

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
 Request Title: Cost Sharing for Medicaid and CHP+
 Priority Number: R-7

Dept. Approval by: John Bartholomew *JB 10/20/11*
 Date

OSPB Approval by: Greg N. Schmitt *10/24/11*
 Date

- Decision Item FY 2012-13
- Base Reduction Item FY 2012-13
- Supplemental FY 2011-12
- Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	\$3,795,958,940	\$0	\$3,785,740,072	(\$3,407,194)	(\$6,049,804)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$936,403,660	\$0	\$1,014,333,063	(\$1,438,020)	(\$2,547,449)
	GFE	\$284,621,517	\$0	\$284,621,517	\$0	\$0
	CF	\$655,100,840	\$0	\$576,931,818	\$91,841	\$70,906
	RF	\$6,488,387	\$0	\$3,202,036	\$0	\$0
	FF	\$1,913,344,536	\$0	\$1,906,651,638	(\$2,061,015)	(\$3,573,261)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	\$6,596,052	\$0	\$6,410,052	\$30,000	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,430,918	\$0	\$1,487,168	\$15,000	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$721,750	\$0	\$497,500	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$4,443,384	\$0	\$4,425,384	\$15,000	\$0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	Total	\$32,412,990	\$0	\$31,767,217	\$523,964	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$6,581,901	\$0	\$6,459,471	\$130,991	\$0
	GFE	\$0	\$0	\$0	\$0	\$0
	CF	\$1,479,670	\$0	\$1,698,513	\$0	\$0
	RF	\$100,328	\$0	\$100,328	\$0	\$0
	FF	\$24,251,091	\$0	\$23,508,905	\$392,973	\$0
(2) Medical Services Premiums^a	Total	\$3,543,863,749	\$0	\$3,559,795,929	(\$2,171,793)	(\$4,003,554)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$898,839,033	\$0	\$981,320,305	(\$1,060,682)	(\$1,955,296)
	GFE	\$284,175,417	\$0	\$284,175,417	\$0	\$0
	CF	\$608,317,175	\$0	\$534,529,617	(\$25,214)	(\$46,480)
	RF	\$6,388,059	\$0	\$3,101,708	\$0	\$0
	FF	\$1,746,144,065	\$0	\$1,756,668,882	(\$1,085,897)	(\$2,001,778)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs^b	Total	\$213,086,149	\$0	\$187,766,874	(\$1,789,365)	(\$2,046,250)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$29,551,808	\$0	\$25,066,119	(\$523,329)	(\$592,153)
	GFE	\$446,100	\$0	\$446,100	\$0	\$0
	CF	\$44,582,245	\$0	\$40,206,188	\$117,055	\$117,386
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$138,505,996	\$0	\$122,048,467	(\$1,383,091)	(\$1,571,483)

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
<p>Letternote Text Revision Required? Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/> If yes, describe the Letternote Text Revision:</p> <p>(a) FY 2012-13; b of this amount, \$379,420,151 \$379,397,984 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., \$67,978,040 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S., \$43,157,867 shall be from the Medicaid Nursing Facility Cash Fund created in Section 25.5-6-203 (2) (a), C.R.S., \$23,401,464 shall be from recoveries and recoupments, \$7,722,438 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program, \$6,638,222 shall be from the Medicaid Buy-In Cash Fund created in Section 25.5-6-1405 (3) (b), C.R.S., \$0 shall be from the Supplemental Old Age Pension Health and Medical Care Fund created in Section 25.5-2-101 (2), C.R.S., \$2,731,400 \$2,728,354 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I), C.R.S., \$878,625 shall be from the Colorado Autism Treatment Fund created in Section 25.5-6-805 (1), C.R.S., \$200,335 shall be from the Coordinated Care for People with Disabilities Fund created in Section 25.5-6-111 (4), C.R.S., and \$170,575 shall be from the the Home Health Telemedicine Cash Fund created in Section 25.5-5-321 (1) (c), C.R.S.</p> <p>(b) FY 2012-13: of this amount, \$27,555,700 \$27,894,248 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., \$12,188,707 \$11,967,294 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., \$461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and \$1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.</p> <p>Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Children's Basic Health Plan Trust Fund (11G); FF: Title XIX, Title XXI.</p> <p>Reappropriated Funds Source, by Department and Line Item Name:</p> <p>Approval by OIT? Yes: <input type="checkbox"/> No: <input type="checkbox"/> Not Required: <input checked="" type="checkbox"/></p> <p>Schedule 13s from Affected Departments:</p> <p>Other Information:</p>						



DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

*FY 2012-13 Funding Request
November 1, 2011*

Susan E. Birch
Executive Director

Department Priority: R-7
Request Title: Cost Sharing for Medicaid and CHP+

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Cost Sharing for Medicaid and CHP+	(\$3,407,194)	(\$1,438,020)	0.0
Cost Sharing for Medicaid	(\$1,617,829)	(\$914,691)	0.0
Cost Sharing for CHP+	(\$1,789,365)	(\$523,329)	0.0

Request Summary:

The Department requests \$3,407,194 total funds, \$1,438,020 General Fund in FY 2012-13 and \$6,049,804 total funds, \$2,547,449 General Fund in FY 2013-14 from increased cost sharing for Medicaid and Child Health Plan *Plus* (CHP+) clients by increasing co-payment and enrollment fees. The estimated reduction of \$264,453 total funds, \$138,601 General Fund in FY 2011-12 is reported for informational purpose only.

The Department currently charges nominal co-payment amounts to clients for various services including inpatient hospital, outpatient hospital, practitioner, and psychiatric services in Medicaid and CHP+. In addition to co-payments, the Department currently charges enrollment fees for clients with family income above 150% of the Federal Poverty Level (FPL) in CHP+. The Department currently does not require any cost sharing for CHP+ clients at or below 100% FPL.

Medicaid Cost Sharing

As part of this proposal, the Department requests to increase the current Medicaid nominal co-payment amounts to the maximum amounts allowable under federal regulations. All Medicaid clients, excluding those clients exempt (see Appendix A), would be required to pay the co-payment amounts at the point of service or sale.

Further, the Department requests to charge co-payment amounts on additional Medicaid services including: Non-Emergency Medical Transportation, Outpatient Substance Abuse, Physical, Occupational and Speech Therapy, Home Health and Private Duty Nursing. The Department would charge the maximum co-payments permitted under federal regulations. By expanding the list of services requiring co-payments, the Department would realize savings and encourage clients to be more responsible for their health, by avoiding unnecessary care.

Finally, the Department requests to increase co-payments above the nominal amount on emergency department services that are determined to be non-emergent to the maximum amount permitted under federal regulation. Based on the federal regulations for cost sharing, the Department anticipates that it must demonstrate that clients needing non-emergent care have alternative locations to receive care. To ensure compliance the Department would hire a contractor to review rural hospitals and determine alternative care locations.

The Department estimates these initiatives would result in savings of \$1,617,829 total funds, \$914,691 General Fund in FY 2012-13 and savings of \$4,003,554 total funds, \$1,955,296 General Fund in FY 2013-14.

Child Health Plan *Plus* Cost Sharing

The Department requests to increase cost sharing in CHP+ through two separate initiatives. First, the Department would triple CHP+ annual enrollment fees for families with children above 205% FPL beginning in January 2012. The Department currently requires these families to pay an enrollment fee of \$25 for one child or \$35 for 2 or more children; these enrollment fees would be increased to \$75 and \$105, respectively. Second, the Department would increase CHP+ co-payment amounts for families above 100% FPL based on income tiers beginning in July 2012.

The Department has actively engaged stakeholders to determine what level of increases to CHP+ cost sharing would result in the lowest attrition of clients and maintain affordability for families while still increasing clients' responsibility in their personal and family health care while realizing savings to the State.

The Department estimates that these initiatives will result in savings of \$264,453 total funds, \$138,601 General Fund in FY 2011-12, savings of \$1,789,365 total funds, \$523,329 General Fund in FY 2012-13 and savings of \$2,046,250 total funds, \$592,153 General Fund in FY 2013-14.

Anticipated Outcomes:

The Department anticipates that increasing co-payment amounts would reduce unnecessary emergency or specialty care and would not only generate savings, but also slow long-term Medicaid and CHP+ cost growth. Shifting some of the cost of health care to clients could encourage a more involved decision-making process when clients decide whether or not they need to visit a physician or hospital.

These increases, in addition to higher CHP+ enrollment fees for clients in higher income brackets would ease some financial burden from the Department while moderately increasing costs for families that are most able to absorb them.

Assumptions for Calculations:

Summary totals are contained in Appendix C. Please see Appendix D for detailed Medicaid calculations and assumptions, and Appendix E for detailed CHP+ calculations and assumptions.

Consequences if not Funded:

If this request is not funded, the Department would not be able to realize the proposed savings. Further, the Department would lose an opportunity to mitigate long-term cost growth by requiring clients to be more financially involved in their health care decisions.

Cash Fund Projections:

See Appendix F, Table H.1.

Relation to Performance Measures:

This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. The initiatives propose to increase co-payment amounts and enrollment fees to increase clients' responsibility for their health care and to reduce costs to the Department.

Current Statutory Authority or Needed Statutory Change:

Cost sharing for Medicaid clients is authorized in sections 1916 and 1916A of the Social Security Act. For detailed information on federal Medicaid regulations, please see Appendix A.

Section 25.5-4-209 (1)(b), C.R.S. (2011) requires clients to pay a portion of any medical benefit as outlined in state rules.

Sections 25.5-8-107 (1)(b) and (c), C.R.S. (2011) authorize the Department to implement a cost sharing structure for the Children's Basic Health Plan that includes an annual enrollment fee based on a sliding fee scale and co-payments. Families with incomes below 151% FPL and pregnant women are exempt from paying enrollment fees.

Appendix A: Medicaid Cost Sharing Detailed Narrative

This appendix describes the Department’s proposed steps for using client cost sharing as a cost saving strategy. Cost sharing is carefully regulated by the Centers for Medicare and Medicaid Services (CMS) to prevent barriers to access for Medicaid clients. This appendix describes these federal regulations, the Department’s current cost sharing strategies, and proposals for additional cost sharing.

Federal Regulations Restricting the Use of Cost Sharing

Prior to 2005, state Medicaid programs had very limited options for cost sharing. The authority for cost sharing, contained in section 1916 of the Social Security Act [42 U.S.C. 1396o], allows the state to impose cost sharing as long as the co-payment amounts are not above nominal amounts specified in federal regulation. Maximum nominal amounts are determined annually by the Secretary of the United States Department of Health and Human Services (the Secretary). Under this authority, providers may not deny services to a client who does not pay the co-payment if the client is at or below 100% of the Federal Poverty Level (FPL).

Co-payment amounts are based on the amount the Department reimburses for services and inflated yearly by the percentage increase in the medical component of the Consumer Price Index - All Urban Consumers (CPI-U). While the absolute maximum co-payment amount (other than the exemption for non-emergent outpatient visits) is currently \$3.80, services with a reimbursement rate less than \$50.01 cannot have a co-payment amount set at that maximum. The maximum for each reimbursement bracket is set by the secretary.

Table 1 below illustrates current co-payment maximums.

Reimbursement Amount for Service	Maximum Co-payment Amount
\$10 or less	\$0.65
\$10.01 to \$25	\$1.25
\$25.01 to \$50	\$2.55
\$50.01 or more	\$3.80

Federal regulations at 42 CFR § 447.55 permit the Department to charge a standard, or fixed, co-payment amount for any service. This standard co-payment may be determined by applying the maximum amounts in Table 1 to the Department’s average or typical payment for that service. Federal regulations describe the following example to illustrate this authority: “...if the agency’s typical payment for prescribed drugs is \$4 to \$5 per prescription, the agency might set a standard co-payment of \$0.65 per prescription.” The Department uses this authority to charge standard co-payments for most services.

Alternative cost sharing regulations under Section 1916A of the Social Security Act were created as part of the Deficit Reduction Act of 2005 (DRA), and were further clarified in the Tax Relief and Health Care Act

¹ The Department is not permitted to charge the maximum amount in all cases. This limitation is discussed in further detail in later sections.

of 2006. These regulations give states more flexibility to impose cost sharing. This flexibility applies largely to clients who are above 100% FPL, and therefore has limited practical application for Colorado's Medicaid program. The flexibility also comes with a greater burden to demonstrate that cost sharing does not exceed 5% of a family's income. For these reasons, the Department does not currently impose cost sharing under the 1916A authority.

Both sets of regulations include protections for certain populations and services, exempting them from co-payments. According to federal regulation, the following populations and services are exempt from paying co-payments:

- Children under 18 years of age;
- Services to pregnant women;
- Services furnished to individuals who are inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded or other medical institution that requires them to spend down their assets to be there;
- Emergency Services and family planning services;
- Services to an individual receiving hospice care; and,
- Native Americans.

In addition, Department regulation at 10 CCR 2505-10, Section 8.754.5 restricts cost sharing for;

- Children under the age of 19; and,
- Services provided under a Community Mental Health Services program and Managed Care programs.

Clients who are not exempt from cost sharing are asked to pay the co-payment amount at the service or purchase point. The Department imposes co-payments on clients by reducing the amount of payment to the provider; it is the providers' responsibility to collect co-payments from clients. If a client cannot pay the co-payment amount at the time of the service, the provider must still provide the service without collecting the co-payment.

Current Cost Sharing Strategies

The Department currently charges nominal standard co-payment amounts on twelve services offered through the Medicaid program. The Department's current cost sharing rates are shown below in Table 2 in the "Increase Nominal Co-payment Amounts" section of the narrative. Under certain conditions, states are permitted to charge amounts above the nominal amount. In particular, states are allowed to charge a co-payment of twice the nominal amount for emergency services determined non-emergent under section 1916(a)(3) of the Social Security Act [42 U.S.C. 1396o] as long as clients have alternative sources of non-emergent outpatient care without an imposed co-payment amount. This higher co-payment, however, requires a waiver from the Secretary.

The Department is not permitted to charge co-payments on emergency services. To ensure the Department is not imposing co-payment amounts on emergency services, providers are required to indicate on the claim form if the services were provided due to an emergency. For emergency services, the Department reimburses the provider the full amount for the service without deducting the co-payment amount.

The Department is requesting authority to implement the following initiatives to increase cost sharing between Medicaid clients and the Department and reduce expenditure in FY 2012-13.

Increase Nominal Co-Payment Amounts

For this initiative the Department would increase current standard nominal co-payment amounts to the maximum allowable amount as set in 42 CFR § 447.52 and 447.56. See Table 2 below for a list of current services requiring co-payment with current and proposed co-payment amounts.

Table 2		
Current and Proposed Co-Payment Rates by Service		
Service	Current Co-Payment	New Co-Payment
Inpatient Hospital Services	\$10 per covered day or 50% of the averaged allowable daily rate, whichever is less.	\$12 per covered day or 50% of the averaged allowable daily rate.
Outpatient Hospital Services	\$3.00 per visit	\$3.80
Practitioner Services (MD, DO, NP, PA)	\$2.00 per visit	\$2.55
Optometrist Visit	\$2.00 per visit	\$2.55
Podiatrist Visit	\$2.00 per visit	\$2.55
Psychiatric Services	\$.50 per unit of service (1 unit = 15 minutes)	\$0.65
Community Mental Health Center Services	\$2.00 per visit	\$2.55
Rural Health Clinic/ FQHC Services	\$2.00 per date of service	\$2.55
Durable Medical Equipment	\$1.00 per unit or period of service, depending on the item.	\$1.30
Laboratory	\$1.00 per date of service	\$1.30
Radiology (X-ray) Services	\$1.00 per date of service. (Dental x-rays do not have a co-pay.)	\$1.30
Prescription Services (each prescription or refill)	Generic drugs - \$1.00 Brand name drugs - \$3.00	Generic: \$1.30 Brand name: \$3.80

In many cases, the Department is proposing to raise co-payments to less than the maximum permitted (as shown in Table 1). As discussed above, the maximum allowable co-payment amount, under section 1916(a)(3) [42 U.S.C. 1396o] of the Social Security Act, is based on the reimbursement amount the Department pays for each service.

In order to increase co-payment amounts, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. State plan amendments require approval from the Centers for Medicare and Medicaid Services (CMS). The Department anticipates that it will submit a SPA to CMS by June 1, 2012, and approval could be expected by August 31, 2012. The Department would then promulgate rules in order for the new co-payment amounts to be effective October 1, 2012.

The Department estimates that increasing the co-payments on these services would reduce fee-for-service expenditure by \$2,125,138 total funds and \$1,037,897 General Fund in FY 2012-13, annualizing to \$2,915,917 total funds and \$1,424,134 General Fund in FY 2013-14. The Department's calculations are located in appendix D, Table A.1.

Add Co-Payments to Additional Services

For this initiative the Department would add nominal co-payment amounts to non-emergency medical transportation, outpatient substance abuse, physical, occupational and speech therapy, home health and private duty nursing services. See Table 3 below for proposed additional services and co-payment amounts.

Table 3 -Proposed Co-Payment Rates for New Services	
Service	New Co-Payment
Non-Emergency Medical Transportation	\$1.30
Outpatient Substance Abuse	\$1.30
Physical, Occupational and Speech Therapy	\$2.55
Home Health	\$2.55
Private Duty Nursing	\$2.55

Because each of the services the Department is proposing to add a co-payment amount to have varying reimbursement amounts, the Department has calculated the co-payment amount based on the current average billed amount. Once the average was determined, the Department selected the closest co-payment amount (from Table 1) to the average. The Department believes that selecting co-payment amounts consistent with other co-payments charged by the Department would reduce provider administrative costs and prevent confusion associated with charging new co-payments. See Table B.1 in Appendix D for further derivation of new co-payment amounts.

In order to implement new co-payment amounts, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. The Department anticipates that it will submit the amendment to CMS by June 1, 2012, and obtain approval by August 31, 2012. In addition, the Department would be required to make system changes to the Medicaid Management Information System (MMIS) in order to add seven new parameters in the system to reflect each new service type. The Department estimates this process would take approximately nine months to complete as the changes impact multiple claim types and pricing logic. The Department anticipates it would take two months to complete the Advanced Planning Document approval, one month for contract execution and approximately six months to complete the system changes. Given this timeline, the Department would set the effective date of the SPA to match system change timelines and anticipates system changes and the new co-payments to be implemented by April 1, 2013. The Department would require \$523,964 total funds, \$130,991 General Fund in FY 2012-13 to make the appropriate changes.

The Department estimates this initiative would cost \$523,964 total funds, \$130,991 General Fund in FY 2012-13 and reduce expenditure by \$895,529 total funds, \$437,367 General Fund in FY 2013-14. See appendix D, Table C.1 for the calculation of this initiatives costs and savings for FY 2012-13 and FY 2013-14.

Increase Co-Payment for Non-Emergent Use of the Emergency Room

For this initiative the Department would implement higher co-payments amounts for clients who use the emergency room for non-emergent conditions. Under federal law, there are multiple ways the Department can implement a higher co-payment for these services. It is not clear, however, what CMS will permit the Department to impose. The remainder of this section details both the Department's preferred option and the alternative method.

Imposing Higher Co-Payment Rates through a Waiver

The Department's preferred option to impose a higher co-payment for clients who use the emergency room for non-emergent conditions is to charge these clients a co-payment of twice the nominal amount, or \$7.30 per episode. This option is based on specific authority in section 1916(a)(3) of the Social Security Act which allows states to implement cost sharing up to twice the nominal amount established for non-emergent outpatient services received at a hospital emergency room. This option requires a waiver granted by the Secretary; the Secretary has specific authority for this type of waiver in section 1916(a)(3). The State must also demonstrate to the satisfaction of the Secretary that individuals have access to alternative sources of non-emergency outpatient services.

Under this option, the Department would apply for a waiver in order to impose co-payments above the nominal amounts for non-emergency use of the emergency room. This would enable the Department to charge \$7.30 for non-emergent services for eligible populations (see restricted populations above).

The Department does not know what restrictions and requirements CMS will include as a condition of approving the waiver, or how likely it is that CMS will approve the waiver. CMS has informed the Department that no state currently has a waiver under this provision, although one state was previously granted waiver authority. At minimum, however, the Department must guarantee that clients have access to alternative sources of non-emergency outpatient services. In order to remain compliant with federal regulations requiring access to non-emergency services, the Department would hire a contractor to survey rural areas and determine alternate care sites for clients unwilling to pay the co-payment amounts. The Department estimates that the contractor would cost \$30,000 total funds, \$15,000 General Fund in FY 2012-13, based on similar Department initiatives. If the Department determines particular areas where a hospital is the only source of care, the Department would exempt those hospitals from the requirement to charge the higher co-payment.

To allow sufficient time for the application of a waiver, as well as time for the contractor to determine any exempt hospitals, the Department assumes that in order to implement this initiative using this first option the program could be implemented by April 1, 2013. This assumption is based on the Department's past experience in submitting demonstration waivers; CMS does not have a specified timeline to approve or deny the Department's waiver request. The Department's experience has been that changes in federal policies and guidelines often require that the Department significantly change components of the initial waiver application, and engage in extended discussions regarding the particulars outlined in the application. The Department does not require additional administrative resources to complete the waiver application, and therefore estimates submitting a waiver application by July 1, 2012; if the approval process and required rule changes require approximately nine months to complete, the Department could implement this initiative by April 1, 2013. However, this is not known. The Department assumes current methodology to determine whether an outpatient service is considered an emergency or not would be sufficient to meet waiver requirements.

The Department anticipates savings of \$16,655 total funds and \$7,785 General Fund in FY 2012-13 and \$192,050 total funds, \$93,795 General Fund in FY 2013-14 from the implementation of this initiative. Please see appendix D, Tables D.1 for the calculation of costs and savings associated with this proposal.

Alternative Method of Imposing Higher Cost-Sharing

The second option the Department has identified is to apply guidance under Section 1916A of the Social Security Act [42 U.S.C. 1396o-1] which would allow the Department to implement cost sharing for non-emergency use of the emergency room through a state plan amendment. Under this allowance the Department is allowed to charge a co-payment amount to exempt populations with the following requirements:

- The Department could not charge more than the maximum nominal co-payment amount (currently \$3.65) for populations at or under 100% of the Federal Poverty Level (FPL);
- The Department could charge double the nominal amount for populations between 100-150% FPL;
- The Department would have to ensure the co-payment amounts charges to each family does not exceed 5% of family's monthly income; and,
- The Department would have to ensure that clients who are exempt from all co-payments except this one (for example, children) have access to alternative facilities to receive care without paying the co-payment amount.

The Department currently does not have the mechanism in place to determine the maximum amount a client could be required to pay in co-payment each month. To enable the system to indentify a client's income level and transmit it to the claims system, the Department would require \$235,440 in FY 2012-13 to implement necessary changes in the Colorado Benefits Management System (CBMS). This preliminary estimate was provided by the Governor's Office of Information Technology, and assumes 2,180 hours of work at \$108 per hour.

In addition to CBMS changes, the Department would require changes to the MMIS to meet the requirements of Section 1916A of the Social Security Act [42 U.S.C. 1396o-1]. The claims system would be required to appropriately transmit the correct co-payment to providers when the service is provided, and to calculate the maximum monthly co-payment amount a family could be charged to ensure that co-payments were not charged above the maximum amount. Providers would continue to be required to indicate if the service provided was due to an emergency; once a claim is indicated as an emergency a co-payment would not be applied. For non-emergent services the Department would need to add logic to the MMIS to match the claim with the proper co-payment amount for each client based on the FPL information transmitted from CBMS. The MMIS would also require programming to track client co-payment charges to ensure compliance with federal law requiring that co-payment amounts remain below 5 percent of a family's monthly income. The MMIS would transfer information to the provider the web portal to indicate whether a client is required to pay the co-payment amount or not. This logic is currently in the system and calculation to ensure the 5 percent threshold is not crossed would occur within the MMIS. In order to transmit this necessary information from CBMS and track co-payment amounts, the Department preliminarily estimates 2,410 hours of work at \$126 per hour for an estimated \$303,660 for MMIS changes. If CMS does not approve the Department's preferred methodology for imposing cost sharing, the Department would request funding for these changes through the normal budget process. The Department assumes it would be able to receive a 75% enhanced match on MMIS related system changes.

The Department assumes that, if necessary, it may request supplemental funding during the FY 2012-13 budget cycle. Assuming the funding is approved and the Department receives supplemental funding to

implement this initiative in March 2013, the Department estimates that a state plan amendment (SPA) and rule changes would be complete by July 1, 2013. However, due to system constraints from federally mandated updates to the MMIS, the Department estimates the earliest this initiative would be able to be implemented is October 2013. The Department would set the effective date of the SPA to October 2013 to be consistent with the system changes.

Under this option, the Department anticipates costs of \$539,100 total funds, \$193,635 General Fund in FY 2012-13 and savings of \$996,194 total funds, \$486,532 General Fund in FY 2013-14 from the implementation of this initiative. Please note, however, that these totals are for informational purposes only; because the Department would pursue a waiver as described in the prior section, the Department is not requesting these amounts. Please see appendix D, Table G.1, for the calculation of costs and savings associated with this proposal.

Appendix B: Child Health Plan *Plus* Cost Sharing Detailed Narrative

The Department is requesting to implement two measures to increase cost-sharing for clients of the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+). Federal regulation at 42 C.F.R. § 457.53 authorizes the Department to vary premiums, deductibles, coinsurance, co-payments or any other cost sharing in CHP+ based on family income in a manner that does not favor children from families with higher incomes over children from families with lower incomes. Families with incomes above 150% of the Federal Poverty Level (FPL) are currently required to pay an annual enrollment fee before their eligible children can enroll in CHP+. Under this policy, families with one child pay \$25 while families with two or more children pay \$35. Co-payments are also charged on a sliding fee scale for children with family incomes above 100% FPL. CHP+ imposes no cost-sharing on children in families with incomes at or below 100% FPL or pregnant women. Since the program's inception, this cost sharing schedule has not been altered other than to add income categories as the program has expanded eligibility. As a result, Colorado has one of the lowest cost-sharing structures in the nation for a Children's Health Insurance Program.

During the 2011 Legislative Session, the General Assembly passed SB 11-213 "Concerning Enrollee Cost-Sharing for Children Enrolled in the Children's Basic Health Plan." This legislation would have increased cost sharing in CHP+ by implementing monthly premiums for families with incomes between 206% and 250% FPL. Each of these families would be required to pay a monthly premium of \$20 for the first child and \$10 for each additional child up to a maximum of \$50 per month. The intent of this legislation was to foster a greater sense of personal responsibility in the health care decisions of CHP+ families, while generating savings to the State. The 1,000% increase in costs to the families affected by the new premiums, however, was estimated to have a significant negative impact on enrollment in CHP+. The Department and Joint Budget Committee Staff estimated that approximately 20% of affected children would drop CHP+ coverage if SB 11-213 was implemented. Because the cost of private insurance is relatively high, it is unlikely that children dropping out of CHP+ would become privately insured. Thus, this legislation would inevitably lead to higher uninsurance and worse health outcomes among children in Colorado. It is also likely that the children dropping CHP+ coverage would include a disproportionately large number of healthy children whose lower health care costs would not make the increased premiums worthwhile, and relatively sicker children with higher utilization and costs would remain in CHP+. This adverse selection would have led to increased per capita costs in CHP+ as the number of healthy relative to unhealthy children declines, resulting in a higher cost risk pool and increased per member per month rates for health care.

After considering the potential negative outcomes described above, Governor John Hickenlooper vetoed SB 11-213 and committed his staff and the Department to developing an approach to increase cost sharing while minimizing any negative impact on CHP+ families. The Department believes that the measures it is proposing, which include a wider range of more reasonable cost increases, will be more effective in fostering a sense of responsibility in the health care decisions of all of its clients while minimizing negative impacts to families and generating savings to the State.

The Department is recommending the following measures:

- Triple the current annual enrollment fees to \$75 for families with one child and \$105 for families with two or more children above 205% FPL; and,
- Increase co-payments for families above 100% FPL on a sliding fee scale.

By distributing the increased costs to clients between enrollment fees and co-payments, the Department believes that each family will be better able to cope with these additional costs. Additionally, the Department's request would not add cost sharing for families at or below 100% FPL. Per federal regulations at 42 C.F.R. §457.560 (a), total cost sharing may not exceed 5% of a family's total income for the length of a child's eligibility period in CHP+. The Department does not believe many families would reach this maximum due to its proposal as these moderate increases are applied on a sliding fee scale. Any family that reaches this 5% maximum, and demonstrates that it has done so receives a co-payment waiver and does not incur any additional costs for the remainder of the enrollment period. Per Colorado's CHIP State Plan, families are required to record and track their own cost sharing amounts and notify the Department if this maximum is reached.

Tripling Annual Enrollment Fees

The Department proposes tripling the annual enrollment fees for families with children above 205% FPL to \$75 for families with one child and \$105 for families with two or more children. Due to the Maintenance of Effort under the Affordable Care Act (ACA), the Department is only allowed to increase enrollment fees for groups that became eligible after March 23, 2010 (the date of enactment of the ACA), which includes only children with income from 206% to 250% FPL. In addition, the Department believes that these families at the higher end of eligible family incomes would be best able to absorb these increased costs. At the same time, the Department assumes that a number of families will choose to no longer enroll in CHP+ as a result of this increase. Given the magnitude of the new enrollment fees and the experiences of other states that have increased their enrollment fees or premiums, the Department estimates a 3% attrition rate, though this is indeterminate at this time. This would result in 118, 294 and 322 children losing health insurance coverage in FY 2011-12, FY 2012-13 and 2013-14, respectively. This decrease in enrollment would result in lower costs to CHP+. Please see Table G.1 in Appendix E for the caseload reduction and savings associated with this attrition rate.

Utilizing historical caseload data, the Department has estimated the distribution of families by size to estimate savings from the increased annual enrollment fees. Based on the number of children required to pay an enrollment fee and this distribution of family size, the Department estimates that these increased enrollment fees would result in \$140,705, \$343,630 and \$377,070 additional revenues to the CHP+ Trust Fund (the Trust) in FY 2011-12, FY 2012-13 and FY 2013-14, respectively. This does not include the decrease in collections resulting from the attrition rate described above. The Trust funds medical and dental expenses for clients up to 205% FPL. Clients from 206% to 250% FPL are funded through the Hospital Provider fee implemented in HB 09-1293. Due to the current insolvency of the Trust, General Fund is required to backfill CHP+ medical and dental expenses for its designated populations. Thus, any increased revenues to the Trust result in equivalent General Fund savings. Since enrollment fees are not eligible to receive federal matching funds, the increased revenue generated by the higher annual enrollment fees results in reduced federal funds. Because the medical and dental premiums expenses for CHP+ populations remain the same for this calculation, additional funds from the Hospital Provider fee are required to replace the reduced federal funds. Please see Table G.2 in Appendix E for calculations of the impact of the increased enrollment fees.

To implement these increased annual enrollment fees, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. The Department would submit the SPA in November 2011 to be approved in January 2012. Therefore the Department anticipates the new annual enrollment fee would be effective January 1, 2012.

Increasing Co-payments

Co-payments for CHP+ clients are collected by providers at the point of service. Currently, CHP+ charges co-payments for various services on a sliding fee schedule for families above 100% FPL. As the Department does not collect these co-payments, the Department’s actuary estimates co-payment collections using CHP+ service utilization. The actuary assumes that co-payments are collected by providers and become part of their compensation for the services they provide to CHP+ clients. This allows the actuary to incorporate these co-payments into lower capitation rates, which result in savings to the Department. At the point of service, however, providers may waive these co-payments if families are unable to pay them. Since the Department is unable to determine whether or not a client actually pays the co-payment amount, the full impact of the cost sharing proposal on providers and clients is difficult to determine.

The Department proposes maintaining the same co-payment amounts for families at or below 100% FPL and raising co-payments for families with higher incomes. The Department’s proposed co-payment schedule maintains the same co-payment for services provided in an office setting, including routine office visits, while increasing other services such as emergency care, specialists, and prescription drugs co-payments. In addition, the Department would impose new co-payments on hospital services, including inpatient, outpatient and hospital physician services, for which cost sharing has historically not been required. The Department believes this structure provides the correct incentives for CHP+ children to continue to utilize routine office visits to maintain overall health through preventive care, and requiring higher cost sharing for more costly inpatient or emergency care. In its calculations, the Department assumes that these additional co-payments would not change the utilization patterns of CHP+. Please Table 4 below for a complete list of the Department’s current and proposed co-payments.

Table 4 - Current CHP+ Co-payments vs. the Department's Proposed CHP+ Co-payments						
Service	101-150% FPL		151 - 200% FPL		201% - 250% FPL	
	Current Co-pays	Proposed Co-pays	Current Co-pays	Proposed Co-pays	Current Co-pays	Proposed Co-pays
Emergency Care and Urgent/After Hours Care	\$3	\$3	\$15	\$20	\$20	\$50
Emergency Transport/Ambulance Services	\$0	\$2	\$0	\$15	\$0	\$25
Hospital/Other Facility Services						
Inpatient (Includes treatment for Mental Illness Care, Intractable Pain and Autism Coverage in an inpatient setting)	\$0	\$2	\$0	\$20	\$0	\$50
Physician	\$0	\$2	\$0	\$5	\$0	\$10
Outpatient/ Ambulatory	\$0	\$2	\$0	\$5	\$0	\$25
Routine Medical Office Visit (Includes treatment for Mental Illness Care, Vision, Audiology, Intractable Pain and Autism Coverage in an office setting)	\$2	\$2	\$5	\$5	\$10	\$10
Laboratory and X-Ray	\$0	\$0	\$0	\$5	\$0	\$10
Prescription Drugs						
Generic	\$1	\$1	\$3	\$3	\$5	\$5
Brand Name	\$1	\$1	\$5	\$10	\$10	\$15

The following service categories would not have co-payments: Preventive, Routine, and Family Planning Services; Maternity Care; Durable Medical Equipment (DME); Transplants; Home Health Care; Hospice Care; Kidney Dialysis; Skilled Nursing Facility Care; Dietary Counseling /Nutritional Services; Therapies: Chemotherapy and Radiation.

The Department has used the children’s caseload estimates from its November 1, 2011, R-3 “Children's Basic Health Plan Medical Dental Premiums Costs” in its calculations. By applying the current and the proposed co-payment amounts for each service to the utilization data provided by the CHP+ actuary, the Department estimates the average total annual co-payment amount per child for each income category. Due to the complexity of the utilization data, the Department has only included the weighted average total annual co-payment amount in this request (Appendix E, Table G.3). As described above, beginning in January 2012, the Department believes that 118 children will leave CHP+. Since the new copayments will not be implemented until July 2012, the Department estimates a \$6,728 decrease in copayment collections in FY 2011-12 due to the reduced caseload. The Department estimates that the new co-payments would result in \$1,081,554 and \$1,237,966 total fund savings in FY 2012-13 and FY 2013-14, respectively. Due to the differing fund sources for CHP+ populations, the Department estimates that \$184,861 of the FY 2012-13 savings and \$220,737 of FY 2013-14 savings will be General Fund. Please see Table G.3 in Appendix E for details on the calculations of these savings.

To implement these increased co-payments, the Department would be required to submit a state plan amendment (SPA) and amend the state rules. The Department would submit the SPA in April 2012, to be approved in June 2012. Therefore the Department anticipates the new cost-sharing measures would be effective July 1, 2012.

The Department assumes that any cost to implement changes to the Colorado Benefits Management System to increase the annual enrollment fees could be absorbed within existing resources. Since the CHP+ co-payments are accounted for in the rates paid to health plans, the Department assumes that it will incorporate changes to the co-payment structure into its rate setting process for the FY 2012-13 rates, and thus there will be no additional administrative costs for this initiative.

Overall, the Department estimates net savings of \$264,453 total funds from the increased enrollment fees in FY 2011-12 and savings from both of the initiatives of \$1,789,365 total funds in FY 2012-13 and savings of \$2,046,250 total funds in FY 2013-14. Of these savings, \$138,601, \$523,329 and \$592,153 would be net General Fund savings in FY 2011-12, FY 2012-13 and FY 2013-14, respectively. Please see Table G.4 for the cumulative effect of these cost sharing measures, including an overview of the Department’s assumptions for its calculations for this request. Tables 5, 6 and 7 below summarize the effect of the Department’s proposal on the estimated average annual cost sharing per child.

Table 5 - Overall Cost Sharing in Colorado Under Current Structure		
Average Estimated Cost Sharing Per Child Per Year (using actual utilization, includes fees and co-pays)	101-150% FPL	\$10
	151-200% FPL	\$56
	201-250% FPL	\$82

Table 6 - Overall Cost Sharing in Colorado Under Department Proposal		
Average Estimated Cost Sharing Per Child Per Year (using actual utilization, includes fees and co-pays)	101-150% FPL	\$12
	151-200% FPL	\$79
	201-250% FPL	\$192

Table 7 - Change in Overall Cost Sharing in Colorado from Current Structure to Department Proposal		
Average Estimated Cost Sharing Per Child Per Year (using actual utilization, includes fees and co-pays)	101-150% FPL	20%
	151-200% FPL	41%
	201-250% FPL	134%

As these tables illustrate, the Department’s proposal has a moderate yet increasing effect on cost sharing per child as family income increases. While SB 11-213 achieved savings by increasing the enrollment fees for only one income category by 1,000%, the Department’s cost sharing initiatives spread the increases over most CHP+ clients and achieve greater total fund savings than SB 11-213. However, since SB 11-213 only increased enrollment fees (premiums) which are deposited directly into the CHP+ Trust Fund, most of the total fund savings would have been General Fund as less General Fund would be required to backfill the insolvent CHP+ Trust Fund. A large portion of the savings from the Department’s proposal is generated by the increased co-payments. As a result, these savings include funding sources other than General Fund, depending on the client’s income level. Thus the Department proposal generates less General Fund savings than SB 11-213. Please see Table 8 below for this comparison.

Table 8 - Comparison of SB 11-213 and Department Proposal- FY 2012-13		
	SB 11-213	Department Proposal
Total Change To Client Cost Sharing Plan (Fees + Co-payments)	\$1,277,441	\$1,609,382
Total General Fund Savings	(\$1,210,626)	(\$592,153)

Appendix C
Summary of Calculations

Summary of Estimate FY 2011-12					
Summary of Estimate FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Estimate	(\$264,453)	(\$138,601)	\$136,133	\$0	(\$261,985)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	(\$264,453)	(\$138,601)	\$136,133	\$0	(\$261,985)

Summary of Request FY 2012-13					
Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	(\$3,407,194)	(\$1,438,020)	\$91,841	\$0	(\$2,061,015)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	\$30,000	\$15,000	\$0	\$0	\$15,000
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	\$523,964	\$130,991	\$0	\$0	\$392,973
(2) Medical Services Premiums	(\$2,171,793)	(\$1,060,682)	(\$25,214)	\$0	(\$1,085,897)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	(\$1,789,365)	(\$523,329)	\$117,055	\$0	(\$1,383,091)

Summary of Request FY 2013-14					
Summary of Request FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Request	(\$6,049,804)	(\$2,547,449)	\$70,906	\$0	(\$3,573,261)
(2) Medical Services Premiums	(\$4,003,554)	(\$1,955,296)	(\$46,480)	\$0	(\$2,001,778)
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	(\$2,046,250)	(\$592,153)	\$117,386	\$0	(\$1,571,483)

Appendix C
Summary of Calculations

FY 2011-12 Impact by Component						
FY 2011-12	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Estimate	(\$264,453)	(\$138,601)	\$136,133	\$0	(\$261,985)	
Increased Cost Sharing in CHP+	(\$264,453)	(\$138,601)	\$136,133	\$0	(\$261,985)	

FY 2012-13 Impact by Component						
FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	(\$3,407,194)	(\$1,438,020)	\$91,841	\$0	(\$2,061,015)	
Increase Nominal Co-Payment Amounts	(\$2,125,138)	(\$1,037,897)	(\$24,672)	\$0	(\$1,062,569)	Table A.1
Add Co-Payments to Additional Services	\$523,964	\$130,991	\$0	\$0	\$392,973	Table C.2
Increase Co-Payment for Non-Emergent Use of the Emergency Room	(\$16,655)	(\$7,785)	(\$542)	\$0	(\$8,328)	Table D.2
Increased Cost Sharing in CHP+	(\$1,789,365)	(\$523,329)	\$117,055	\$0	(\$1,383,091)	Table G.4

FY 2013-14 Impact by Component						
FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	(\$6,049,804)	(\$2,547,449)	\$70,906	\$0	(\$3,573,261)	
Increase Nominal Co-Payment Amounts	(\$2,915,975)	(\$1,424,134)	(\$33,853)	\$0	(\$1,457,988)	Table A.1
Add Co-Payments to Additional Services	(\$895,529)	(\$437,367)	(\$10,397)	\$0	(\$447,765)	Table C.3
Increase Co-Payment for Non-Emergent Use of the Emergency Room	(\$192,050)	(\$93,795)	(\$2,230)	\$0	(\$96,025)	Table D.3
Increased Cost Sharing in CHP+	(\$2,046,250)	(\$592,153)	\$117,386	\$0	(\$1,571,483)	Table G.4

Appendix D
Medicaid Cost Sharing Calculations

Table A.1 - Estimated Nominal Co-Payment Savings

Row	Service	Current Co-Payments Charged	Number of Units	Proposed Increase to Co-Payment	Estimated FY 2010-11 Savings	Estimated FY 2012-13 Savings	Estimated FY 2013-14 Savings
	Column	A	B	C	D	E	F
	Formula/Source	MMIS Data	MMIS Data	Narrative	Col B * Col C	Col D * (1 + Row A) ² * (Row B / 12)	Col D * (1 + Row A) ³ * (Row B / 12)
A	Estimated Trend ⁽¹⁾					2.91%	2.91%
B	Effective Months					9	12
C	Inpatient Hospital Services	(\$324,192)	26,627	\$2.00	(\$53,254)	(\$42,299)	(\$58,040)
D	Outpatient Hospital Services	(\$805,565)	387,232	\$0.80	(\$309,786)	(\$246,058)	(\$337,625)
E	Practitioner Services	(\$704,386)	1,207,793	\$0.55	(\$664,286)	(\$527,633)	(\$723,982)
F	Optometrist Visit	(\$25,263)	12,632	\$0.55	(\$6,947)	(\$5,518)	(\$7,572)
G	Podiatrist Visit	(\$6,548)	3,274	\$0.55	(\$1,801)	(\$1,430)	(\$1,963)
H	Psychiatric Services	(\$138)	69	\$0.15	(\$10)	(\$8)	(\$11)
I	Community Mental Health Center Services	(\$11,575)	5,788	\$0.55	(\$3,183)	(\$2,528)	(\$3,469)
J	Rural Health Clinic/ FQHC Services	(\$2,807)	1,404	\$0.55	(\$772)	(\$613)	(\$841)
K	Durable Medical Equipment	(\$222,273)	222,273	\$0.30	(\$66,682)	(\$52,964)	(\$72,674)
L	Laboratory	(\$362)	358	\$0.30	(\$107)	(\$85)	(\$117)
M	Radiology (X-ray) Services	(\$4,902)	4,103	\$0.30	(\$1,231)	(\$978)	(\$1,342)
N	Prescription Services - Brand Name Drugs	(\$1,361,450)	453,817	\$0.30	(\$136,145)	(\$108,138)	(\$148,380)
O	Prescription Services - Generic Drugs	(\$1,789,165)	1,789,165	\$0.80	(\$1,431,332)	(\$1,136,886)	(\$1,559,959)
P	Total Estimated Cost Savings	(\$5,258,626)	4,114,533	-	(\$2,675,536)	(\$2,125,138)	(\$2,915,975)

⁽¹⁾ Estimated trend is based on the growth rate of Acute Care total expenditure for FY 2009-10

Appendix D
Medicaid Cost Sharing Calculations

Table A.2 - Summary of Additional Co-Payment Amounts for FY 2012-13

Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$0	\$0	\$0	\$0	\$0
Savings	(\$2,125,138)	(\$1,037,897)	(\$24,672)	\$0	(\$1,062,569)
Total	(\$2,125,138)	(\$1,037,897)	(\$24,672)	\$0	(\$1,062,569)

Table A.3 - Summary of Additional Co-Payment Amounts for FY 2013-14

Summary of Request FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$0	\$0	\$0	\$0	\$0
Savings	(\$2,915,975)	(\$1,424,134)	(\$33,853)	\$0	(\$1,457,988)
Total	(\$2,915,975)	(\$1,424,134)	(\$33,853)	\$0	(\$1,457,988)

Appendix D
Medicaid Cost Sharing Calculations

Table B.1 - Proposed Additional Nominal Co-Payment Amounts				
Service	Number of Paid Units in FY 2010-11	Maximum Co-Payment Amount	Estimated FY 2010-11 Co- Payment	Maximum Co-Payment Amount
Column	A	B	C	D
Formula/Source	MMIS data	Table 1	Column A * Column B	See Narrative
<i>Non-Emergency Medical Transportation</i>				
\$10 or less	12,596	\$0.65	\$8,187	
\$10.01 to \$25	10,379	\$1.25	\$12,974	
\$25.01 to \$50	5,898	\$2.45	\$14,450	
\$50.01 or more	1,203	\$3.65	\$4,391	
Sub-Total NEMT	30,076		\$40,002	
Average Co-payment Amount per Paid Unit (Column C / Column A)			\$1.33	\$1.30
<i>Outpatient Substance Abuse</i>				
\$10.01 to \$25	16,219	\$1.25	\$20,274	
\$25.01 to \$50	8,386	\$2.45	\$20,546	
\$50.01 or more	1,158	\$3.65	\$4,227	
Sub-Total Outpatient Substance Abuse	25,763		\$45,047	
Average Co-payment Amount per Paid Unit (Column C / Column A)			\$1.75	\$1.30
<i>Physical, Occupational and Speech Therapy</i>				
\$10 or less	5,368	\$0.65	\$3,489	
\$10.01 to \$25	49,836	\$1.25	\$62,295	
\$25.01 to \$50	7,549	\$2.45	\$18,495	
\$50.01 or more	34,370	\$3.65	\$125,451	
Sub-Total Therapies	97,123		\$209,730	
Average Co-payment Amount per Paid Unit (Column C / Column A)			\$2.16	\$2.55
<i>Home Health</i>				
\$10 or less	5,275	\$0.65	\$3,429	
\$25.01 to \$50	117,773	\$2.45	\$288,544	
\$50.01 or more	110,853	\$3.65	\$404,613	
Sub-Total Home Health	233,901		\$696,586	
Average Co-payment Amount per Paid Unit (Column C / Column A)			\$2.98	\$2.55
<i>Private Duty Nursing</i>				
\$10.01 to \$25	12	\$1.25	\$15	
\$25.01 to \$50	5,733	\$2.45	\$14,046	
Sub-Total Private Duty Nursing	5,745		\$14,061	
Average Co-payment Amount per Paid Unit (Column C / Column A)			\$2.45	\$2.55

Appendix D
Medicaid Cost Sharing Calculations

Table C.1 - Estimated Savings from Additional Co-Payments			
Row	Item	FY 2012-13	FY 2013-14
	Column	A	B
	Formula/Source	(Paid Units) * (1 + Row A) ² * (Co-Payment Amount) * Row B / 12	(Paid Units) * (1 + Row A) ³ * (Co-Payment Amount) * Row B / 12
A	Estimated Trend	2.91%	2.91%
B	Effective Months	0	11
	<i>Non-Emergency Medical Transportation</i>		
C	FY 2010-11 Number of Paid Units	30,076	30,076
D	Co-Payment Amount	\$1.30	\$1.30
E	Estimated NEMT Savings	\$0	(\$39,061)
	<i>Outpatient Substance Abuse</i>		
F	FY 2010-11 Number of Paid Units	25,763	25,763
G	Co-Payment Amount	\$1.30	\$1.25
H	Estimated Outpatient Substance Abuse Savings	\$0	(\$32,173)
	<i>Physical, Occupational and Speech Therapy</i>		
I	FY 2010-11 Number of Paid Units	97,123	97,123
J	Co-Payment Amount	\$2.55	2.45
K	Estimated Therapy Savings	\$0	(\$237,724)
	<i>Home Health</i>		
L	FY 2010-11 Number of Paid Units	233,901	233,901
M	Co-Payment Amount	\$2.55	2.45
N	Estimated Home Health Savings	\$0	(\$572,509)
	<i>Private Duty Nursing</i>		
O	FY 2010-11 Number of Paid Units	5,745	5,745
P	Co-Payment Amount	\$2.55	2.45
Q	Estimated Private Duty Nursing Savings	\$0	(\$14,062)
R	Total Estimated Savings	\$0	(\$895,529)

Appendix D
Medicaid Cost Sharing Calculations

Table C.2 - Summary of Additional Co-Payment Amounts for FY 2012-13					
Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$523,964	\$130,991	\$0	\$0	\$392,973
Savings	\$0	\$0	\$0	\$0	\$0
Total	\$523,964	\$130,991	\$0	\$0	\$392,973

Table C.3 - Summary of Additional Co-Payment Amounts for FY 2013-14					
Summary of Request FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$0	\$0	\$0	\$0	\$0
Savings	(\$895,529)	(\$437,367)	(\$10,397)	\$0	(\$447,765)
Total	(\$895,529)	(\$437,367)	(\$10,397)	\$0	(\$447,765)

Appendix D
Medicaid Cost Sharing Calculations

Table D.1 - Estimated Savings from Increased Non-Emergent Co-Payments under 1916 Waiver

Row	Service	Current Co-Payment Savings	Number of Units	Proposed Increase to Co-Payment	Estimated FY 2010-11 Savings	Estimated FY 2012-13 Savings	Estimated FY 2013-14 Savings
	Column	A	B	C	D	E	F
	Formula/Source	MMIS Data	MMIS Data	Narrative	Column C * Column D	Column D * (1 + Row A) ² * Row B / 12	Column D * (1+ Row A) ³ * Row B / 12
A	Estimated Trend ⁽¹⁾					2.91%	2.91%
B	Effective Months					3	12
C	Non-Emergent Hospital Services	(\$144,834)	48,278	\$3.65	(\$176,215)	(\$46,655)	(\$192,050)
D	Total Estimated Cost Savings	(\$144,834)	48,278	\$3.65	(\$176,215)	(\$46,655)	(\$192,050)

⁽¹⁾ Estimated trend is based on the growth rate of Acute Care total expenditure for FY 2009-10

Appendix D
Medicaid Cost Sharing Calculations

Table D.2 - Summary of Increased Non-Emergent Co-Payments under 1916 Waiver FY 2012-13					
Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$30,000	\$15,000	\$0	\$0	\$15,000
Savings	(\$46,655)	(\$22,785)	(\$542)	\$0	(\$23,328)
Total	(\$16,655)	(\$7,785)	(\$542)	\$0	(\$8,328)

Table D.3 - Summary of Increased Non-Emergent Co-Payments under 1916 Waiver FY 2013-14					
Summary of Request FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$0	\$0	\$0	\$0	\$0
Savings	(\$192,050)	(\$93,795)	(\$2,230)	\$0	(\$96,025)
Total	(\$192,050)	(\$93,795)	(\$2,230)	\$0	(\$96,025)

Appendix D
Medicaid Cost Sharing Calculations

Table E.1 - Estimated Savings from Increased Non-Emergent Co-Payments under 1916A							
Row	Service	Current Co-Payment Savings	Number of Units⁽²⁾	Proposed Increase to Co-Payment	Estimated FY 2010-11 Savings	Estimated FY 2012-13 Savings	Estimated FY 2013-14 Savings
	Column	A	B	C	D	E	F
	Formula/Source	MMIS Data	MMIS Data	Narrative	Column B * Column C	Column D * (1+ Row A) ² * Row B / 12	Column D * (1+ Row A) ³ * Row B / 12
A	Estimated Trend ⁽¹⁾					2.91%	2.91%
B	Effective Months					-	11
C	Outpatient Hospital Services for < 100% FPL	(\$268,522)	129,077	\$0.65	(\$83,900)	\$0	(\$81,450)
D	Outpatient Hospital Services for 100% -150% FPL	(\$268,522)	129,077	\$3.65	(\$471,132)	\$0	(\$457,372)
E	Outpatient Hospital for > 150% FPL	(\$268,522)	129,077	\$3.65	(\$471,132)	\$0	(\$457,372)
F	Total Estimated Cost Savings	(\$805,565)	387,232	\$7.95	(\$1,026,165)	\$0	(\$996,194)

⁽¹⁾ Estimated trend is based on the growth rate of Acute Care total expenditure for FY 2009-10

⁽²⁾ The MMIS claims system does not currently hold information on clients' FPL bracket. In order to calculate savings associated with this initiative the Department assumed a proportional distribution of clients between these brackets.

Appendix D
Medicaid Cost Sharing Calculations

Table E.2 - Summary of Increased Non-Emergent Co-Payments under 1916A FY 2012-13					
Summary of Request FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
CBMS Costs	\$235,440	\$117,720	\$0	\$0	\$117,720
MMIS Costs	\$303,660	\$75,915	\$0	\$0	\$227,745
Savings	\$0	\$0	\$0	\$0	\$0
Total	\$539,100	\$193,635	\$0	\$0	\$345,465

Table E.3 - Summary of Increased Non-Emergent Co-Payments under 1916A FY 2013-14					
Summary of Request FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Cost	\$0	\$0	\$0	\$0	\$0
Savings	(\$996,194)	(\$486,532)	(\$11,565)	\$0	(\$498,097)
Total	(\$996,194)	(\$486,532)	(\$11,565)	\$0	(\$498,097)

Appendix D
Medicaid Cost Sharing Calculations

Table F.1 - Cost Sharing Administrative Costs				
Row	Item	FY 2012-13	FY 2013-14	Comments
A	MMIS System Changes for additional co-payments	\$523,964	\$0	1,800 hours at \$126/hr
B	Rural Hospital Contractor	\$30,000	\$0	Based on similar Departmental projects
C	Total Administrative Costs	\$553,964	\$0	Row A + Row B

Appendix E
CHP+ Cost Sharing Calculations

Table G.1 - Savings from Caseload Attrition										
	Current Cost Sharing Structure			Department's Proposal			Difference			Notes
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	
Estimated Caseload	7,891	9,785	10,737	7,891	9,785	10,737		0	0	Assumes that 3% of children with family income between 206-250% FPL will choose to no longer enroll in CHP+ due to the high monthly premium. Please see narrative
Change In Caseload due to Attrition	0	0	0	(118)	(294)	(322)	(118)	(294)	(322)	
Net Caseload	7,891	9,785	10,737	7,773	9,491	10,415	(118)	(294)	(322)	
Medical Per Capita	\$2,129.17	\$2,231.79	\$2,326.98	\$2,129.17	\$2,231.79	\$2,326.98	\$0.00	\$0	\$0	
Dental Per Capita	\$168.97	\$175.73	\$183.22	\$168.97	\$175.73	\$183.22	\$0.00	\$0	\$0	
Total Medical and Dental Costs	\$18,134,623	\$23,557,583	\$26,952,017	\$17,863,442	\$22,849,772	\$26,143,733	(\$271,181)	(\$707,811)	(\$808,284)	
General Fund	(\$140,705)	(\$171,815)	(\$188,535)	(\$138,601)	(\$166,653)	(\$182,881)	\$2,104	\$5,162	\$5,654	
Cash Funds (CHP+ Trust Fund)	\$140,705	\$171,815	\$188,535	\$138,601	\$166,653	\$182,881	(\$2,104)	(\$5,162)	(\$5,654)	
Cash Funds (Hospital Fee)	\$6,438,576	\$8,356,834	\$9,555,754	\$6,342,295	\$8,105,745	\$9,269,179	(\$96,281)	(\$251,089)	(\$286,575)	
Federal Share	\$11,696,047	\$15,200,749	\$17,396,263	\$11,521,147	\$14,744,027	\$16,874,554	(\$174,900)	(\$456,722)	(\$521,709)	

Table G.2 - Savings from Increased Enrollment Fees										
	Current Cost Sharing Structure			Department's Proposal			Difference			Notes
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	
Estimated Caseload in 206-250% FPL (After Attrition)	7,773	9,491	10,415	7,773	9,491	10,415		0	0	Assumes no non-compliance as the annual fee is a condition of eligibility.
Medical Per Capita	2,129	2,232	2,327	\$2,129.17	\$2,231.79	\$2,326.98	\$0.00	\$0	\$0	
Dental Per Capita	169	176	183	\$168.97	\$175.73	\$183.22	\$0.00	\$0	\$0	
Total Medical and Dental Costs	\$17,863,442	\$22,849,772	\$26,143,733	\$17,863,442	\$22,849,772	\$26,143,733	\$0	\$0	\$0	
General Fund	(\$140,705)	(\$171,815)	(\$188,535)	(\$281,410)	(\$515,445)	(\$565,605)	(\$140,705)	(\$343,630)	(\$377,070)	
Cash Funds (CHP+ Trust Fund)	\$140,705	\$171,815	\$188,535	\$281,410	\$515,445	\$565,605	\$140,705	\$343,630	\$377,070	
Cash Funds (Hospital Fee)	\$6,343,663	\$8,109,100	\$9,272,854	\$6,435,121	\$8,332,459	\$9,517,950	\$91,458	\$223,359	\$245,096	
Federal Share	\$11,519,779	\$14,740,672	\$16,870,879	\$11,428,321	\$14,517,313	\$16,625,783	(\$91,458)	(\$223,359)	(\$245,096)	

Table G.3 - Savings from Increased Copayments										
	Current Cost Sharing Structure			Department's Proposal			Difference			Notes
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	
Estimated Caseload	54,023	55,343	60,874	53,905	55,049	60,552	(118)	(294)	(322)	Assumes no change in utilization due to increased copays. Includes decreased caseload due to 3% attrition for children between 205% and 250% FPL.
Weighted Average Annual Copay per Child	\$24.70	\$26.28	\$27.14	\$24.63	\$46.06	\$47.73	(\$0.07)	\$19.79	\$20.59	
Total Co-payment Collections (Decreased Capitation Rates)	\$1,334,388	\$1,454,208	\$1,652,225	\$1,327,660	\$2,535,762	\$2,890,191	\$6,728	(\$1,081,554)	(\$1,237,966)	
Cash Funds (CHP+ Trust Fund/General Fund)	(\$309,567)	(\$313,709)	(\$364,017)	(\$309,567)	(\$498,570)	(\$584,754)	\$0	(\$184,861)	(\$220,737)	
Cash Funds (Hospital Fee)	(\$157,469)	(\$195,264)	(\$214,262)	(\$155,114)	(\$388,947)	(\$426,813)	\$2,355	(\$193,683)	(\$212,551)	
Federal Share	(\$867,352)	(\$945,235)	(\$1,073,946)	(\$862,979)	(\$1,648,245)	(\$1,878,624)	\$4,373	(\$703,010)	(\$804,678)	

Appendix E
CHP+ Cost Sharing Calculations

Table G.4 - Costs/(Savings) From All CHP+ Cost Sharing Initiatives			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Caseload Affected by Cost Sharing	53,905	55,049	60,552
Caseload Decrease due to Attrition (3%)	(118)	(294)	(322)
Increased Copayment Costs/(Savings)	\$6,728	(\$1,081,554)	(\$1,237,966)
Additional Annual Fee Collections	\$138,601	\$338,468	\$371,416
Total Fund Savings	(\$264,453)	(\$1,789,365)	(\$2,046,250)
Total CHP+ Trust Fund Increase	\$138,601	\$338,468	\$371,416
Total Hospital Provider Fee Savings	(\$2,468)	(\$221,413)	(\$254,030)
Total Federal Funds Savings	(\$261,985)	(\$1,383,091)	(\$1,571,483)
Total General Fund Savings	(\$138,601)	(\$523,329)	(\$592,153)
Total Change To Client Cost Sharing Plan (Fees + Copayments)	\$145,329	\$1,420,022	\$1,609,382

Appendix F
Medicaid Cost Sharing Calculations

Table H.1 - Cash Fund Projections			
Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund	Breast and Cervical Cancer Prevention and Treatment Fund
Cash Fund Number	11G	24A	15D
FY 2010-11 Expenditures	\$43,062,875	\$426,069,052	\$2,903,163
FY 2010-11 End of Year Cash Balance	\$7,745,026	\$22,198,436	\$6,553,278
FY 2011-12 End of Year Cash Balance Estimate	\$9,332,096	\$22,198,436	\$4,135,739
FY 2012-13 End of Year Cash Balance Estimate	\$8,036,989	\$22,198,436	\$3,040,811
FY 2013-14 End of Year Cash Balance Estimate	\$6,924,385	\$22,198,436	\$660,592