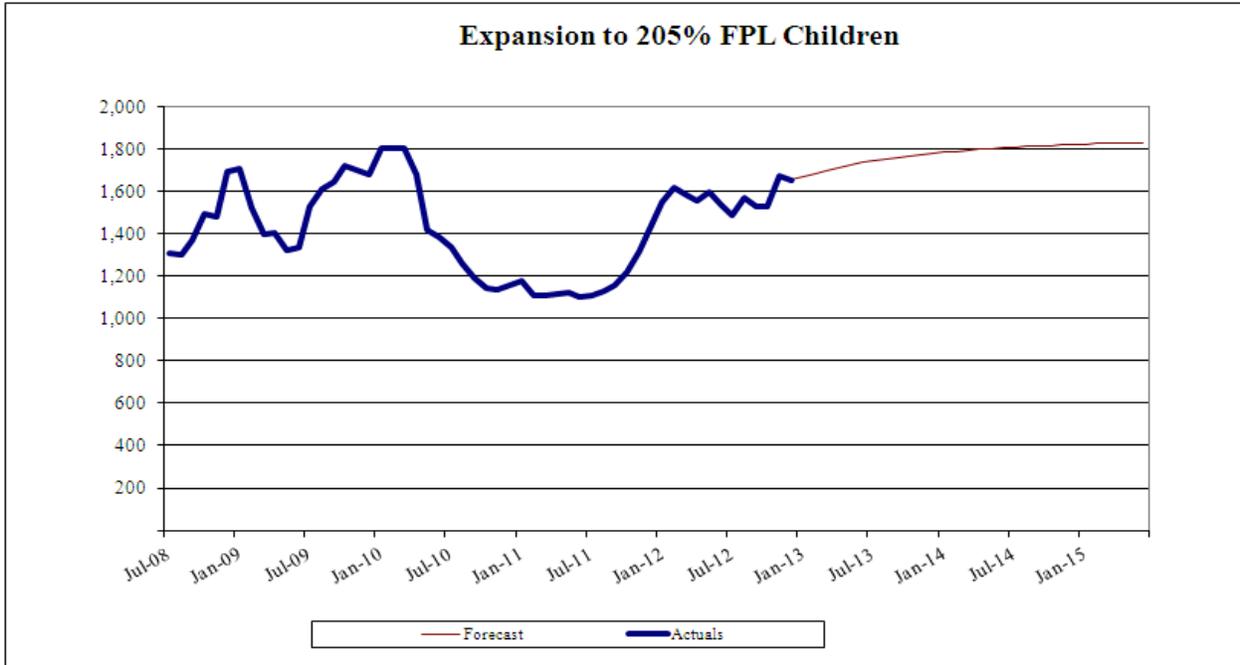
MAGI Adjustment

FY 2012-13	0
FY 2013-14	(4,551)
FY 2014-15	(12,895)

Projections After Adjustments

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

Expansion to 205% FPL Children



- This population was authorized through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201 and 205% FPL.
- Growth in Expansion to 205% FPL children during the first half of FY 2012-13 was higher than the Department's November 2012 forecast, in which annual caseload was projected to be 1,585 and average monthly growth was projected to be 8. In contrast to the caseload for Children to 200% FPL, caseload for this population increased substantially during the first half of FY 2012-13.

- The selected trend for FY 2012-13 for Expansion to 205% FPL children is higher than the Department's November 2012 forecast, and would result in average growth of 17 per month. The Department anticipates caseload will continue to increase during the second half of FY 2012-13, but at a slightly lower rate. Growth is forecasted to decrease from 1.37% per month during the first half of the year, to 0.83% during the second half, resulting in annual average growth of 1.10% per month in FY 2012-13.
- The FY 2013-14 forecast for the Expansion to 205% FPL assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. The resulting average growth is 6, or 0.31%, per month in FY 2013-14.

Expansion to 205% FPL Children							
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change
Dec-10	1,156	22	1.94%	FY 2007-08	330	-	-
Jan-11	1,178	22	1.90%	FY 2008-09	1,445	337.88%	1,115
Feb-11	1,110	(68)	-5.77%	FY 2009-10	1,649	14.12%	204
Mar-11	1,108	(2)	-0.18%	FY 2010-11	1,164	-29.41%	(485)
Apr-11	1,118	10	0.90%	FY 2011-12	1,402	20.45%	238
May-11	1,121	3	0.27%	FY 2012-13	1,640	16.98%	238
Jun-11	1,104	(17)	-1.52%	FY 2013-14	1,780	8.54%	140
Jul-11	1,112	8	0.72%	FY 2014-15	1,822	2.36%	42
Aug-11	1,130	18	1.62%				
Sep-11	1,157	27	2.39%				
Oct-11	1,217	60	5.19%				
Nov-11	1,313	96	7.89%				
Dec-11	1,441	128	9.75%				
Jan-12	1,553	112	7.77%				
Feb-12	1,620	67	4.31%				
Mar-12	1,585	(35)	-2.16%				
Apr-12	1,559	(26)	-1.64%				
May-12	1,601	42	2.69%				
Jun-12	1,535	(66)	-4.12%				
Jul-12	1,491	(44)	-2.87%				
Aug-12	1,570	79	5.30%				
Sep-12	1,529	(41)	-2.61%				
Oct-12	1,528	(1)	-0.07%				
Nov-12	1,672	144	9.42%				
Dec-12	1,656	(16)	-0.96%				

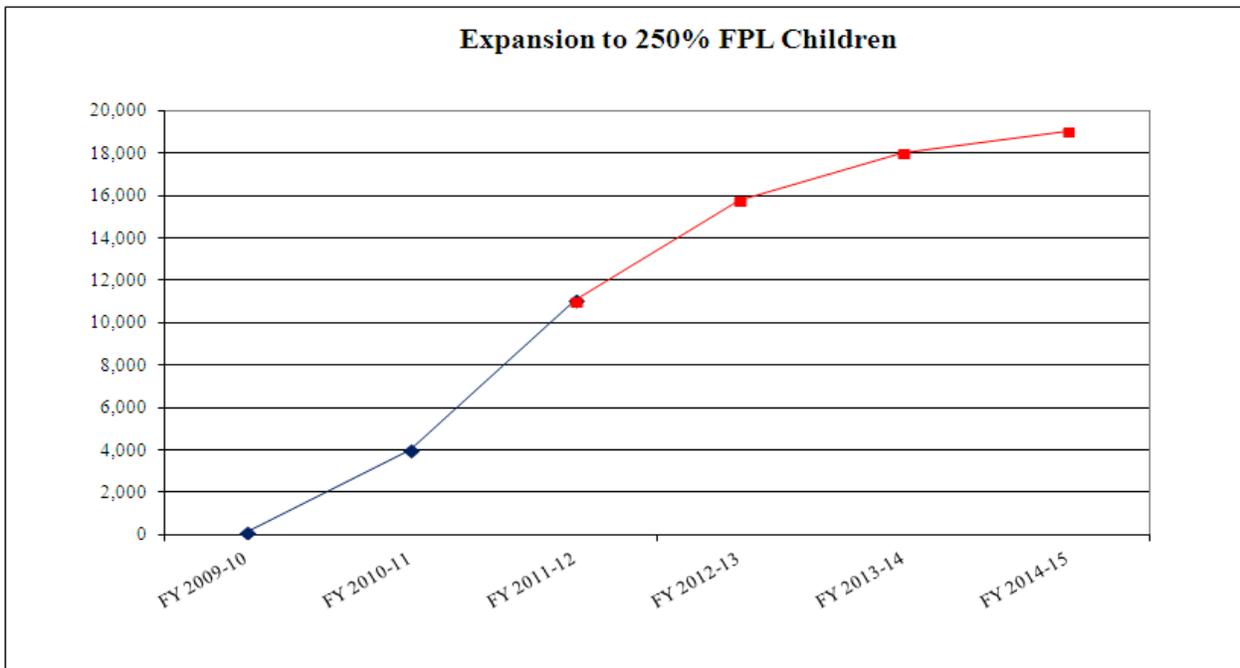
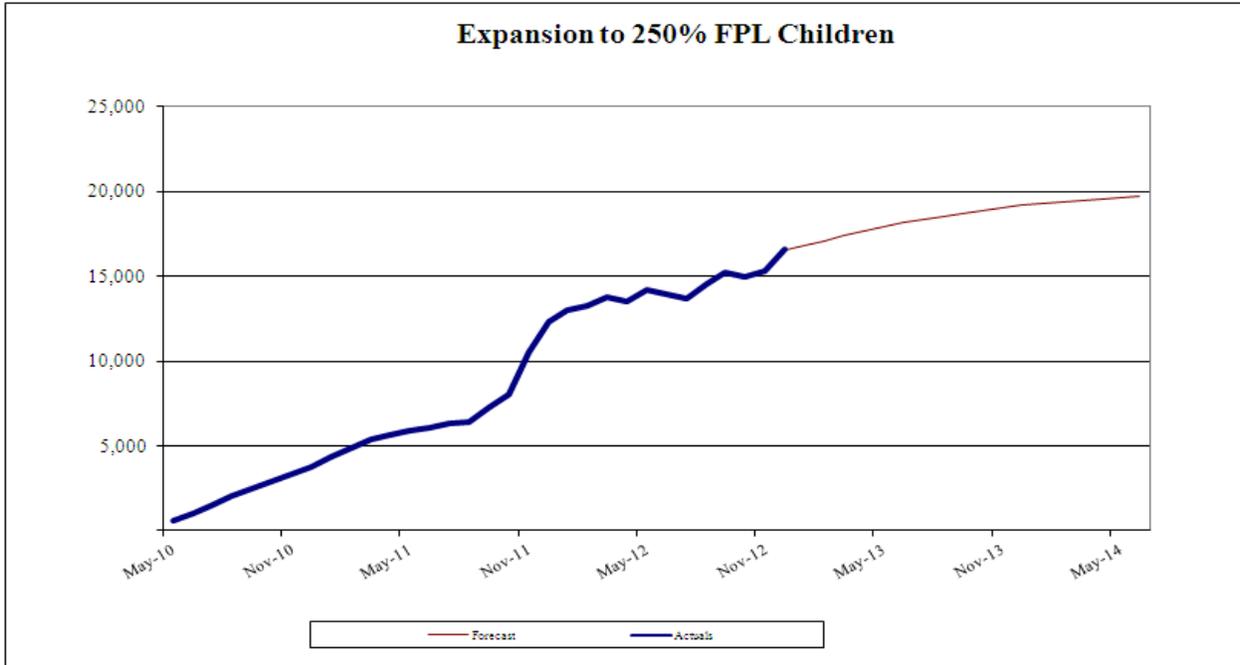
Monthly Average Growth Comparisons		
FY 2011-12 Actuals	36	2.87%
FY 2012-13 1st Half Actuals	20	1.37%
FY 2012-13 2nd Half Forecast	14	0.83%
FY 2012-13 Forecast	17	1.10%
November 2012 Forecast	8	0.48%
FY 2013-14 Forecast	6	0.31%
November 2012 Forecast	4	0.24%

Actuals		
	Monthly Change	% Change
6-month average	20	1.37%
12-month average	18	1.26%
18-month average	31	2.37%
24-month average	21	1.59%

November 2012 Trend Selections			
FY 2012-13	1,585	13.05%	183
FY 2013-14	1,654	4.35%	69
FY 2014-15	1,684	1.81%	30

Base trend from December 2012 level			
FY 2012-13	1,615	15.20%	213

Expansion to 250% FPL Children



- This population was authorized through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206 and 250% of the federal poverty level.
- Growth during the first half of FY 2012-13 was higher than the Department's November 2012 estimates in which annual caseload was projected to be 15,795 and average monthly growth was projected to be 262. Actual caseload in December 2012 was 16,575 and average monthly growth was 433 for the first half of FY 2012-13. The Department has incorporated this substantial level shift upwards and increased its caseload growth forecast.

- The selected trend for FY 2012-13 for Expansion to 250% FPL children is 2.26%, and would result in average growth of 351 per month. This is based on the average monthly growth over the past year.
- The FY 2013-14 forecast for the Expansion to 250% FPL incorporates the substantial level shift upwards and high monthly growth during the first half of FY 2012-13. The Department assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. This results in average monthly growth of 128, or 0.68%, per month in FY 2013-14.

Expansion to 250% Children			
	Actuals	Monthly Change	% Change
Dec-10	3,759	-	-
Jan-11	4,316	557	14.82%
Feb-11	4,888	572	13.25%
Mar-11	5,358	470	9.62%
Apr-11	5,674	316	5.90%
May-11	5,872	198	3.49%
Jun-11	6,098	226	3.85%
Jul-11	6,320	222	3.64%
Aug-11	6,444	124	1.96%
Sep-11	7,275	831	12.90%
Oct-11	8,075	800	11.00%
Nov-11	10,493	2,418	29.94%
Dec-11	12,338	1,845	17.58%
Jan-12	12,985	647	5.24%
Feb-12	13,250	265	2.04%
Mar-12	13,774	524	3.95%
Apr-12	13,492	(282)	-2.05%
May-12	14,169	677	5.02%
Jun-12	13,975	(194)	-1.37%
Jul-12	13,731	(244)	-1.75%
Aug-12	14,509	778	5.67%
Sep-12	15,267	758	5.22%
Oct-12	14,955	(312)	-2.04%
Nov-12	15,289	334	2.23%
Dec-12	16,575	1,286	8.41%

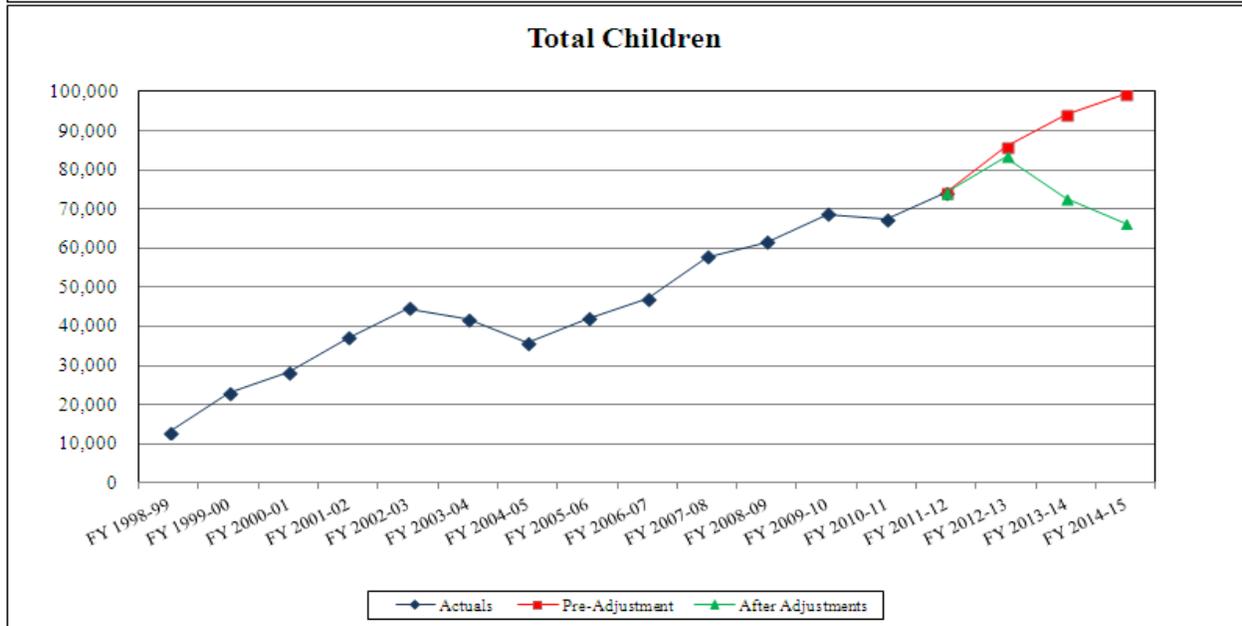
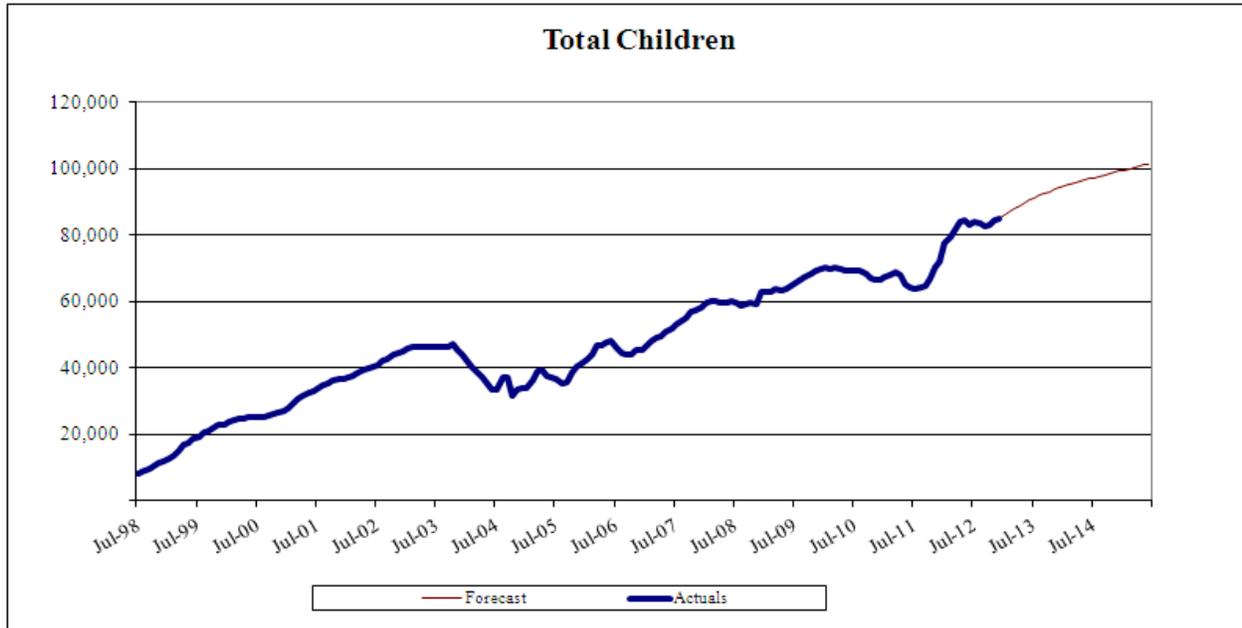
Monthly Average Growth Comparisons			
	Caseload	% Change	Level Change
FY 2009-10	136	-	-
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	16,284	47.38%	5,235
FY 2013-14	19,148	17.59%	2,864
FY 2014-15	20,222	5.61%	1,074

Actuals			
	Monthly Change	% Change	
6-month average	433	2.96%	
12-month average	353	2.55%	
18-month average	582	5.98%	
24-month average	534	6.61%	

November 2012 Trend Selections			
	Caseload	% Change	Level Change
FY 2012-13	15,795	42.95%	4,746
FY 2013-14	18,002	13.97%	2,207
FY 2014-15	19,045	5.79%	1,043

Base trend from December 2012 level			
	Actuals	Monthly Change	% Change
FY 2011-12	15,815	43.13%	4,766

Total Children



- The FY 2012-13 base children's caseload forecast is 85,946, a 15.73% increase over the FY 2011-12 caseload of 74,266. This forecast results in average increases of 626 (0.73%) per month in FY 2012-13.
- The Department estimates that the slow improvement in economic conditions will continue, resulting in lower growth in the CHP+ children caseload compared to FY 2012-13. Moreover, the Department believes the high growth rates experienced over the last two years will moderate in the out-years. The annual base FY 2013-14 caseload is projected to increase by 9.73% to 94,306, and the FY 2014-15 caseload is forecasted to grow 5.31% to 99,316. Total children's caseload is projected to increase by 0.58% (540 clients) per month in FY 2013-14 and 0.38% (379 clients) per month in FY 2014-15.
- In January 2013, the Department began allowing the children of State employees eligible for CHP+ to enroll in the program. Although this policy change is anticipated to have a positive impact on

children's caseload, the effects are difficult to anticipate. Per section 25.5-8-109(1) C.R.S. (2012), the newly eligible children must still comply with a waiting period that requires that they are not insured by a comparable health plan during the three months prior to enrolling in CHP+. The Department believes that the growth rates it has incorporated into the forecast will account for any increases due to this policy change.

- As described in the CHP+ Children to 200% FPL section, there is a bottom-line adjustment to the CHP+ children's caseload from SB 11-008, which increased Medicaid eligibility for children from six through 18 years of age up to 133% FPL in January 2013. This adjustment is expected to have a negative impact on CHP+ caseload as some children that would otherwise be eligible for CHP+ will become eligible for and enroll in Medicaid.
- Another bottom-line adjustment to the CHP+ children's caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. As described in the CHP+ Children to 200% FPL section, the Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for children whose incomes are currently documented at or below 133% FPL in CHP+. Although the exact effect of MAGI is unknown at this time, the Department has included a negative adjustment to its caseload forecast for FY 2013-14 forward.
- The adjustment for SB 11-008 decreases the FY 2012-13 caseload projection to 83,316 which is a 12.19% increase over FY 2011-12 caseload. The SB 11-008 and MAGI adjustments decrease the FY 2013-14 caseload projection to 72,649, which is a 12.80% decrease from the adjusted FY 2012-13 projection. Both adjustments also decrease the FY 2014-15 caseload projection to 66,368, which is an 8.65% decrease from the adjusted FY 2013-14 projection.

Total Children							
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change
Dec-10	66,577	-	-	FY 1998-99	12,825	-	-
Jan-11	67,419	842	1.26%	FY 1999-00	22,935	78.83%	10,110
Feb-11	67,820	401	0.59%	FY 2000-01	28,321	23.48%	5,386
Mar-11	68,563	743	1.10%	FY 2001-02	37,042	30.79%	8,721
Apr-11	67,621	(942)	-1.37%	FY 2002-03	44,600	20.40%	7,558
May-11	65,082	(2,539)	-3.75%	FY 2003-04	41,786	-6.31%	(2,814)
Jun-11	63,956	(1,126)	-1.73%	FY 2004-05	35,800	-14.33%	(5,986)
Jul-11	63,669	(287)	-0.45%	FY 2005-06	41,945	17.16%	6,145
Aug-11	64,069	400	0.63%	FY 2006-07	47,047	12.16%	5,102
Sep-11	64,781	712	1.11%	FY 2007-08	57,795	22.85%	10,748
Oct-11	66,841	2,060	3.18%	FY 2008-09	61,582	6.55%	3,787
Nov-11	70,044	3,203	4.79%	FY 2009-10	68,725	11.60%	7,143
Dec-11	72,037	1,993	2.85%	FY 2010-11	67,267	-2.12%	(1,458)
Jan-12	77,274	5,237	7.27%	FY 2011-12	74,266	10.40%	6,999
Feb-12	79,449	2,175	2.81%	FY 2012-13	85,946	15.73%	11,680
Mar-12	81,825	2,376	2.99%	FY 2013-14	94,306	9.73%	8,360
Apr-12	84,052	2,227	2.72%	FY 2014-15	99,316	5.31%	5,010
May-12	84,290	238	0.28%				
Jun-12	82,856	(1,434)	-1.70%				
Jul-12	83,708	852	1.03%				
Aug-12	83,447	(261)	-0.31%				
Sep-12	82,463	(984)	-1.18%				
Oct-12	83,035	572	0.69%				
Nov-12	84,371	1,336	1.61%				
Dec-12	85,028	657	0.78%				

Monthly Average Growth Comparisons		
FY 2011-12 Actuals	1,575	2.21%
FY 2012-13 1st Half Actuals	362	0.44%
FY 2012-13 2nd Half Forecast	890	1.02%
FY 2012-13 Forecast	626	0.73%
November 2012 Forecast	643	0.75%
FY 2013-14 Forecast	540	0.58%
November 2012 Forecast	498	0.53%

Actuals		
	Monthly Change	% Change
6-month average	362	0.44%
12-month average	1,083	1.42%
18-month average	1,171	1.62%
24-month average	769	1.05%

SB 11-208 Adjustments	
FY 2012-13	(2,630)
FY 2013-14	(17,106)
FY 2014-15	(20,054)

Base trend from December 2012 level			
FY 2012-13	84,352	13.58%	10,086

MAGI Adjustments	
FY 2012-13	0
FY 2013-14	(4,551)
FY 2014-15	(12,895)

November 2012 Trend Selections			
FY 2012-13	84,691	14.04%	10,425
FY 2013-14	94,563	11.66%	9,872
FY 2014-15	98,541	4.21%	3,978

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

Children's Medical Per Capita (Exhibit C.5)

CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor. As capitation rates for CHP+ are set on a fiscal year basis, and no new information is available, the estimated per capita costs for medical and dental services have not been changed from the Department's November 2012 estimates.

For projecting FY 2012-13 SMCN rates, the contracted actuary used actual claims data for FY 2009-10 and FY 2010-11. As the actuary was developing rates for CHP+ during FY 2011-12, data from FY 2011-12 was not available for use in rate-setting. The large annual negative cost trend the contracted actuary found for FY 2009-10 continued into FY 2010-11, becoming more negative at 30.8%. This trend is driven primarily by the change in the hospital reimbursement schedule that was effective on July 1, 2010. While the hospitals were paid 44% of billed charges in FY 2009-10, beginning in FY 2010-11 they are now reimbursed at 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. Although the FY 2011-12 rates were adjusted to include the projected impact of this change, actual changes in hospital charges could not be included in the base data until the FY 2012-13 rate-setting, which was able to incorporate data from FY 2010-11 when the reimbursement change was in effect. These new reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative annual cost trend for FY 2010-11. The contracted actuary also reviewed published studies to determine industry norms for current and projected health care cost trends, which ranged from 6.0% to 11.6%. To account for the larger than anticipated cost savings generated by the change in hospital reimbursement in the SMCN, the actuary set the unit cost base trend across services at 0.0%. Along with an annual utilization trend of 3.0%, the actuarially set combined utilization and unit cost base trend across services is 3.0% for FY 2012-13.

The FY 2012-13 SMCN children's per member per month rate is \$135.21, which includes administrative costs of \$24.22 for claims administration and case management and \$0.57 for medical home incentive payments. This is a 19.51% decrease from the final FY 2011-12 SMCN rate. The rate decrease is the result of fully accounting for the change in hospital reimbursement methodologies. When SB 11-008, which transitions children aged six to 18 from 100% FPL to 133% FPL from CHP+ to Medicaid, is implemented on January 1, 2013, the enrollment distribution of CHP+ children will change. Although rates set for the individual age and income groups will not change, the blended rate is expected to change as the number of children with incomes between 101% and 133% FPL in CHP+ decreases. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly to \$136.66, based on anticipated changes in the enrollment distribution of CHP+ children. As a result, the average children's per member per month SMCN rate for FY 2012-13 is \$135.95.

The Department is continuing the 3% HMO rate cut that was part of its November 1, 2011 FY 2011-12 Budget Request BRI-4 "CHP+ Program Reductions" and incorporating it into the FY 2012-13 rates. To ensure that this reduced rate is reasonable, the Department asked the contracted actuary to set an actuarial sound rate range for HMO capitation rates for FY 2012-13 rather than a point estimate. For projecting the FY 2012-13 HMO capitation rate, the contracted actuary used actual HMO experience in FY 2009-10 and FY 2010-11 combined with published studies of health care cost trends. Data from FY 2011-12 was not available for use in rate-setting as the actuary was developing rates for CHP+ during FY 2011-12. The range for the annual per member per month trend is 5.5% to 13.4%, with higher cost trends in outpatient

hospital services and higher cost and utilization trends in prescription drugs due to high long-term utilization patterns in these services. For the FY 2012-13 rate setting, the mid range trend was used, which includes average combined utilization and unit cost trend of 9.4%.

With agreement from participating HMOs, the administrative load of 8.5% of total costs is maintained from the previous year. The FY 2012-13 HMO children's per member per month rate is \$157.86. This includes the 3% reduction taken from the base rate at the middle of the calculated rate range which results in projected claims costs of \$144.54, administrative costs of \$12.91 and \$0.41 for medical home incentive payments. This is a 3.98% increase from the final FY 2011-12 HMO rate. Similar to the SMCN rates, the Department's actuary has estimated a new combined rate that will result from implementation of SB 11-008 in January 2013. As children previously eligible for CHP+ in the 101% to 133% FPL range move to Medicaid, the overall CHP+ caseload distribution will change. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly, to \$158.02, based on anticipated changes in the enrollment distribution of CHP+ children. As a result, the average children's per member per month HMO rate for FY 2012-13 is \$157.94.

Based on historical experience, the Department estimates that approximately 19% of children will be served in the self-funded network and the remaining 81% will be enrolled in an HMO during FY 2012-13. The Department continues to work with HMOs to expand into geographical areas that were previously served only by the SMCN. The Department is currently working with Colorado Access to expand its CHP+ HMO line of business into El Paso and Teller counties. As Colorado Access and other CHP+ HMOs continue to expand, the estimated percentage of children in HMOs will increase. Since the effects are unknown at this time, the Department is maintaining its conservative estimate of 81% HMO enrollment and will update this figure as more information becomes available. Applying these weights to the actuarial rates yields a blended rate of \$153.74 for all children in FY 2012-13. This is a decrease of 1.87% over the final FY 2011-12 blended rate of \$156.67 (calculated based on actual caseload shares between HMOs and the self-funded network). See Exhibit C.5, page C.5-2 for calculations.

On July 1, 2012, the Department implemented the increased copayments for CHP+ children with incomes above 100% FPL that were described in the Department's November 1, 2011 FY 2012-13 Budget Request R-7 "Cost Sharing for Medicaid and CHP+." The contracted actuary has included these increases in the 2012-13 SMCN and HMO rates.

Per Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which amended section 2107(e)(1) of the Social Security Act, federal CHIP programs are required to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) prospectively on a per-visit basis, beginning October 1, 2009. The per-visit rate is specified in the Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Through this prospective payment system (PPS), states are required to reimburse FQHCs and RHCs at 100% of their average cost of providing services during certain "base years," which are adjusted annually by a health care costs index. States are allowed to use the Medicaid PPS or design another prospective payment methodology, including one that is incentive-based, as long as these reimburse at least at the BIPA minimum. After on-going discussions since the fall of 2009, the Department was unable to reach an agreement with FQHCs and RHCs on an incentive-based alternative payment system. In order to be in compliance with federal regulations, however, the Department requested an additional \$1,650,176 total funds in FY 2011-12 in its January 3, 2012 FY 2011-12 Budget Request S-11 "Federally Mandated CHP+ PPS Payments" to bring payments for services provided by FQHCs and RHCs from October 2009 to June 30, 2012 to the Medicaid BIPA minimum rate. The Department also anticipated implementing a PPS methodology in a budget-neutral fashion beginning in FY 2012-13.

Some challenges, however, presented themselves as the Department approached the end of FY 2011-12 which delayed the implementation of the PPS going forward. Inconsistencies in the way FQHCs and RHCs were identified by individual CHP+ HMOs were discovered. As a result, the contracted actuary's initial calculation of retroactive payments did not include all FQHC and RHC claims. Since then, the Department has worked with its new contracted actuary to update the calculation of the retroactive payment amount and implement a PPS methodology going forward. These calculations were provided in the Department's January 2, 2013 FY 2012-13 request, S-15 "Federally Mandated CHP+ PPS Payments True-up." The Department's request included \$9,020,710 to make retroactive payments through the end of FY 2012-13, but did not include an estimate for FY 2013-14. Although the Department is still collaborating with FQHCs and RHCs regarding a process to ensure they receive the correct reimbursement for their CHP+ encounters, a bottom-line adjustment to FY 2013-14 expenditures has been included in this request for the implementation of PPS on an on-going basis beginning July 1, 2013. This adjustment of \$2,591,104 total funds is based on the CHP+ actuary's most recent estimate. The actuary's analysis has been adjusted for the anticipated decrease in CHP+ caseload and the difference between the BIPA minimum encounter rate used by the actuary and the Medicaid Alternative Payment Methodology (APM) that will be implemented in FY 2013-14 on an on-going basis. While the first adjustment decreased the estimated payment amount, the latter had the opposite effect. Please see the Appendix A of the Department's FY 2012-13 S-15 budget request for additional details regarding the actuary's calculations and the difference between the BIPA minimum and Medicaid APM encounter rates.

The children's medical per capita for FY 2011-12 exhibited a decline from FY 2010-11 and was lower than the Department's November 2011 forecast. This is the result of systems issues that began in the summer of 2011 and affected the number of capitations paid through the Medicaid Management Information System (MMIS). Due to differences between the eligibility determination system, the Colorado Benefits Management System (CBMS), and the MMIS, processing issues occur when loading data from CBMS into the MMIS. Although eligibility information, which shows the period for which a client is eligible for CHP+ benefits is loaded correctly into the MMIS, enrollment information, which shows which managed care plan the client is enrolled in and triggers the generation of a capitation payment, may not complete the loading process. As a result, the number of capitations generated by the MMIS is lower than actual CHP+ enrollment. The problem of enrollment spans in the MMIS, however, has not impacted eligibility determinations for the program.

The Department has established a number of processes to alleviate the cash flow issues for the CHP+ health plans. These ensure that they have accurate records of their enrollees and are receiving appropriate reimbursement for the children that they serve. Moreover, the Department is currently in the process of implementing a systems change that will resolve this issue on an on-going basis. A manual reconciliation process was established when the Department began using CBMS and has been operational for years to address the discrepancy in capitation payments to the participating health plans. This manual reconciliation process is part of the contract with all CHP+ HMOs and requires a 6-month runout period to allow for retroactive enrollments and disenrollments to accurately measure enrollment in the plan for any given month. For a number of years, the level of discrepancy was relatively constant. However, during the summer of 2011, the proportion of capitations being generated out of the MMIS relative to total CHP+ caseload decreased by approximately 20% to 30% and has remained relatively steady since then. While the number of medical capitations being paid for children and pregnant women has decreased, children's dental capitations have remained unaffected.

In order to further alleviate the cash flow issues created for the CHP+ HMOs since the summer of 2011, the Department began making interim reconciliation payments during the last quarter of FY 2011-12 based on enrollment estimates prior to the 6-month runout period. Although this mitigated a portion of the decrease

in overall expenditures for the program, the children's medical per capita was still lower than it would have been if the number of capitations generated by the system had not decreased so significantly. The large increase in children's caseload over that year also contributed to the lower per capita in FY 2011-12.

The Department's FY 2012-13 forecasted per capita has not been changed from the November 2012 request. This forecast assumes that the FY 2012-13 capitation rate for the self-funded network is indeed in line with the costs incurred for these children, and that other factors that may affect per capita costs remain constant from FY 2011-12. Examples of other factors that may affect per capita costs include the length of stay in the program and the enrollment mix between the SMCN and HMOs. The low growth forecasted for the FY 2012-13 per capita is the result of three factors. First, the negative growth in the blended capitation rate results in a lower per capita. Second, by making interim reconciliation payments to CHP+ MCOs, expenditures in FY 2011-12 more accurately reflect the services rendered during that year as some of the payments that would have been made during FY 2012-13 due to the six month runout period for the final enrollment reconciliations were made in FY 2011-12. This results in a lower FY 2012-13 per capita that does not include these payments for services rendered in FY 2011-12. The downward pressure on the per capita is mitigated by the third factor, the permanent fix to the capitations issue discussed above. The Department worked with the Office of Information Technology, and implemented a permanent solution which was in place January 2013. As in its November 2012 request, the Department anticipates that the number of MMIS capitations being generated will increase substantially. The more accurate enrollment records will result not only in an increase in the number of concurrent capitations, it should also result in the generation of retroactive capitations that were not paid in the previous five months for eligible children. This permanent solution will also greatly reduce the volume of reconciliation payments made to HMOs as the correct number of capitations will be generated automatically, which will eliminate the need to wait until the end of the 6-month runout period for HMOs to receive the correct payments. This results in more predictable cash flow for both the Department and the HMOs. As these effects have already been included in the November 2012 per capita estimates, the Department has not changed them for this request. The Department anticipates that most of the relatively large reconciliation payments will be finalized and paid in FY 2012-13.

Due to the interaction between these factors, the Department estimates that the children's medical per capita will experience slight growth of 0.25% over the FY 2011-12 per capita of \$1,957.63 for a projected FY 2012-13 per capita of \$1,962.55.

Similar to the FY 2012-13 per capita, the Department has not changed its FY 2013-14 per capita estimate from November 2012. The Department assumes that the FY 2012-13 capitation rates have captured all relevant reimbursement and policy changes, so that the volatility experienced during recent years will even out and resume normal trends in FY 2013-14. Based on research and historical experience, the Department believes the children's medical capitation rate will grow by 4.0% in FY 2013-14. As explained above, the changes in cash flow that have occurred due to systems issues and the Department's efforts to mitigate and resolve them have led to low expenditure and per capita growth estimates for FY 2012-13. After a transition period following the implementation of the systems fix for the capitation issue, the Department believes that expenditures will begin to follow caseload plus the growth in the capitation rate more closely, and that expenditures will even out in FY 2013-14 forward. Due to this change in expenditures, along with the estimated children's medical capitation rate, the per capita for FY 2013-14 is projected to be \$2,201.30, an increase of 12.17% from the previous year. This per capita accounts for the correction in expenditures that is projected to occur in FY 2013-14 and only appears large when compared to the minimal growth in prior years, particularly FY 2012-13. In addition, the high growth rate is largely driven by the relatively low per capita in FY 2012-13 discussed above.

Children's Dental Per Capita (Exhibit C.5)

As capitation rates for CHP+ are set on a fiscal year basis, and no new information is available, the estimated per capita costs for medical and dental services have not been changed from the Department's November 2012 estimates. For the development of the FY 2012-13 dental per member per month capitation rate, the contracted actuary used actual claims data from FY 2008-09 and FY 2009-10 to estimate an annual unit cost trend of 2% and an annual utilization trend of 3.5%. As the actuary was developing rates for CHP+ during FY 2011-12, data from FY 2011-12 was not available for use in rate-setting. The annual utilization trend was increased from the base data estimate to reflect Department initiatives aimed specifically at increasing dental service utilization in Colorado. The actuarial set rate of \$16.08 is a 4.9% increase over the FY 2011-12 rate. The FY 2012-13 monthly capitation rate includes \$1.14 in administrative costs and a 1% fully insured risk margin. Similar to the children's medical rates, the Department's actuary has estimated a new combined dental rate that will result from implementation of SB 11-008 in January 2013. As children previously eligible for CHP+ in the 101% to 133% FPL range move to Medicaid, the overall CHP+ caseload distribution will change. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly, to \$15.96, based on anticipated changes in the enrollment distribution of CHP+ children. As a result, the average per member per month dental rate for FY 2012-13 is \$16.02.

The Department's FY 2012-13 forecasted dental per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that other factors that may affect per capita costs, such as the length of stay in CHP+ and the average length of time taken for a child to receive dental benefits, remain constant from the FY 2010-11 base period. Additionally, dental capitations have not been affected by the same systems issue that has decreased the number of medical capitations generated over the past year. The base growth of 4.91% from the capitation rate is applied to the calculated FY 2011-12 per capita of \$167.16, resulting in a projected FY 2012-13 per capita of \$175.37.

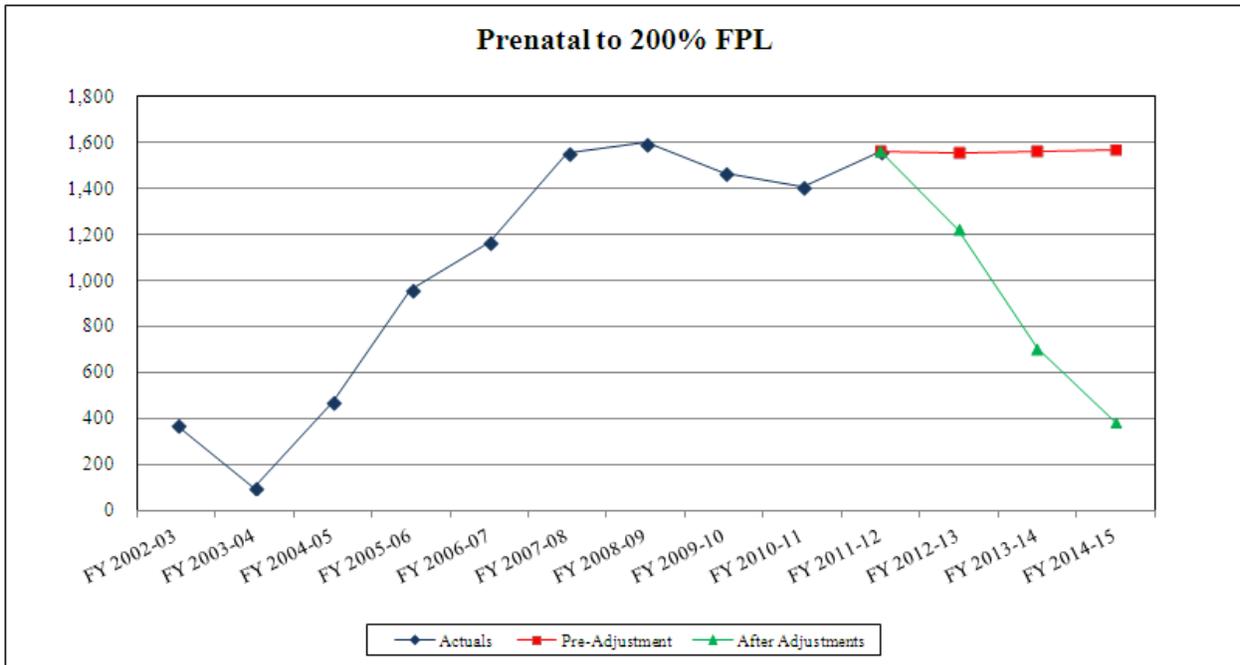
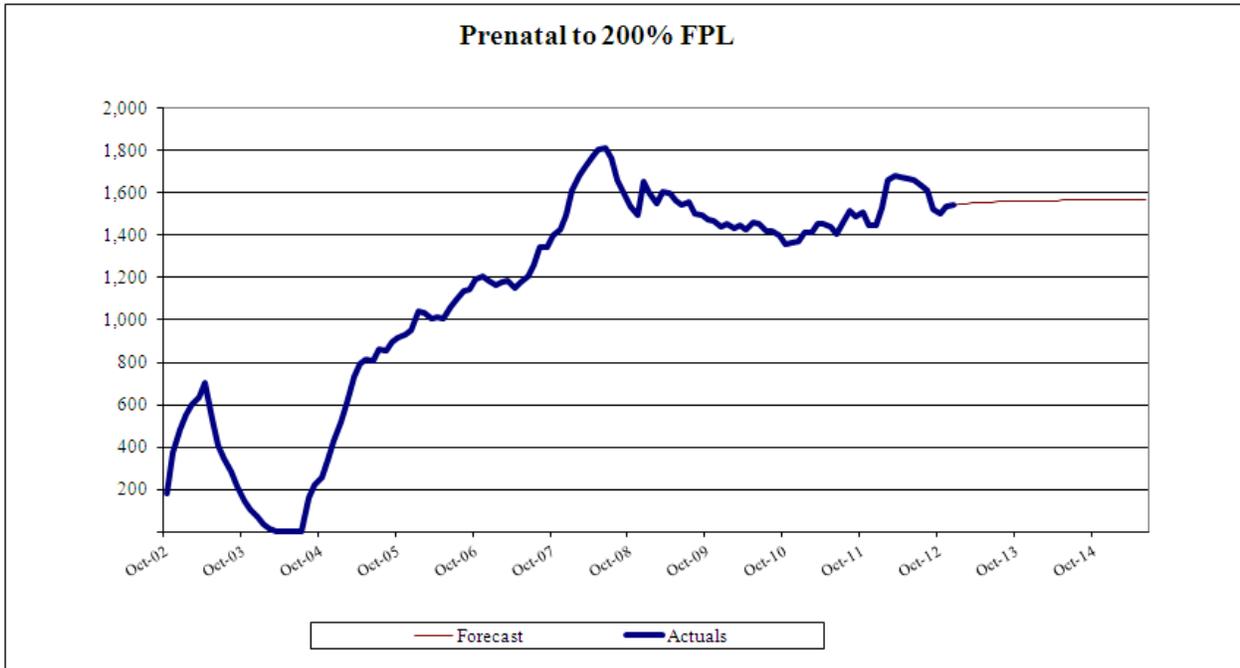
After discussions with Delta Dental, the Department included a provision in their contract that assures a risk margin for Delta Dental but allows the Department to recuperate reimbursements made above this margin. Per the contract between the Department and Delta Dental, if the amount paid in CHP+ dental claims for FY 2011-12 is less than 91.7% of the total per member per month capitation paid to Delta Dental in FY 2011-12, Delta Dental will return the difference to the Department. If that amount is greater than 91.7% there is no action. The Department believes this measure protects the State from unnecessary expenditures while ensuring that Delta Dental receives an acceptable and agreed upon risk margin for the CHP+ line of business. After allowing for six months of dental claims runout, the Department began calculating this amount in January 2013. Initial estimates suggest that the Department will recover funds from Delta Dental, but the exact amount is not yet known at this time.

To estimate the FY 2013-14 per capita trends, the Department analyzed the historical growth in dental rates. Given the negative trend in adjusted claims cost for the base period for the FY 2012-13 rates, the Department has assumed that the growth rate for FY 2013-14 will be slightly lower than the average growth found in the literature, which averages at 4.0%. Thus, the projected FY 2013-14 per capita is \$180.63, which is 3.0% higher than the FY 2012-13 estimate. Similar to the FY 2012-13 estimates, the FY 2013-14 per capita estimates have not been updated from the Department's November 2012 estimate.

II. Description of Request Related to the Prenatal Program

Prenatal Caseload Projections (Exhibit C.7)

Prenatal to 200% FPL



- Caseload growth in Prenatal to 200% FPL during the first half of FY 2012-13 was lower than the Department’s November 2012 forecast, in which December 2012 caseload was projected to be 1,672 and average monthly growth was projected to be 2. The Prenatal to 200% FPL caseload experienced declines similar to the Children to 200% FPL during the first half of FY 2012-13, decreasing by an

average of 1.19% per month. The Department believes this may be related to the implementation of the federally required Income Eligibility Verification System (IEVS) in August 2011. Per Section 1137 of the Social Security Act, States must use IEVS to request information from other federal and state agencies to verify applicants' income and resources. IEVS extracts wage information reported by employers to the Colorado Department of Labor and Employment each month to update family incomes for the previous quarter. Since individual and family incomes may vary frequently, even from month to month, the implementation of IEVS has resulted in an increased number of pregnant women in low-income FPL categories moving between Medicaid and CHP+ each month.

- The Department is modeling the FY 2012-13 forecast for the Prenatal to 200% FPL population on the monthly growth experienced over the last 20 months. Thus, monthly caseload for the second half of FY 2012-13 is forecasted to grow at 3 per month, reversing the average monthly declines of 20 experienced during the first half of the year. The Department believes that the steep declines experienced during the first half of FY 2012-13 will not continue as caseload in this eligibility group has been volatile for 3 years, yet has exhibited a slightly positive trend overall. Due to the large decreases during the first half of FY 2012-13, caseload in this category is forecasted to decline by an average 9 clients, or -0.52%, per month in FY 2012-13.
- The FY 2013-14 forecast for the Prenatal to 200% FPL assumes that the slow historical growth in this category will resume. The resulting average growth is 0.04%, or 1 per month.
- There is a bottom-line adjustment to the CHP+ prenatal caseload from SB 11-250, which increased Medicaid eligibility for pregnant women from 133% FPL to 185% FPL in January 2013 to comply with federal mandate. This is expected to have a negative impact on CHP+ caseload as pregnant women who would otherwise be in CHP+ become eligible for Medicaid. .
- Similar to the Children's caseload, another bottom-line adjustment to the Prenatal to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in health Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with household incomes that appear to be within the official Medicaid eligibility range are actually eligible for CHP+. In FY 2011-12, for example, 39.0% of clients in the Prenatal to 200% caseload reported family incomes within the existing Medicaid eligibility limit of 133% FPL and 88.7% reported family incomes under 185% FPL. The Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for pregnant women whose incomes are documented at or below 185% FPL in CHP+ prior to the change. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has included an adjustment to its caseload forecast for FY 2013-14 forward.

Prenatal to 200% FPL			
	Actuals	Monthly Change	% Change
Dec-10	1,370	-	-
Jan-11	1,413	43	3.14%
Feb-11	1,415	2	0.14%
Mar-11	1,453	38	2.69%
Apr-11	1,452	(1)	-0.07%
May-11	1,443	(9)	-0.62%
Jun-11	1,409	(34)	-2.36%
Jul-11	1,468	59	4.19%
Aug-11	1,516	48	3.27%
Sep-11	1,490	(26)	-1.72%
Oct-11	1,507	17	1.14%
Nov-11	1,446	(61)	-4.05%
Dec-11	1,451	5	0.35%
Jan-12	1,528	77	5.31%
Feb-12	1,664	136	8.90%
Mar-12	1,682	18	1.08%
Apr-12	1,674	(8)	-0.48%
May-12	1,671	(3)	-0.18%
Jun-12	1,660	(11)	-0.66%
Jul-12	1,639	(21)	-1.27%
Aug-12	1,610	(29)	-1.77%
Sep-12	1,526	(84)	-5.22%
Oct-12	1,501	(25)	-1.64%
Nov-12	1,536	35	2.33%
Dec-12	1,542	6	0.39%

	Caseload	% Change	Level Change
FY 2002-03	372	-	-
FY 2003-04	101	-72.85%	(271)
FY 2004-05	472	367.33%	371
FY 2005-06	963	104.03%	491
FY 2006-07	1,169	21.39%	206
FY 2007-08	1,557	33.19%	388
FY 2008-09	1,598	2.63%	41
FY 2009-10	1,469	-8.07%	(129)
FY 2010-11	1,409	-4.08%	(60)
FY 2011-12	1,563	10.93%	154
FY 2012-13	1,555	-0.51%	(8)
FY 2013-14	1,562	0.45%	7
FY 2014-15	1,568	0.38%	6

Monthly Average Growth Comparisons		
FY 2011-12 Actuals	21	1.43%
FY 2012-13 1st Half Actuals	(20)	-1.19%
FY 2012-13 2nd Half Forecast	3	0.16%
FY 2012-13 Forecast	(9)	-0.52%
November 2012 Forecast	2	0.12%
FY 2013-14 Forecast	1	0.04%
November 2012 Forecast	1	0.03%

Actuals		
	Monthly Change	% Change
6-month average	(20)	-1.19%
12-month average	8	0.57%
18-month average	7	0.55%
24-month average	7	0.54%

SB 11-250 Adjustment	
FY 2012-13	(332)
FY 2013-14	(668)
FY 2014-15	(670)

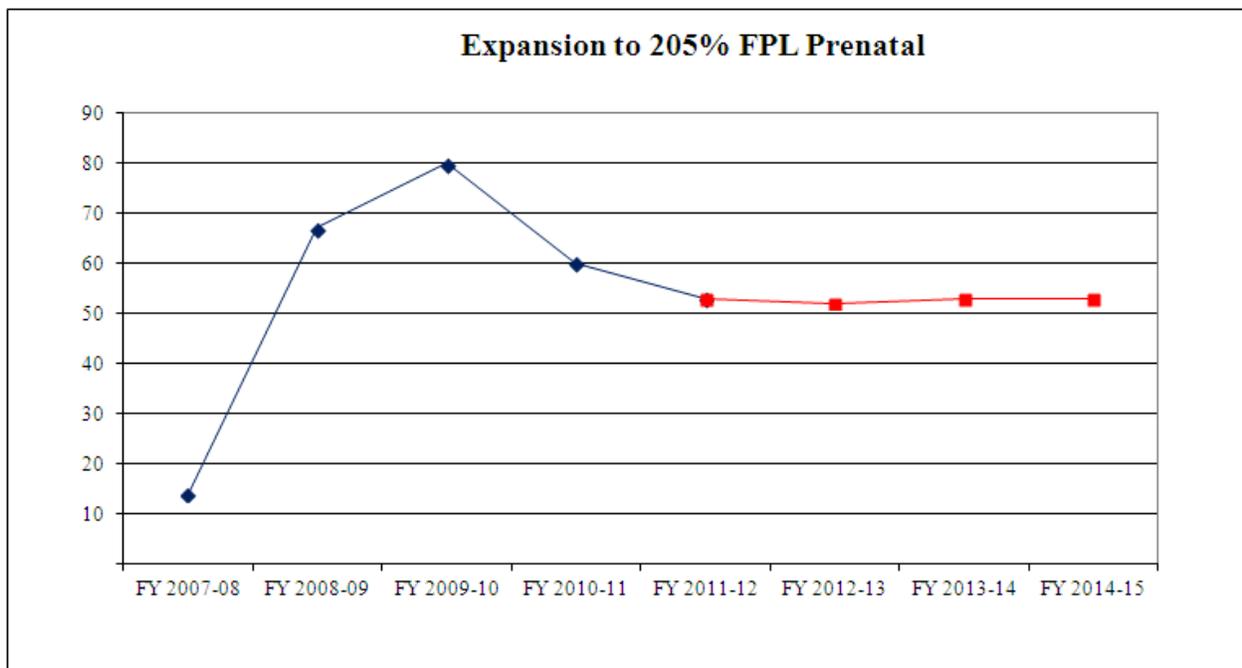
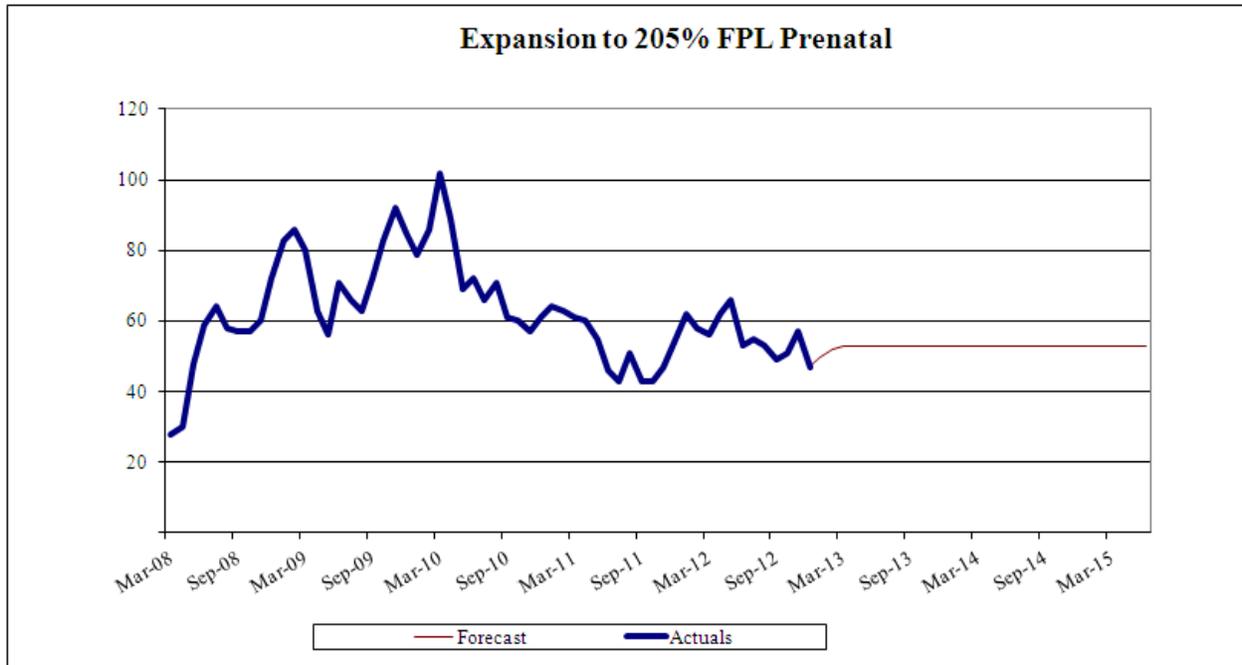
Base trend from December 2012 level			
FY 2012-13	1,551	-0.80%	(13)

MAGI Adjustment	
FY 2012-13	0
FY 2013-14	(187)
FY 2014-15	(511)

November 2012 Trend Selections			
FY 2012-13	1,673	7.04%	110
FY 2013-14	1,689	0.96%	16
FY 2014-15	1,690	0.06%	1

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

Expansion to 205% Prenatal



- Along with the children’s expansion to 205% FPL, this population was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this population have family incomes between 201 and 205% of the federal poverty level.
- Growth in the Expansion to 205% FPL Prenatal during the first half of FY 2012-13 was lower than the Department’s November 2012 forecast, in which annual caseload was projected to be 53 and average monthly growth was forecasted to be 0. The selected trend for the remainder of FY 2012-13 for Expansion to 205% FPL Prenatal is slightly higher than the Department’s November 2012 forecast, and

would result in average growth of 1 per month. This is based on the average monthly caseload of 53 that was experienced over the last 20 months.

- The Department's forecast assumes that the annual FY 2012-13 growth trend of 0 per month will continue in out-years, with zero growth on average.

Expansion to 205% FPL Prenatal			
	Actuals	Monthly Change	% Change
Dec-10	61	4	7.02%
Jan-11	64	3	4.92%
Feb-11	63	(1)	-1.56%
Mar-11	61	(2)	-3.17%
Apr-11	60	(1)	-1.64%
May-11	55	(5)	-8.33%
Jun-11	46	(9)	-16.36%
Jul-11	43	(3)	-6.52%
Aug-11	51	8	18.60%
Sep-11	43	(8)	-15.69%
Oct-11	43	0	0.00%
Nov-11	47	4	9.30%
Dec-11	55	8	17.02%
Jan-12	62	7	12.73%
Feb-12	58	(4)	-6.45%
Mar-12	56	(2)	-3.45%
Apr-12	62	6	10.71%
May-12	66	4	6.45%
Jun-12	53	(13)	-19.70%
Jul-12	55	2	3.77%
Aug-12	53	(2)	-3.64%
Sep-12	49	(4)	-7.55%
Oct-12	51	2	4.08%
Nov-12	57	6	11.76%
Dec-12	47	(10)	-17.54%

Expansion to 205% FPL Prenatal			
	Caseload	% Change	Level Change
FY 2007-08	14	-	-
FY 2008-09	67	378.57%	53
FY 2009-10	80	19.40%	13
FY 2010-11	60	-25.00%	(20)
FY 2011-12	53	-11.67%	(7)
FY 2012-13	52	-1.89%	(1)
FY 2013-14	53	1.92%	1
FY 2014-15	53	0.00%	0

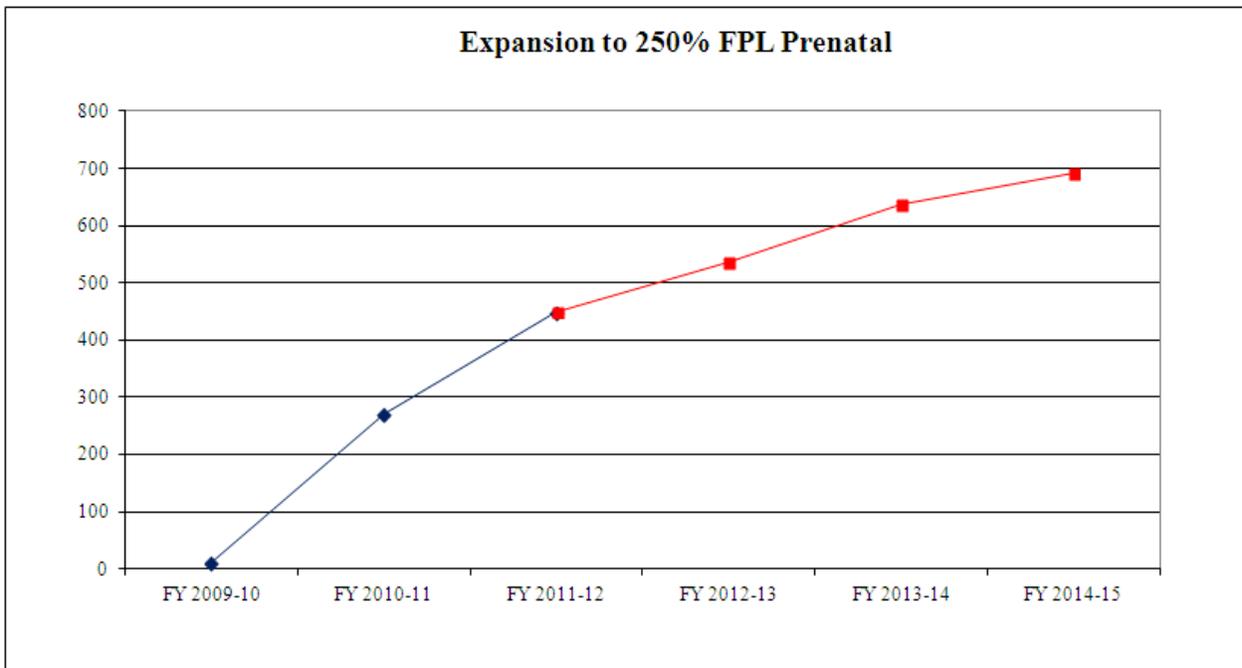
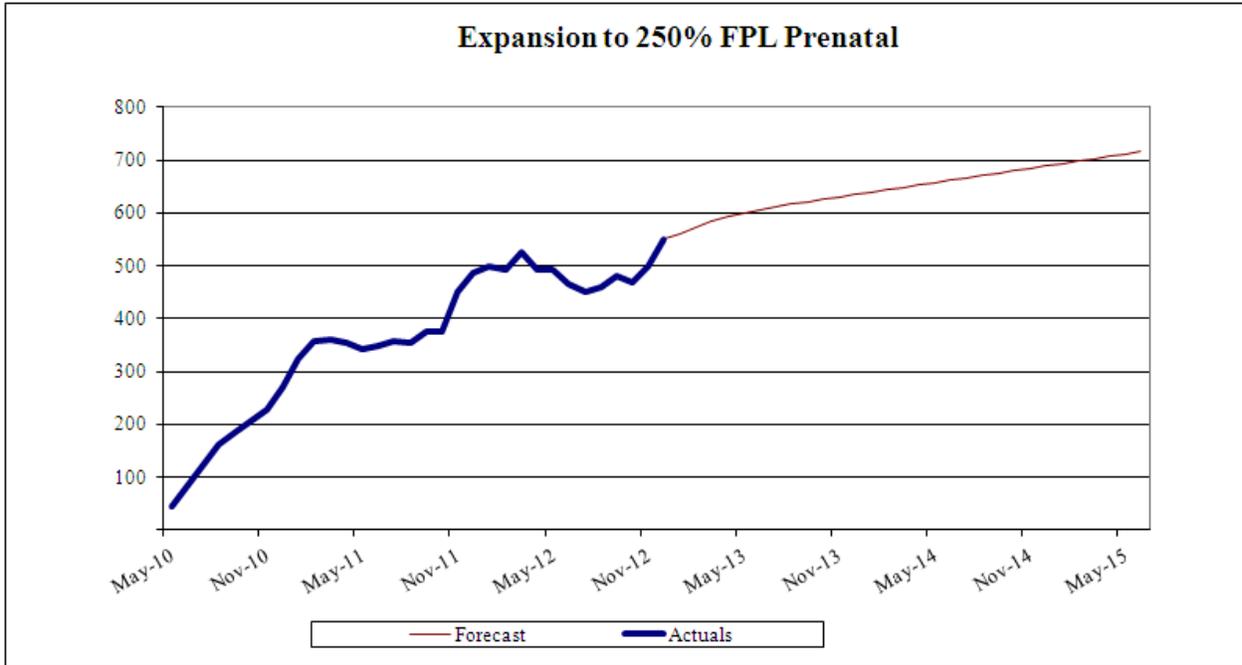
Monthly Average Growth Comparisons		
FY 2011-12 Actuals	1	1.92%
FY 2012-13 1st Half Actuals	(1)	-1.52%
FY 2012-13 2nd Half Forecast	1	2.05%
FY 2012-13 Forecast	0	0.27%
November 2012 Forecast	0	0.12%
FY 2013-14 Forecast	0	0.00%
November 2012 Forecast	0	0.03%

Actuals		
	Monthly Change	% Change
6-month average	(1)	-1.52%
12-month average	(1)	-0.73%
18-month average	0	0.77%
24-month average	(1)	-0.51%

November 2012 Trend Selections			
FY 2012-13	53	0.00%	0
FY 2013-14	53	0.00%	0
FY 2014-15	53	0.00%	0

Base trend from December 2012 level			
FY 2012-13	50	-6.60%	(4)

Expansion to 250% FPL Prenatal



- This population was authorized through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206 and 250% of the federal poverty level.
- Growth during the first half of FY 2012-13 was higher than the Department’s November 2012 estimates in which annual caseload was projected to be 526 and average monthly growth was projected to be 9. The Department has increased its caseload growth forecast to account for this higher growth.

- The selected trend for FY 2012-13 for Expansion to 250% FPL Prenatal is higher than the Department's November 2012 forecast, and would result in average growth of 12 per month. This is based on the average monthly growth over the last two years and results in average growth of 2.28% per month in FY 2012-13.
- The FY 2013-14 forecast for the Expansion to 250% FPL Prenatal assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. The average monthly growth is estimated at 5, or 0.73%, per month in FY 2013-14.

Expansion to 250% Prenatal			
	Actuals	Monthly Change	% Change
Dec-10	270	-	-
Jan-11	325	55	20.37%
Feb-11	357	32	9.85%
Mar-11	361	4	1.12%
Apr-11	355	(6)	-1.66%
May-11	342	(13)	-3.66%
Jun-11	349	7	2.05%
Jul-11	357	8	2.29%
Aug-11	355	(2)	-0.56%
Sep-11	377	22	6.20%
Oct-11	375	(2)	-0.53%
Nov-11	451	76	20.27%
Dec-11	487	36	7.98%
Jan-12	498	11	2.26%
Feb-12	494	(4)	-0.80%
Mar-12	525	31	6.28%
Apr-12	494	(31)	-5.90%
May-12	494	0	0.00%
Jun-12	466	(28)	-5.67%
Jul-12	452	(14)	-3.00%
Aug-12	459	7	1.55%
Sep-12	482	23	5.01%
Oct-12	470	(12)	-2.49%
Nov-12	498	28	5.96%
Dec-12	550	52	10.44%

Expansion to 250% Prenatal			
	Caseload	% Change	Level Change
FY 2009-10	11	-	-
FY 2010-11	272	2372.73%	261
FY 2011-12	448	64.71%	176
FY 2012-13	536	19.64%	88
FY 2013-14	637	18.84%	101
FY 2014-15	692	8.63%	55

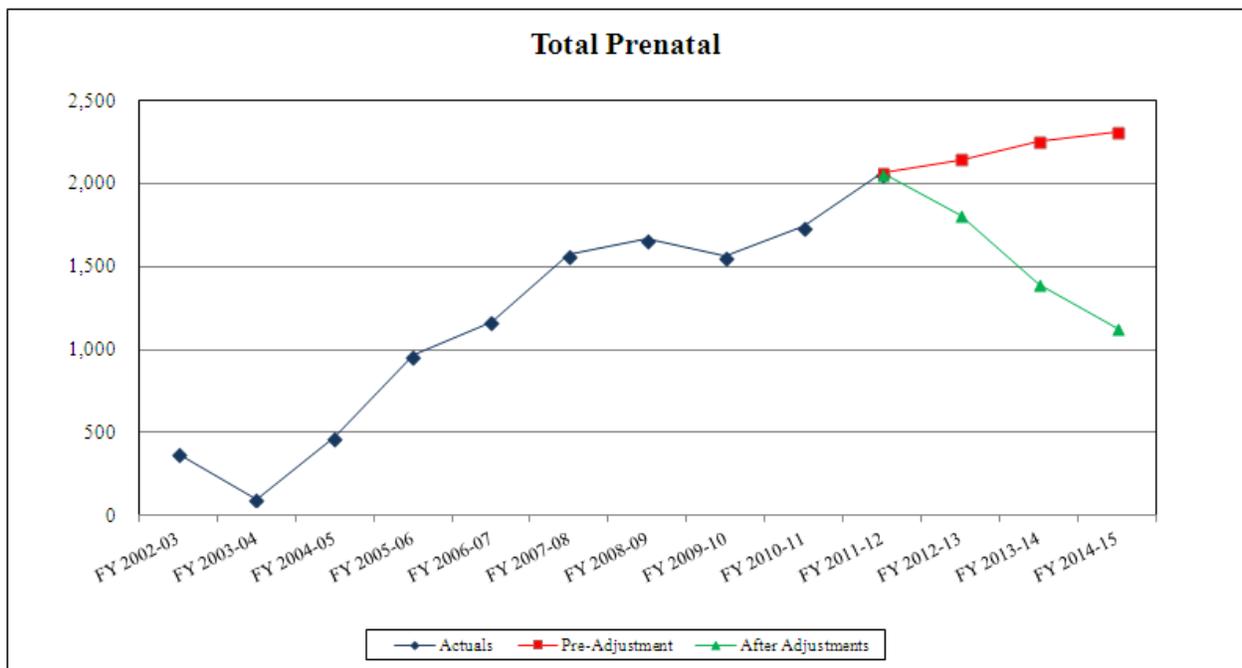
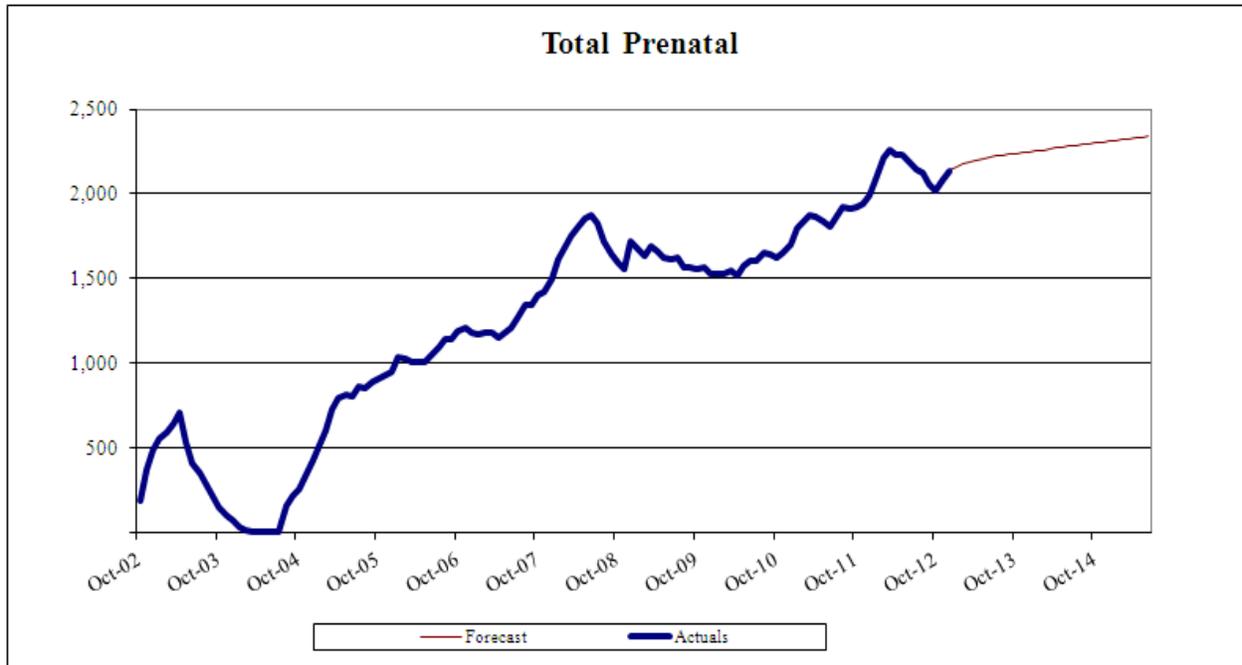
Monthly Average Growth Comparisons		
FY 2011-12 Actuals	10	2.65%
FY 2012-13 1st Half Actuals	14	2.91%
FY 2012-13 2nd Half Forecast	10	2.49%
FY 2012-13 Forecast	12	2.28%
November 2012 Forecast	9	1.66%
FY 2013-14 Forecast	5	0.73%
November 2012 Forecast	4	0.60%

Actuals			
	Monthly Change	% Change	
6-month average	14	2.91%	
12-month average	5	1.14%	
18-month average	11	2.74%	
24-month average	12	3.22%	

November 2012 Trend Selections			
FY 2012-13	526	17.41%	78
FY 2013-14	593	12.74%	67
FY 2014-15	630	6.24%	37

Base trend from December 2012 level			
FY 2012-13	518	15.53%	70

Total Prenatal



- The FY 2012-13 total base prenatal caseload forecast is 2,143, a 3.83% increase over the FY 2011-12 caseload of 2,064. This forecast includes average increases of 3 (0.16%) per month.
- The Department estimates that the slow improvement in economic conditions will continue, resulting in continuing growth for the higher income populations, but at a lower rate in out-years. The FY 2013-14 base caseload is projected to increase 5.09% to 2,252, and FY 2014-15 caseload is forecasted to grow 2.71% to 2,313. Total prenatal caseload is projected to increase by 0.22% (5 clients) per month in FY 2013-14 and 0.21% (5 clients) per month in FY 2014-15.

- As described in the CHP+ Prenatal to 200% FPL section, there is a bottom-line adjustment to the CHP+ prenatal caseload from SB 11-250, which increased Medicaid eligibility for pregnant women from 133% to 185% FPL in January 2013. This is expected to have a negative impact on CHP+ caseload as pregnant women who would otherwise enroll in CHP+ become eligible for and enroll in Medicaid.
- Another bottom-line adjustment to the CHP+ prenatal caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. As described in the CHP+ Prenatal to 200% FPL section, the Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for pregnant women whose incomes are documented at or below 185% FPL in CHP+ prior to this change. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has adjusted its caseload forecast downwards for FY 2013-14 forward.
- The adjustment for SB 11-250 decreases the FY 2012-13 caseload projection to 1,812 which is a 12.23% decrease over FY 2011-12 caseload. The SB 11-250 and MAGI adjustments decrease the FY 2013-14 caseload projection to 1,398, which is a 22.85% decrease from the adjusted FY 2012-13 projection. Both adjustments also decrease the FY 2014-15 caseload projection to 1,132, which is a 19% decrease from the adjusted FY 2013-14 projection.

Total Prenatal							
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change
Dec-10	1,701	-	-	FY 2002-03	372	-	-
Jan-11	1,802	101	5.94%	FY 2003-04	101	-72.85%	(271)
Feb-11	1,835	33	1.83%	FY 2004-05	472	367.33%	371
Mar-11	1,875	40	2.18%	FY 2005-06	963	104.03%	491
Apr-11	1,867	(8)	-0.43%	FY 2006-07	1,170	21.50%	207
May-11	1,840	(27)	-1.45%	FY 2007-08	1,570	34.19%	400
Jun-11	1,804	(36)	-1.96%	FY 2008-09	1,665	6.05%	95
Jul-11	1,868	64	3.55%	FY 2009-10	1,560	-6.31%	(105)
Aug-11	1,922	54	2.89%	FY 2010-11	1,741	11.60%	181
Sep-11	1,910	(12)	-0.62%	FY 2011-12	2,064	18.55%	323
Oct-11	1,925	15	0.79%	FY 2012-13	2,143	3.83%	79
Nov-11	1,944	19	0.99%	FY 2013-14	2,252	5.09%	109
Dec-11	1,993	49	2.52%	FY 2014-15	2,313	2.71%	61
Jan-12	2,088	95	4.77%				
Feb-12	2,216	128	6.13%				
Mar-12	2,263	47	2.12%				
Apr-12	2,230	(33)	-1.46%				
May-12	2,231	1	0.04%				
Jun-12	2,179	(52)	-2.33%				
Jul-12	2,146	(33)	-1.51%				
Aug-12	2,122	(24)	-1.12%				
Sep-12	2,057	(65)	-3.06%				
Oct-12	2,022	(35)	-1.70%				
Nov-12	2,091	69	3.41%				
Dec-12	2,139	48	2.30%				

Monthly Average Growth Comparisons		
FY 2011-12 Actuals	31	1.62%
FY 2012-13 1st Half Actuals	(7)	-0.28%
FY 2012-13 2nd Half Forecast	13	0.60%
FY 2012-13 Forecast	3	0.16%
November 2012 Forecast	11	0.47%
FY 2013-14 Forecast	5	0.22%
November 2012 Forecast	4	0.17%

Actuals		
	Monthly Change	% Change
6-month average	(7)	-0.28%
12-month average	12	0.63%
18-month average	19	0.98%
24-month average	18	0.99%

Base trend from December 2012 level			
FY 2012-13	2,118	2.60%	54

November 2012 Trend Selections			
FY 2012-13	2,252	9.11%	188
FY 2013-14	2,335	3.69%	83
FY 2014-15	2,373	1.63%	38

SB 11-250 Adjustments	
FY 2012-13	(332)
FY 2013-14	(668)
FY 2014-15	(670)

MAGI Adjustments	
FY 2012-13	0
FY 2013-14	(187)
FY 2014-15	(511)

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

Prenatal Per Capita (Exhibit C.5)

All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State. As capitation rates for CHP+ are set on a fiscal year basis, and no new information is available, the estimated per capita costs for medical and dental services have not been changed from the Department's November 1, 2012 estimates.

Similar to the SMCN children annual trend, the prenatal cost trend from FY 2009-10 to FY 2010-11 was negative, at 14.4%. As the actuary was developing rates for CHP+ during FY 2011-12, data from FY 2011-12 was not available for use in rate-setting. This is also similar to the negative trend experienced in the previous year. This trend is driven primarily by the change in the hospital reimbursement schedule that was effective on July 1, 2010. While the hospitals were paid 44% of billed charges in FY 2009-10, beginning in FY 2010-11 they are paid 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. Although the FY 2011-12 rates were adjusted to include the projected impact of this change, actual changes in hospital charges were not included in the base data until the FY 2012-13 rate-setting, which was able to incorporate data from FY 2010-11 when the reimbursement change was in effect. This change in reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative annual cost trend for FY 2010-11.

The contracted actuary also reviewed published studies to determine industry norms for current and projected health care cost trends, which ranged from 6.0% to 11.6%. To account for the larger than anticipated cost savings generated by the change in hospital reimbursement in the SMCN, the actuary set the unit cost base trend across services at 0.0%. The actuarially set combined utilization and unit cost base trend across services is 3.0% for FY 2012-13.

The FY 2012-13 prenatal per member per month rate is \$930.32, which includes administrative costs of \$24.22 for claims administration and case management. This is an 18.70% decrease from the final FY 2011-12 rate. The decrease is the result of fully accounting for the change in hospital reimbursement methodologies. The Department believes that once SB 11-250, which increases Medicaid eligibility for pregnant women from 133% to 185% FPL to comply with federal mandate, is implemented on January 1, 2013, the enrollment distribution of CHP+ prenatal clients will change as these women move into Medicaid. Although rates set for the various income groups will not change, the combined rate is expected to change as the decreased number of pregnant women with incomes between 134% and 185% FPL alters the distribution of the CHP+ prenatal population. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly, to \$927.03, based on anticipated changes in the enrollment distribution of CHP+ prenatal clients. As a result, the average prenatal per member per month rate for FY 2012-13 is \$928.65.

The Department's FY 2012-13 forecasted per capita is based on the actuarially developed rate. This forecast assumes that the FY 2012-13 prenatal capitation rate is indeed in line with the costs incurred for these women. The negative growth forecasted for the FY 2012-13 per capita is mostly the result of the significant negative trend in the prenatal rate. The downward pressure on the per capita is mitigated by another factor, the permanent fix to the MMIS capitation issue. Although the Department is not making interim reconciliation payments to the SMCN, prenatal capitations will still be affected by the systems fix implemented in January 2013. As the MMIS is able to generate a more accurate number of capitations for the month, as well as retroactive capitations that were not generated in the previous five months for enrolled prenatal clients, expenditures that would have been incurred in the manual reconciliation 6 months

out will be shifted to FY 2012-13. Due to the interaction of these factors, the Department estimates that the prenatal per capita will experience a decrease of 6.48% over the FY 2011-12 per capita of \$11,702.58 for a projected FY 2012-13 per capita of \$10,944.36.

The Department assumes that the FY 2012-13 capitation rates have captured all relevant reimbursement and policy changes, so that the volatility experienced during recent years will even out and resume normal trends in FY 2013-14. Based on research and historical experience, the Department believes the prenatal capitation rate will grow by 3.0% in FY 2013-14. This is consistent with historical annual growth in capitation rates that has ranged from -17.35% to 33.06%. The Department believes that the fix for the capitation issue will result in expenditures that more closely follow caseload, allowing expenditures for the program to even out in FY 2013-14 forward. Thus, the per capita for FY 2013-14 is projected to increase to \$13,337.05, an increase of 21.86% from the previous year. This per capita accounts for the correction in expenditures that is projected to occur in FY 2013-14 and only appears large when compared to the decreases experienced in the prior two years. In addition, the high growth rate is largely driven by the relatively low per capita in FY 2012-13 discussed above. Similar to the FY 2012-13 per capita, the FY 2013-14 estimated per capita has not been changed from the Department's November 2012 estimate.

III. Other CHP+ Updates

The Department has been notified that its CHP+ eligibility expansion for pregnant women from 206% to 250% FPL was not authorized in the Standard Terms and Conditions (STCs) outlined in its existing Section 1115 waiver. Due to political uncertainties around the time of the waiver's expiration date of October 1, 2009, CMS requested that the Department not immediately renew the waiver, which covered prenatal women in CHP+ up to 205% FPL. At that time, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was being debated in Congress. Since the future provisions of the law were uncertain, CMS specifically requested that the Department not submit a renewal waiver until CHIPRA was passed. Since then, the Department has worked closely with CMS to implement a new waiver for the prenatal population. In the meantime, CMS approved monthly extensions of Colorado's waiver while the state implemented HB 09-1293 which expanded CHP+ eligibility from 205% to 250% FPL beginning in May 2010. A new Section 1115 waiver was approved effective August 1, 2012 that includes STCs that authorize pregnant women in CHP+ up to 250% FPL. The Department is currently in consultation with the Office of the Attorney General to form its response to the disallowance and to address factual errors included in the disallowance letter issued by the Centers for Medicare and Medicaid Services.