

**Schedule 13
Funding Request for the 2013-14 Budget Cycle**

Department: Health Care Policy and Financing
 Request Title: Medical Services Premiums Request
 Priority Number: R-1

Dept. Approval by: John Bartholomew *JB 10/29/12* Date
 OSPB Approval by: Grant R. Schell *10/30/12* Date

- Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information	Fund	FY 2012-13		FY 2013-14		FY 2014-15
		1 Appropriation FY 2012-13	2 Supplemental Request FY 2012-13	3 Base Request FY 2013-14	4 Funding Change Request FY 2013-14	5 Continuation Amount FY 2014-15
Total of All Line Items	Total	\$3,985,613,386	\$0	\$4,026,532,673	\$255,256,258	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$1,050,603,677	\$0	\$1,092,869,207	\$78,363,224	\$0
	GFE	\$312,202,624	\$0	\$312,202,624	\$0	\$0
	CF	\$651,181,857	\$0	\$626,082,971	(\$1,837,669)	\$0
	RF	\$3,215,340	\$0	\$1,215,340	\$0	\$0
	FF	\$1,968,409,888	\$0	\$1,994,162,531	\$178,730,703	\$0
(2) Medical Services Premlums	Total	\$3,985,613,386	\$0	\$4,026,532,673	\$255,256,258	\$0
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	GF	\$1,050,603,677	\$0	\$1,092,869,207	\$78,363,224	\$0
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	RF	\$3,215,340	\$0	\$1,215,340	\$0	\$0
	FF	\$1,968,409,888	\$0	\$1,994,162,531	\$178,730,703	\$0

Letternote Text Revision Required? Yes: No: If yes, describe the Letternote Text Revision: See Exhibit D

Cash or Federal Fund Name and COFRS Fund Number: See Exhibit D

Reappropriated Funds Source, by Department and Line Item Name: See Exhibit D

Approval by OIT? Yes: No: Not Required:

Schedule 13s from Affected Departments: N/A

Other Information: N/A



Department of Health Care Policy and Financing
Medical Services Premiums

FY 2012-13, FY 2013-14, and FY 2014-15 Budget Request

November 1, 2012

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MEDICAL SERVICES PREMIUMS

I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per-capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year. The first section of the Medical Services Premiums Budget Narrative describes the Medicaid caseload projection. The second section describes the development of the per-capita cost, the application of per-capita caseload and bottom-line adjustments. A series of exhibits in this budget request support the narrative.

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

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

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

- Additional pages showing the effect of the delay are included in Exhibit C, Exhibit M, and Exhibit N.
 - In all cases, the Department's forecasts are based on the delay-adjusted cash-based actuals. As a result, the Department consistently forecasts a 52-week period in Exhibits F, G, H, and I.
2. The Department's request includes a number of references to various budget reduction items and early supplemental budget reductions. Effective July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010, July 1, 2011, and again on July 1, 2012, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced-budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding.

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3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom-line impacts. Bottom-line impacts can be found by service category (e.g., Acute Care, Community-Based Long-Term Care, Long-Term Care, Insurance, etc.) in the respective sections of this request. Those bottom-line impacts include the identification number of the originally submitted request, so that the bottom-line impact in the current year may be traced to the originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom-line impacts. Revisions to bottom-line impacts between requests are primarily limited to changes in implementation timeline. The Department generally does not adjust fiscal impact assumptions unless a deviation from assumptions in the original budget action is clear and significant.
4. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J.
5. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations, which gain eligibility as a result of HB 09-1293. This includes implementation of the Disabled Buy-In program and expansion of eligibility to Adults without Dependent Children in FY 2011-12. These expansions increase Medicaid caseload and are discussed further in Sections II and III of this narrative.
6. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for administration and case management are included in Exhibit I. The Department's revised estimates are described in section V of this narrative.
7. The Department's request includes a forecast for FY 2012-13, FY 2013-14, and FY 2014-15. Because previous requests included only forecasts for the current and request years, additional exhibits and changes in formatting to accommodate the additional year are present throughout.
8. Due to changes in how the Department is appropriated funds from the Health Care Expansion Fund, adjustments for Expansion Adults to 60% are no longer made at the service category level. This is reflected in both exhibits A and J.
9. The Department has added a new calculation for its Money Follows the Person grant program, known as Colorado Choice Transitions, to exhibit G. Please see the narrative for Exhibit G and section V for additional information.

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10. Effective November 2012, the Department has changed the way it forecasts expenditure for Community-Based Long-Term Care services. Previously, the forecast was done at the eligibility category level for all services. Now, the forecast is specific to each individual service.

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

II. MEDICAID CASELOAD

The Medicaid caseload analysis, including assumptions and calculations, are included in a separate section of this request. Please refer to the section titled "Medicaid Caseload."

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

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

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

Rationale for Grouping Services for Projection Purposes

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

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

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

Acute Care:

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

Community Based Long-Term Care:

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

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

Long-Term Care:

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

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

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

Financing:

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

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Note that for services in the Long-Term Care, Insurance, and Service Management categories and Financing, separate forecasts are performed. Only Acute Care and is forecast as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from page EA-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

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

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

Federal Medical Assistance Percentages

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

The FMAP was impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA was an enhanced FMAP for specified Medicaid programs. The effective period of this enhanced rate was originally October 1, 2008, through December 31, 2010; however, federal legislation (HR 1586) extended the effective period of ARRA to June 30, 2011. The enhanced FMAP from ARRA beyond December 31, 2010, underwent a staged phase-out. Additional relief was available for states that

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experienced increased unemployment; there were three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA included a “hold harmless period”; if the FMAP for any calendar quarter from January 1, 2009, and ending before July 1, 2010, was less than the FMAP for the preceding quarter, the higher percent continued to be in effect for each subsequent calendar year ending before July 1, 2010. Below is a table detailing the Department’s FMAP for FY 2008-09 through FY 2011-12. ARRA continues to be a relevant component of the Department’s request as certified public expenditure receives the enhanced FMAP associated with the period of time during which the expenditure was initially included. This specifically impacts upper payment limit financing. See Exhibit K for additional details.

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

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

Calculation of Fund Splits

These pages take the total estimated expenditure by service group and calculate the required source of funding for each. For each service category, the federal medical assistance percentage (FMAP) is listed on the right-hand side of the table. The FMAP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services (CMS), as reported through the Federal Register or as specified in federal law and/or regulation.

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

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- **Breast and Cervical Cancer Program:** This program receives a 65% federal financial participation rate. To determine State funding, the population is separated into two groups: traditional clients and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308(9), C.R.S. (2012). For FY 2012-13 and FY 2013-14, 50% of state funding for traditional clients comes from the Breast and Cervical Prevention and Treatment Fund and 50% comes from the General Fund. For FY 2014-15, 100% of the state share comes from General Fund. This is due to the sunset of legislation authorizing the cash fund June 30, 2014. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive State funding through the Prevention, Early Detection, and Treatment fund, which is administered by the Department of Public Health and Environment. Please see Exhibit F for calculations.
- **Family Planning:** The Department receives a 90% FMAP available for all documented family planning expenditures. This includes those services rendered through health maintenance organizations. Please see Exhibit F for calculations. This line also includes reappropriated funds from the Department of Public Health and Environment to fund the State share of a family planning waiver program; see section V for additional details.
- **Home Health Telemedicine Services:** In HB 10-1005, the Department received authority to use gifts, grants, and donations to fund home health telemedicine services. The Department has been informed by CMS that these funds are not eligible for a federal match. Therefore, the Department assumes the grant funding will be used as State-only funds and that the remainder of the expenditure will be funded with General Fund and federal funds. See section V for additional details.
- **Indian Health Services:** The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.
- **Affordable Care Act Drug Rebate Offset:** The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the State. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in exhibit A, as the increased drug rebate will offset total federal funds expenditure.
- **SB 11-008: "Aligning Medicaid Eligibility for Children":** This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children between the ages of six to 19. Beginning January 1, 2013, children under the age of 19 will be eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for clients these clients will remain at the same level had the clients enrolled in the

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Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%. The Department estimates the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.

- SB 11-250: "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare reimbursement. The difference in rates between July 1, 2009, and January 1, 2013, will be paid for by the federal government through an enhanced FMAP of 100%. Additional details are provided in sections IV and V.
- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per-diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.
- Tobacco Tax Funded Disease Management: The Department annually receives funding from the Department of Public Health and Environment for the operation of disease management programs that address cancer, heart disease, lung disease, and the risk factors associated therewith. The funding for these programs is a constant \$2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by the Department of Public Health and Environment. For FY 2012-13, the Department received authority to use a portion of the funding for chronic disease management programs administered by the Unit on Aging in the Department of Public Health and Environment; see Exhibit I for further details. In accordance with SB 08-118, Money Transfer for Medicaid Programs, FY 2012-13 is the last year in which this transfer will occur.
- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to 75 children living with autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to \$1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Clients are limited to a cap of \$25,000 in waiver services. The Department estimates the funding needed from the Colorado Autism Treatment Fund based on the program estimate in Exhibit G, which includes \$163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.

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- **Disabled Buy-In:** Funds for this population come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.
- **Adults without Dependent Children:** This population began participation in Medicaid in FY 2011-12. The population is funded with a combination of federal funds and Hospital Provider Fee. Calculations and information regarding this population can be found in Exhibit J.
- **Physician Supplemental Payments:** The Department draws a federal financial match on uncompensated expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The State share of funding is through certification of public expenditure.
- **Expansion Adults to 100% Adjustment:** HB 09-1293, the Colorado Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the State's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medical assistance; and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate Hospital Provider Fee to each applicable service categories. See Exhibit J for additional information and detailed calculations.
- **Supplemental Medicare Insurance Benefit:** Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 84.5% of the total will receive federal financial participation in FY 2012-13, 82.5% in FY 2013-14, and 80.5% in FY 2014-15. The Department anticipates the decline in the portion of premiums matched with federal funds as a result increased Disabled Buy-In enrollment over time.
- **Coordinated Care for People with Disabilities Program:** The coordinated care for people with disabilities pilot program, as authorized by SB 06-128, allows the Department to pay per-member per-month administration fees to a nonprofit organization which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations. The State funding for this program comes from the Coordinated Care for People with Disabilities Fund, which was created by SB 06-128 and is generated by interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund.

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- **Upper Payment Limit Financing:** The Upper Payment Limit financing offset to General Fund is a bottom-line adjustment to total expenditures. This is further described in Exhibit K.
- **Denver Health Outstationing:** Federal funds are drawn to reimburse Denver Health federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2012-13, FY 2013-14, and FY 2014-15 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.
- **Department Recoveries Adjustment:** Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in exhibit L.
- **Cash Funds Financing:** This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers. The table below shows the impact, by cash fund for FY 2012-13, FY 2013-14, and FY 2014-15.

Cash Funds	FY 2012-13	FY 2013-14	FY 2014-15
Tobacco Tax Cash Fund (SB 11-210)	\$2,230,500	\$2,230,500	\$2,230,500
Hospital Provider Fee Cash Fund (SB 11-212, HB 12-1335)	\$40,700,000	\$15,700,000	\$15,700,000
Total	\$42,930,500	\$17,930,500	\$17,930,500

In addition, the Department’s appropriation includes a \$1,750,000 transfer of reappropriated funds for FY 2012-13 from the Prevention, Early Detection, and Treatment fund, which is funded through the Department of Public Health and Environment’s Prevention Programs line. This amount is eliminated in FY 2013-14 when the statutory authority for this transfer expires.

- **Provider Settlements:** The Department’s forecast includes a one-time General Fund only impact due a expected provider settlement in FY 2012-13. The estimated impact is \$3,900,000.
- **Health Care Expansion Fund Transfer Adjustment:** In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund was insolvent and no longer covered the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department’s calculations in this

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exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

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

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2014-15. Adjustments for HB 09-1293 funded populations such as Disabled Buy-In and Adults without Dependent Children, and children and women who gain eligibility through SB 11-08 and SB 11-250, are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3

Pages EB-4 and EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2011-12.

A description of the forecasting methodology for Medicaid caseload is located in the section titled "Medicaid Caseload" of this request.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER-CAPITA COSTS

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

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

EXHIBIT D - CASH FUNDS REPORT

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

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

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

Comparison of Request to Long Bill Appropriation and Special Bills

This exhibit contains a detailed summary of the Department's Budget Request by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation, as well as compares the current request to the Department's most recent prior requests for Medical Services Premiums. The Department has isolated individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. This exhibit includes all bottom-line impacts and financing but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical per-capita costs and the annual percent changes are also provided. The first step of the calculation is to select a historical per-capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom-line adjustments are made for legislation and other impacts not included in historical trends. Total expenditure after

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bottom-line adjustments is divided by the projected caseload to obtain a final per-capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita, including a per-capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per-Capita Percent Change

The per-capita percent change for several different years is computed for each eligibility category on a per-capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2011-12. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-2, the Department has provided a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per-capita costs were used to modify the request-year per-capita costs, although the Department makes adjustments to the selected trend where necessary. In light of changes resulting from the Medicare Modernization Act of 2003, trends that incorporate historical data from FY 2005-06 or earlier have been omitted for the following eligibility types: Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59. For these categories, pharmaceutical expenditure was drastically reduced in FY 2006-07, resulting in artificially deflated trends.

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

The table below describes the trend selections for FY 2012-13, FY 2013-14, and FY 2014-15. In some cases, though not all, the Department has held the trend constant between the three years. On Exhibit F, the selected trend factors have been bolded for clarification. As described in the Department's caseload narrative, populations sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth leads to per-capita declines, due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per-capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per-capita cost.

The selected trend factors for FY 2012-13, FY 2013-14, and FY 2014-15, with the rationale for selection, are as follows:

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Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	Following several years of rate and budget reductions, per-capita expenditure is expected to revert to an underlying pattern of growth in the population. The Department has selected a trend that captures the underlying stability in the per-capita growth pattern for this population for FY 2012-13 through FY 2014-15.
Disabled Adults 60 to 64 (OAP-B)	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	This eligibility type displayed growth despite rate reductions and other bottom line impacts which put downward pressure on per-capita growth. The Department anticipates continued per-capita growth over the next three years, similar to what was experienced between FY 2009-10 and FY 2010-11.
Disabled Individuals to 59 (AND/AB)	2.38% The per-capita growth from FY 2009-10 to FY 2010-11	2.38% The per-capita growth from FY 2009-10 to FY 2010-11	2.38% The per-capita growth from FY 2009-10 to FY 2010-11	This eligibility category experienced modest growth in FY 2011-12. Primary cost drivers for this eligibility type (Physician, Inpatient Hospital, Outpatient Hospital, Pharmacy, and Home Health) increased by approximately 4% in per-capita expenditure in the last fiscal year. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns.
Disabled Buy-in	22.60%	2.38%	2.38%	The Department has limited expenditure data for this newly eligible population. Consequently, the Department assumes per-capita expenditure will be equal to the weighted average per-capita expenditure of the traditional Medicaid disabled populations (OAP-B and AND/AB) in FY 2012-13 and will assume the same growth rate as Disabled adults to 59 in FY 2013-14 and FY 2014-15.

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Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	0.91% The per-capita growth rate from FY 2005-06	0.91% The per-capita growth rate from FY 2005-06	0.91% The per-capita growth rate from FY 2005-06	With high growth in caseload, per-capita figures have declined in the last three years. Caseload is anticipated to continue to grow but at a less aggressive rate over the next three years. Consequently, the Department has selected a trend that accounts for the expected reversion to per-capita growth for this population.
Expansion Adults to 60%	2.18%	2.18%	2.18%	Per-capita growth for this population has stabilized, indicating the population has matured. The trend selected for this population allows for a modest amount of continued growth over the next three years.
Expansion Adults to 100%	8.21%	2.03%	2.13%	In recent months, per-capita expenditure for Expansion Adults to 100% has appeared to converge to 95% of the per capita of Expansion Adults to 60%. This occurrence is consistent with previous Department assumptions, which are based on the expectation that marginally higher income is correlated with marginally better health status. Base per-capita expenditure for this population is held at 95% of the base per capita of Expansion Adults to 60% for all three forecast years.
Adults without Dependent Children	324.81%	2.57%	3.22%	The Department has limited data for this newly implemented population. Consequently, per-capita expenditure is assumed to be equal to 90% of the Disabled to 59 population, plus 10% of the Categorically Eligible Low-Income Adults' per-capita expenditure for all three forecast years.

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Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Breast & Cervical Cancer Program (Page EF-7)	-3.24%	-1.62%	-0.81%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per-Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/BCKC-C)	-3.39% One half the FY 2011-12 growth rate	-3.39% One half the FY 2011-12 growth rate	0%	Growth in per-capita costs has been decreasing over the last three fiscal years. However, the magnitude of the most recent years decrease includes factors such as rate cuts, efficiency measures, and increases in caseload. Continued strong caseload growth indicates continuation of decline in per capita. In FY 2014-15, as growth in caseload is expected to decline and with it the downward pressure on per-capita expenditure, the Department assumes no growth in per-capita expenditure for children.
Foster Care	1.97% One half the average per-capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per-capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per-capita growth from FY 2007-08 through FY 2010-11	Historically, this eligibility category has had significant variation in per-capita growth from year to year; on average, growth is moderate to strongly positive. FY 2010-11 growth reflected this trend of moderate positive growth. The Department expects FY 2012-13 through FY 2014-15 growth to follow this trend.
Baby Care Program - Adults (BCKC-A)	-1.64% One half the per-capita growth rate of FY 2011-12	-1.64% One half the per-capita growth rate of FY 2011-12	-1.64% One half the per-capita growth rate of FY 2011-12	The most recent two years have demonstrated per-capita declines. To account for a long-term history of stability, the Department assumes a growth rate that is one half the FY 2011-12 growth rate.

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Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Non-Citizens	7.45% The average per-capita growth from FY 2010-1 through FY 2011-12	7.45% The average per-capita growth from FY 2010-1 through FY 2011-12	7.45% The average per-capita growth from FY 2010-1 through FY 2011-12	The Department has selected a per-capita trend for these clients that reflects the most recent years aggressive per-capita growth while maintaining consideration for the volatile history of the population.
Partial Dual Eligibles	7.39% The average per-capita growth from FY 2008-09 through FY 2011-12	7.39% The average per-capita growth from FY 2008-09 through FY 2011-12	7.39% The average per-capita growth from FY 2008-09 through FY 2011-12	Continued aggressive growth is expected for this population, as both utilization increases and the portion of expenditure not covered by Medicare increase over time.

Legislative Impacts and Bottom-line Adjustments

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

- R-5 (FY 2012-13), FQHC/RHC Gainsharing, allows the Department to share budgetary savings with FQHC/RHC providers that assist in the generation of savings.
- R-5 (FY 2012-13), BHO Gainsharing, allows the Department to share savings with behavioral health organization that help generate savings through the better management of psychotropic drugs for significantly and persistently mentally ill clients.
- R-6 (FY 2012-13), Synagis Prior Authorization Review, changed prior authorization criteria and review processes to ensure that utilization of this expensive drug is restricted to cases where utilization is clinically appropriate.
- R-6 (FY 2012-13), Expansion of Physician Administered Drug Rebate Program, is a Department initiative to ensure rebates collection on physician administered drugs is maximized.
- R-6 (FY 2012-13), Reimbursement Rate Alignment for Developmental Screenings, changed rates for select screening procedures to better align with industry standards.

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- R-6 (FY 2012-13), Public Transportation Utilization, seeks to generate cost savings by increasing utilization of public transportation by clients utilizing the non-emergent medical transportation benefit.
- R-6 (FY 2012-13), Seroquel Restrictions, altered prior authorization criteria to eliminate off-label utilization of the antipsychotic drug.
- R-6 (FY 2012-13), Dental Efficiency, reflects a refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated.
- R-6 (FY 2012-13), Augmentative Communication Devices, accounts for the availability of new, cheaper, communication assistance technology for clients with disabilities impairing their ability to communicate.
- R-6 (FY 2012-13), DME Preferred Provider, generates additional rebate revenue as the Department leverages purchasing power to ensure diabetes testing supplies are purchased at the lowest net cost possible.
- R-6 (FY 2012-13), Pharmacy Rate Methodology Transition, is a significant fiscal impact driven by a change in reimbursement methodology for pharmaceuticals.
- SB 12-060, Improving Medicaid Fraud Detection, accounts for savings expected due to increased client fraud recovery activities by counties.
- SB 11-008, Aligning Medicaid Eligibility for Children, is an adjustment made to account for lower average per-capita expenditure expectations for clients migrating from CHP+ to Medicaid under the implementation of the bill.
- BRI-1 (FY 2011-12), Client Overutilization, expanded the Department's Client Over-Utilization Program (COUP). The program reduced expenditure by identifying clients that over utilize ER, pharmaceutical, or physician services and assisting them in managing their care in a more cost-effective manner.
- BRI-5 (FY 2011-12), State Maximum Allowable Cost Expansion, expands the list of drugs reimbursed under the State Maximum Allowable Cost (SMAC) pricing methodology. Savings results as drugs reimbursed under this methodology typically have lower levels of reimbursement than other pricing methodologies.
- BRI-5 (FY 2011-12), Reduce Rates for Diabetes Supplies, reduced reimbursement for diabetic test strips. Prices were reduced to reflect the current median market price for the product, \$18.00 per box of 50.
- BRI-5 (FY 2011-12), Reduce Payment for Uncomplicated C-Sections, set reimbursement for uncomplicated c-sections equal to the rate paid for complicated vaginal deliveries.
- BRI-5 (FY 2011-12), Reduce Payments for Renal Dialysis, reduced the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers.
- BRI-5 (FY 2011-12), Deny Payment of Hospital Readmissions within 48 hours, stopped payment to hospitals for clients readmitted to the same hospital within 48 hours of the original discharge for a condition related to the original admission.

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- BRI-5 (FY 2011-12), Prior Authorize Certain Radiology, requires prior authorization for MRI, CT, PET, and SPECT scans in the outpatient setting except in the case of emergency.
- BRI-5 (FY 2011-12), Limit Acute Home Health Services, requires enforcement of the Department's policy to require prior authorization for acute home health services beyond 60 days.
- BRI-5 (FY 2011-12), HMO Impact to Rates, accounts for the impact to HMO rates that results when fee-for-service rates are reduced.
- BA-9 (FY 2011-12), 0.75% Provider Rate Reduction, reduced reimbursement for most acute care services by 0.75%. The Department's original request was for a 0.50% rate reduction.
- BA-9 (FY 2011-12), Limit Fluoride Application Benefit, restricts the fluoride application benefit to three applications per year.
- BA-9 (FY 2011-12), Limit Dental Prophylaxis Benefit, limits the routine dental cleaning benefit to two per year.
- BA-9 (FY 2011-12), Eliminate Reimbursement for Oral Hygiene Instruction, terminated the oral hygiene instruction benefit.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year, regardless of prior authorization.
- BA-9 (FY 2011-12), Home Health Billing Changes, requires providers to utilize a brief visit billing code for services that should require only a brief home health visit.
- Estimated Impact of Increasing PACE Enrollment – accounts for the Department's initiative to increase enrollment of new PACE providers. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community-Based Long-Term Care service groups to the PACE service category.
- SB 11-177, Sunset of Pregnancy Prevention Program, provides for the continuation and expansion of the Department's teen pregnancy and dropout prevention program. Through the program, teens receive vocational, health, and educational counseling.
- Managed Care Organization Reconciliations account for recoupment payments the Department received from managed care organizations in FY 2011-12. The Department does not know when future reconciliations will occur and therefore annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.
- BRI-1 (FY 2010-11), Prevention and Benefits for Enhanced Value (P-BEV) and BA-12 (FY 2010-11) Evidence-Guided Utilization Review (EGUR), increased utilization review funding in order to provide an evidence-guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures to be performed by dental hygienists and improve non-emergency medical transportation policies.
- BRI-2 (FY 2010-11), Coordinated Payment and Payment Reform, implements proposed steps toward payment coordination and payment reform. Payment coordination is characterized by streamlined payment processes, enhanced recovery efforts, and proactive integration of care. The payment reform component supports performance-based payment structures which incentivize desired outcomes.

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- Accountable Care Collaborative (ACC) Savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Saving estimates were previously reported under S-6 (FY 2010-11) and BA-9 (FY 2011-12); savings estimates have been consolidated. Additional detail can be found both in section V and in the Service Management section of the narrative.
- SB 10-167, Colorado False Claims Act, has four components. The first component increases enrollment in the Health Insurance Buy-In (HIBI) program. Beginning in April, 2011, 1,500 new enrollees will be added incrementally to the HIBI program. The second component of SB 10-167 is an automated prepayment review of claims. This system will produce savings by identifying coding errors prior to reimbursement of claims. The third component is a systems change that allows for coordination of the Department's pharmacy benefit with other payers. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid who are eligible to enroll in the Medicaid programs of other states.
- ACA 4107 Smoking Cessation Counseling for Pregnant Women – Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit, the Department has restricted services by allowing a maximum of five counseling sessions up to 10 minutes and three counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.
- Implementation of SB 10-117, Over the Counter Medications, accounts for savings incurred through the implementation of SB 10-117. This bill allows pharmacists to directly prescribe certain over-the-counter medication to Medicaid clients without prior authorization or a prescription from the client's primary care physician. The Department anticipates initial implementation by January 1, 2013.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- Colorado Choice Transitions. This adjustment accounts for increased home health service expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.

Initiatives that impact FY 2013-14 or FY 2014-15 only:

- Fifty-Three Pay Periods in FY 2013-14 – the Department's claims processing cycle includes a 53rd payment period every seven years; this next occurs in FY 2013-14. This adjustment accounts for the addition payment period in FY 2013-14. The annualization of this one-time impact returning to expenditure to a 52-week base is found in FY 2014-15.

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

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program within the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. The Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 funds. The Department suggested the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection, and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" clients.

Per-Capita Cost

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

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per-capita expenditures. The Department assumes the decline in the per-capita expenditures is a temporary product of the increasing caseload and, as the new clients incur costs, the per-capita rate will begin to slow down in its decline. In the past 12 months, the per-capita expenditure has decreased more slowly than in previous periods, indicating the negative growth is beginning to moderate. For the current and request years, the Department analyzed per-capita data since April 2008, when there were enough clients in the program for a robust time-series analysis. The Department regressed rolling average per-capita expenditure on caseload, monthly dummy variables, and a time trend, producing a model that explained much of the variation in the per-capita expenditures with an R-squared of 0.9965. The Department calculated the average of the percent changes of the predicted values produced by the regression model for the current year and annualized the average for a full-year effect. The resulting trend factor is -3.24%. The Department reduces this trend by half for the request year and again in half for the out year – the regression model produces much larger negative trends

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for those years but, as discussed above, the Department believes per-capita expenditure will not continue to decline as quickly as it has in the past. The trend factor for each year is applied to the base per capita on page EF-4.

Fund Splits

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

Per 25.5-5-308(9)(d) and (e), C.R.S. (2012), enacted in HB 08-1373, State funding for "traditional" Medicaid Breast and Cervical Program clients comes, in part, from the Breast and Cervical Cancer Prevention and Treatment Fund. According to the original legislation, beginning in FY 2009-10 and into the future, State funding would be split: 50% from General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund.

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

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

At the end of FY 2013-14, the legislation authorizing the Breast and Cervical Cancer Prevention and Treatment fund sunsets. The Department assumes the State portion of funding for traditional BCCP clients will be 100% General Fund in FY 2014-15 as a result.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group within the Pharmaceutical Drug service category. Exhibit F, page EF-8 through EF-9, shows annual costs by aid category and per-capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational-only line item in Long Bill group (3), effective with HB 08-1375.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on data through quarter four of FY 2011-12. Historical actuals have been restated as the Department has transitioned from accrual-based accounting to cash-based accounting.

Family Planning - Calculation of Enhanced Federal Match

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

As of FY 2005-06, the Department no longer has contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the

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

The Department believes the 40.31% increase in reported total expenditure between FY 2007-08 and FY 2008-09 represents a level shift in expenditure that is the result of a concerted effort to educate providers as to which services are billable as family planning services. This effort was motivated by research indicating that, at the time of the study, only a fraction of allowable services were being appropriately billed.

In light of the Department's view of the increase between FY 2007-08 and FY 2008-09 as a one-time level shift, the FY 2012-13 estimate for total reported expenditure is the average of annual total reported expenditures for FY 2008-09 through FY 2011-12. This methodology is motivated by the Department's expectation of an upward expenditure trend, despite the sporadic behavior of total annual expenditures observed over the previous four fiscal years. As the Department anticipates family planning expenditures to resolve into a more stable growth pattern, estimates for FY 2013-14 and FY 2014-15 total expenditure are the result of the application of the average of annual growth rates for FY 2005-06 and FY 2006-07 to the previous year's estimated expenditure. The Department selected this time period as a model for future expenditure growth because it represents the most recent occasion for which moderate growth was observed in consecutive fiscal years.

In FY 2010-11, the Department submitted BA-16 "Implementation of Family Planning Waiver." which would add \$1,903,500 in FY 2012-13 to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. The State share of the funding was to be transferred from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds. However, after further discussion between the two agencies, the Department has removed its application for federal waiver approval. Populations that would have been served under the waiver would be eligible by July 2014 for services either through Medicaid or through a subsidized plan under the Colorado Health Benefit Exchange. In addition, system changes necessary to implement the program would be delayed due to federally mandated changes that could not be done concurrently with the changes necessary to implement the family planning waiver. The Department has removed all impacts of the family planning waiver from this request.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" is expected to contribute \$13,327 in local funds for FY 2012-13, \$13,780 in local funds for FY 2013-14, and \$14,248 in local funds for FY 2014-15. These contributions represent a substantial decrease relative to previous estimates. This is largely attributable to the Montrose County Department of Health of Human Services discontinuing their implementation of the program due to funding limitations. The Department will continue to explore opportunities to expand this program.

Indian Health Service

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

The Department uses historical expenditure to estimate total expenditure for services to these clients. In FY 2008-09, Indian Health Service expenditure grew by 44.48%; in FY 2011-12, expenditure decreased by 14.21%. In an effort to forecast future expenditure growth in a fashion representative of more-regular patterns observed in other fiscal years, the average annual growth for FY 2009-10 and FY 2010-11 was applied to previous-year expenditure to derive estimated expenditures for FY 2012-13, FY 2013-14, and FY 2014-15.

Prior-Year Expenditure

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

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home- and Community-Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range through FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2011-12, the Department paid HCBS claims for an average of 23,651 clients per month.

Clients receiving CBLTC services have access to 12 HCBS waivers each targeted to specific populations. Of the 12 waivers, nine are administered by the Department, and the other three are managed by the Department of Human Services. The waivers administered by the Department of Health Care Policy and Financing include;

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- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver
- Disabled Children's Waiver
- Persons Living with AIDS Adult Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver
- Spinal Cord Injury Adult Waiver

Calculation of Community-Based Long-Term Care Expenditure

In FY 2012-13, the Department adjusted the CBLTC forecasting methodology from an eligibility-type forecast to one that forecasts each of the Department's HCBS waivers individually. The Department believes this to be a more accurate way of forecasting CBLTC because each waiver targets certain populations and provides services targeted at those clients. In CBLTC, each eligibility type has clients receiving services in a number of waivers. Because each waiver's services vary depending on the target population, any change to a program could impact multiple eligibility types thus making it difficult to forecast and identify the root of significant changes in historical trend.

The new methodology includes a forecast for each waiver's enrollment and cost per enrollee. Percentages selected to modify enrollment or per-enrollee costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, trend factors must not take into account changes accounted for as bottom-line adjustments. Because each HCBS waiver differs in eligibility requirements, demographics, and utilization, different trends are used for each waiver.

The selected enrollment trend factors for FY 2012-13, FY 2013-14, and FY 2014-15, with the rationale for selection, are below. In most cases, the Department kept the trend for the out year the same as the request year. In situations where the out years do not carry the same trend, the variation is noted.

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Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	Enrollment Trend Selection	Per Enrollee Trend Selection	Justification
Elderly, Blind and Disabled Waiver	5.41%, FY 2010-11 through FY 2011-12 trend	2.16%, FY 2009-10 growth rate	<p>Enrollment history is very steady, growing a little over 5% per year. This trend was selected to be consistent with the history.</p> <p>Many service cost per-enrollee costs have recently dropped (Personal Care, ACFs); however, CDASS per enrollee continues to grow, as does the percentage of the population enrolled in high-utilizer cost programs such as CDASS and IHSS. Because cost per enrollee for these programs appears to be tapering off slightly, the Department selected the FY 2009-10 trend to represent positive but tapering growth.</p>
Community Mental Health Supports Waiver	Linear Forecast	1.92%, Half the FY 2008-09 trend	<p>Enrollment history is very steady but appears to be tapering off. The linear trend is consistent with this slowing.</p> <p>While per-enrollee costs for ACFs (the highest per enrollee expenditure category) decreased last year, some of this decline could be attributed to rate cuts. In addition, enrollment in personal care and CDASS continue to grow. Because the per-utilizer cost for CDASS is much higher than the average CMHS client, the Department chose a positive trend for FY 2012-13 and carried it over through FY 2014-15.</p>

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Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	Enrollment Trend Selection	Per Enrollee Trend Selection	Justification
Disabled Children's Waiver	FY 2012-13: -0.67%, Half the FY 2009-10 growth rate FY 2013-14 and FY 2014-15: -0.34%, half the FY 2012-13 trend.	FY 2012-13: 41.5%, Average FY 2010-11 through FY 2011-12 growth rate FY 2013-14 and FY 2014-15: 20.75%, half the FY 2012-13 trend.	Enrollment growth has been significantly negative, as the waiver eligibility criteria changed. The Department anticipates this shifting of clients has slowed and so selected the FY 2009-10 trend. Only two services are offered on the waiver: IHSS and case management. Extremely large growth in per-utilizer costs driven by IHSS enrollment and expenditures. Nearly doubled the number of clients and a 37% increase in cost per client on IHSS in FY 2011-12. With only 60 out of 1,000 clients on the waiver enrolled in IHSS, the Department does not foresee per-utilizer cost growth slowing any time soon as more families enroll in IHSS.
Persons Living with AIDS Waiver	5.26%, FY 2011-12 growth rate	FY 2008-09 growth rate, -0.45%	Enrollment has been increasing steadily. This trend was selected to be consistent with the history, as there are no indications this should change. Per-utilizer costs have been dropping over the last few years. There have been major advances in drug therapy for these clients, so it is likely they do not need as intensive services provided in the waiver, as their health is more easily stabilized with medication.
Consumer Directed Attendant Support-State Plan	-4.88%, FY 2010-11 growth rate	7.58%, Average FY 2010-11 through FY 2011-12 growth rate	Additional enrollment in this program is currently prohibited; the selected negative growth rates reflect clients leaving the program. The Department chose a trend to be

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Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	Enrollment Trend Selection	Per Enrollee Trend Selection	Justification
			<p>consistent with a small number of clients leaving the program each year.</p> <p>The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit. As clients continue to age, the Department assumes their needs will continue to increase. The trend was selected in anticipation that costs per enrollee would continue to grow.</p>
Brain Injury Waiver	1.84%, FY 2011-12 growth rate	1.80%, Average of FY 2010-11 to FY 2011-12 trend	<p>Historically there has been a slow and steady growth trend for BI enrollment. The Department chose the FY 2011-12 growth rate to be consistent with the trend.</p> <p>There has been steady, small, positive, per-enrollee cost growth over the last several years. The Department chose the average of FY 2010-11 to FY 2011-12 to reflect this growth.</p>
Children with Autism Waiver	0.00%	0.00%	<p>This waiver is capped at 75 clients. This cap has already been met, and the waiver currently has a waiting list. Average monthly enrollment is consistently below 75 clients because of client churn; however, there are no available spots on the waiver.</p> <p>It is likely the reason costs per enrollee have been dropping is that clients are not on the waiver very long before they age out. As a result, the clients do not receive many services while on the waiver. The Department anticipates this will slow and chose a trend of 0% to reflect it.</p>

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Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	Enrollment Trend Selection	Per Enrollee Trend Selection	Justification
Children with Life Limiting Illness Waiver	FY 2012-13: 19.76%, FY 2011-12 growth rate FY 2013-14 and FY 2014-15: 0%	5.77%, half the FY 2011-12 trend	<p>The Department anticipates children will continue to enter the waiver, especially as programmatic changes improve the program. The Department selected the FY 2011-12 growth rate for FY 2012-13 enrollment and then a trend of 0.00%, as the waiver is capped at 200 clients.</p> <p>The program has only been operational since FY 2008-09, resulting in limited data that has been highly variable. To be conservative, the Department took half the FY 2011-12 trend to trend FY 2012-13.</p>
Alternative Therapies Waiver	0.00%	2.16%, trend selected for the Elderly, Blind, and Disabled waiver.	<p>The Department anticipates 67 clients will enroll immediately. There will be little turnover as clients are likely to remain on the waiver for an extended period of time as they receive services.</p> <p>For per-enrollee growth, the Department chose the same trend as the EBD waiver, as the services are EBD, other than chiropractic care, acupuncture, and massage.</p>

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-enrollee or trend factors, the Department adds total-dollar bottom-line impacts to the projected enrollment or expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the Request for Community-Based Long-Term Care:

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Enrollment Impacts:

- HB 09-1047 “Alternative Therapies” - This legislation created a new HCBS waiver to allow chiropractic care, massage, and acupuncture services for clients with spinal cord injuries. The Department assumed clients would be moving from the EBD waiver to the Spinal Cord Injury (SCI) waiver and adjusted estimated enrollment by shifting 67 clients from the EBD waiver to the SCI waiver.

Expenditure

- BA-9 “Medicaid Reductions,” 0.50% Rate Reduction - Reduce long-term care providers by 0.5%, effective July 1, 2011.
- Annualization of BRI-5 Medicaid Reductions, Cap CDASS Wage Rates - The Department proposed to put a limit on the wages that CDASS attendants could be paid. This change was implemented in March 2012.
- HB 10-1146 “State Funded Public Assistance Programs” - This bill clarifies that persons currently receiving both Home Care Allowance program and Medicaid Home- and Community-Based Services benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010. While the Department anticipated an increase in HCBS enrollment as a result of this bill, implementation of the project has been delayed. DHS has assumed responsibility for payment to SEPs for enrollment of clients into the HCA program, but system changes necessary to move clients into solely HCBS waivers delayed implementation to FY 2011-12.
- HB 09-1047 “Alternative Therapies for Clients with Spinal Cord Injuries” - HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services include massage, acupuncture, and chiropractic care. The Department received approval for the waiver in July 2012.
- Colorado Choice Transitions - The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community-based services. The program will begin enrolling clients in January 2013.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community-Based Long-Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services, and home health services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. Savings from the enhanced match are required to be used to improve the long-term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the two types

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

The Department has had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The Department currently anticipates approximately 100 clients will transition per calendar year beginning in January 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of \$8,188 total funds in FY 2012-13 and a reduction of \$603,033 in FY 2013-14. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2010-11 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2012-13, FY 2013-14, and FY 2014-15 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – are expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. These expenditures represented approximately 78% of total hospice expenditure in FY 2011-12. The remaining portion of hospice expenditure is represented under the Hospice Services category and includes Hospice General Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

Payments made to nursing facilities for services provided to hospice clients differ from payments made for Class I Nursing Facility clients, most significantly in two predominant ways: there is no patient payment component of the per diem, and the per diem for hospice clients is prescribed to 95% of the per diem for Class I Nursing Facility clients. Otherwise, the methodology for forecasting nursing facility room and board expenditures for hospice clients mirrors the Class I Nursing Facility forecast.

To create the patient days forecast, the Department used claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day counts; then, the Department used an autoregressive model with seasonality and linear time trend to

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estimate patient days for the years covered in this request. As hospice client nursing facility per diems are linked to the per diem for Class I Nursing Facility clients, they are assumed to grow at the same 3% per-year rate. Rate reductions are accounted for in the same fashion as they are for nursing facilities: their impact is included in calculations as a bottom-line impact. Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted patient per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year.

Please refer to the portion of the narrative devoted to Class I Nursing Facilities for a more detailed description of IBNR analysis, the 3% general fund growth cap for nursing facility rates, and nursing facility rate reductions. Additional information is available in footnotes (1) through (6) in the footnotes section of the hospice forecast.

The second category of hospice expenditure, referred to throughout the hospice forecast as Hospice Services, contains all hospice expenses other than those accrued as payments to nursing facilities for room and board for hospice clients.

The largest component of this expenditure category is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two to three times per week, generally by nurses. In FY 2011-12, Hospice Routine Home Care expenditure was approximately \$7.5 million and thus represented 81% of hospice services expenditure and 22% of total hospice expenditure, respectively. Hospice Routine Home Care expenditures are computed as a product of patient days and the daily rate. The Department arrives at an estimate for FY 2012-13 days by adding the average change in annual days between FY 2008-09 and FY 2011-12 to observed FY 2011-12 days. Estimates for FY 2013-14 and FY 2014-15 are the result of adding the same number to the previous fiscal year's estimate. The Hospice Routine Home Care per diem is forecasted by applying a linear time trend to observed daily rates between FY 2007-08 and FY 2011-12.

The next-largest component of hospice services expenditures is hospice general inpatient care. These expenditures are incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2011-12, the Department paid approximately \$1.7 million for Hospice General Inpatient Care. As a linear time trend applied to historical claims data explains 98.6% of expenditure variation, the Department selected that methodology to develop expenditure forecasts for FY 2012-13, FY 2013-14, and FY 2014-15.

The remaining components of hospice services expenditures in total represent less than \$80,000 of expenditure for FY 2011-12; in every prior year, they accounted for less than \$50,000 of combined expenditure. As such, the Department chose to aggregate the remaining expenditure and apply the average growth rate for FY 2008-09, FY 2009-10, and FY 2010-11 to the FY 2011-12 observation for the same aggregation to develop an estimate for FY 2012-13 expenditure. FY 2013-14 and FY 2014-15 expenditure estimates are results of the application of the same growth rate to the previous fiscal year's estimate.

Private Duty Nursing

Private Duty Nursing (PDN) services are face-to-face skilled nursing services provided in a more individualized fashion than comparable services available under the home health benefit or in hospitals or nursing facilities and are generally provided in a client's home. PDN services are billed hourly; maximum daily eligibility is 16 hours for adults and 24 hours for pediatric clients. There are five categories of PDN expenditure: individual services provided by a registered nurse (RN), group services provided by a registered nurse (RN-group), individual services provided by a licensed practical nurse (LPN), group services provided by a licensed practical nurse (LPN-group), and blended services. RN services are associated with the highest hourly rate and LPN-group services with the lowest. The remaining three services – RN-group, LPN, and blended – charge the same intermediate rate. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change.

As PDN expenditure is the product of the hourly rate and the number of hours, and the Department expects rates to remain constant, expenditure forecasts for FY 2012-13, FY 2013-14, and FY 2014-15 are primarily based on days forecasts for those fiscal years. The days forecast is separated into three pieces that are consistent with the three rate groups: RN hours; RN-group, LPN, and blended hours; and LPN-group hours.

In FY 2011-12, the Department paid claims for 1,036,429 total hours for PDN services; 596,723 were billed as RN hours. Linearly regressing RN hours between FY 2008-09 and FY 2011-12 explains 98.8% of the variation in hours. As such, the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2012-13, FY 2013-14, and FY 2014-15. This model predicts growth between 10% and 12% annually over the course of the next three fiscal years.

RN hours were stable prior to FY 2008-09 but began increasing significantly in FY 2009-10. The Department examined RN hours per distinct client per month between FY 2005-06 and FY 2011-12 in an effort to investigate potential causes for the increase in hours. While there was a slight upward trend in RN hours per distinct client per month over the course of this period, this alone is far from sufficient to explain the growth in aggregate hours. This analysis was extended to the other two groups of PDN service. No discernible trend exists in changes of hours per distinct client per month. For all three categories of PDN service, changes in usage appear to be driven entirely or almost entirely by the addition of new clients.

As is consistent with RN services, paid hours for the intermediate-rate group of PDN services – RN-group, LPN, and blended – were largely stable between FY 2005-06 and FY 2008-09 before reporting rapid growth in FY 2009-10 and FY 2010-11. Unlike RN services, however, growth for these services was very small between FY 2010-11 and FY 2011-12. To this end, the Department elected to estimate hours for FY 2012-13 for these services by applying the average annual growth rate between FY 2008-09 and FY 2011-12 to the FY 2011-12 observation. This methodology produces a more moderate increase in hours relative to the previous year

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than a linear forecast. The same growth rate is applied to the previous year's estimate to derive forecasts for FY 2013-14 and FY 2014-15.

LPN-group services have both the smallest rate and represent by far the smallest portion of PDN claims. In FY 2011-12, these services accounted for only 29,004 hours of claims, or 2.8% of total hours. Due to erratic growth rates in recent years, the Department chose to forecast future LPN-group hours by applying the annual growth rate from FY 2011-12 (3.4%) to the FY 2011-12 hours observation. This same growth rate is again applied to the previous year's estimate to produce estimates for FY 2013-14 and FY 2014-15.

Final expenditure estimates for FY 2012-13, FY 2013-14, and FY 2014-15 are produced by multiplying projected hours by the projected rate for each of the three service category and then summing these figures. The Department is forecasting between 9% and 10% growth in annual total expenditure for PDN services in each of the three upcoming fiscal years.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

This section is for a series of services that, for a variety of reasons, are individually computed and then allocated to the eligibility categories based on experience. Those services are:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request

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

Class I Nursing Facilities

Class I nursing facility costs are a function of the application and interpretation of rate reimbursement methodology specified in detail in State statute, the utilization of the services by Medicaid clients, and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict: 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient

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payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% (through the FY 2009-10 total) since FY 1999-00. This is due to efforts by the Department to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Recent history indicates this trend is changing and the Department no longer anticipates a continued decline in patient days.

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

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities that do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

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

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

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non-Medicare day. These changes, however, had no impact on the General Fund

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portion of nursing facility rates. SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

HB 12-1340 extended the 1.5% rate reduction of SB 11-125 into FY 2012-13. As all other rate reductions expired before the start of FY 2012-13, this reduction represents the total value of the rate reduction for FY 2012-13. The reduction expires June 30, 2013. For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows¹:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2012-13.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment for claims that will be incurred in FY 2012-13. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2012-13 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2012-13.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2012-13.
- Of the estimated total reimbursement for claims incurred in FY 2012-13, only a portion of those claims will be paid in FY 2012-13. The remainder is assumed to be paid in FY 2013-14. The Department estimates that 92.43% of claims incurred in FY 2012-13 will also be paid during FY 2012-13. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2012-13.
- During FY 2012-13, the Department will also pay for some claims incurred during FY 2011-12 and prior years (“prior year claims”). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2011-12 to calculate an estimate of outstanding claims to be paid in FY 2012-13.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2012-13 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2012-13, this includes run out from SB 11-215, which introduced a 1.5% rate reduction effective July 1, 2011. HB 12-1340, which continued the SB 11-215 rate reduction into FY 2012-13, is also included.

¹ For clarity, FY 2012-13 is used as an example. The estimates for FY 2013-14 and FY 2014-15 are based on the estimate for FY 2012-13, and follow the same methodology.

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- Once the “non-rate” factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2012-13 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2012-13, FY 2013-14, and FY 2014-15 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2012-13 through FY 2014-15. Please refer to Footnote 6 on page EH-8 for more detail. The estimates for FY 2012-13, FY 2013-14, and FY 2014-15 are predicated on an assumption of stable enrollment: the HBU program is being evaluated by the Department and additional clients are to be enrolled on a case-by-case basis.
- Prior to FY 2010-11, the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2012-13, FY 2013-14, and FY 2014-15. FY 2010-11 BRI-2, “Coordinated Payment and Payment Reform,” increased the number of Department auditors resulting in additional audits of nursing facilities. As such, there was a large increase in recoveries observed in FY 2012-13 related to the prior fiscal year. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-9 contains additional detail about these recoveries.
- SB 11-215 implemented a 1.5% rate reduction for Class I nursing facilities per diems effective July 1, 2011, through June 30, 2012. As a result of claims run-out, the fiscal impact of this bill extends into FY 2012-13. Footnote 9 on page EH-9 contains additional detail regarding the fiscal impact of this bill.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non-Medicare day increased to \$12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments but will be unable to fully fund growth beyond the General Fund cap. The Department estimates approximately 68% of growth beyond the General Fund cap will be supported by the provider fee.
- HB 12-1340 extended the 1.5% nursing facility per diem rate cut of SB 11-215 into FY 2012-13, effective July 1, 2012.

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- The Colorado Choice Transitions adjustment accounts for the reduction in class I nursing facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.

Incurred-But-Not-Reported Adjustments

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

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

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department’s estimate of claims paid in the current year for current year dates of service, particularly footnotes 4 and 5 of Exhibit H, page EH-4. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2011-12 that will be paid in FY 2012-13 and the percentage of claims incurred in FY 2012-13 that will be paid in FY 2012-13 and subsequent years. The Department applies the same factor to the FY 2013-14 and FY 2014-15 estimates.

The Department uses the IBNR adjustment calculation for the November 2012 Budget Request using paid claims data through April 2012. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting the time between the date of service and the payment date of a typical claim may be decreasing.

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Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009, November 2009, February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%
November 2012	92.43%

Patient Days Forecast Model

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

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

Testing the Overall Predictive Ability of the Model

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

Testing the Stationarity of the Model

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

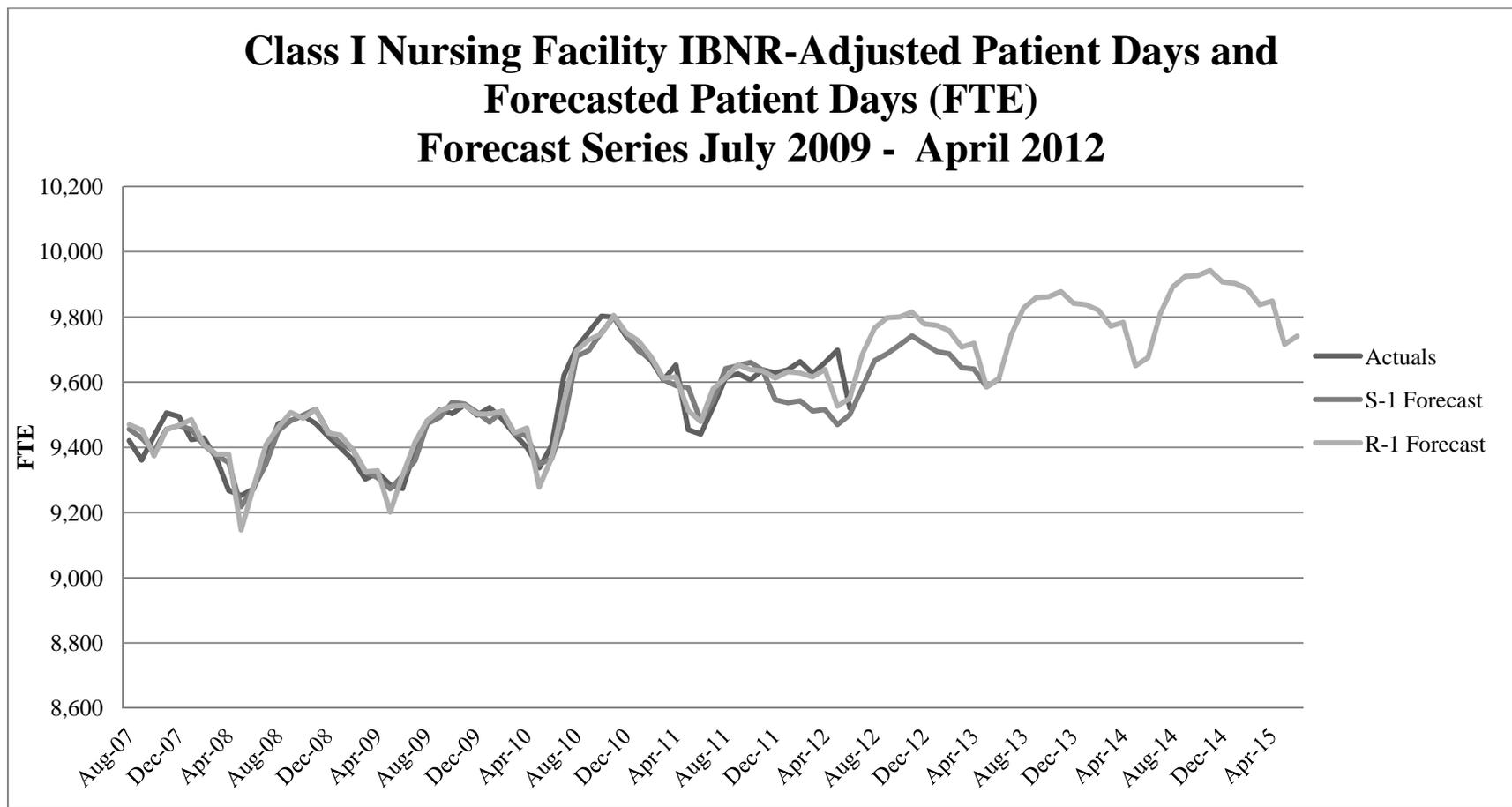
Technically, the test is performed by creating a model where the first difference (the current month minus the previous month’s value) of each value predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The corresponding coefficient from this regression is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

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	P-Value
Augmented Dickey-Fuller Test Statistic	-3.622	0.0368
Conclusion: Reject that null hypothesis that there is a unit root at the 96% confidence level. An auto-regressive model can be used with this series.		

Forecasting Patient Days

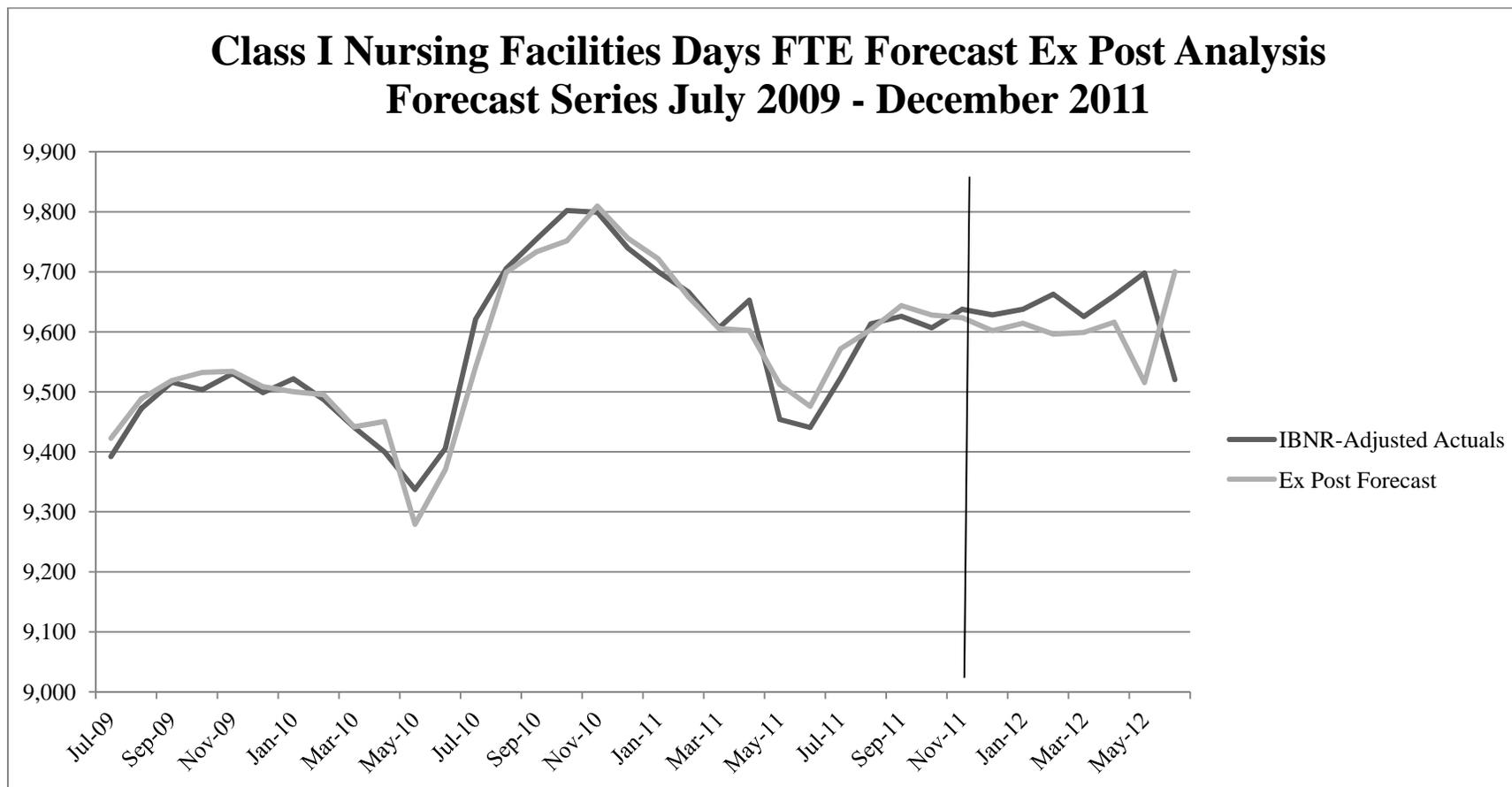
Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the number of FTE (fulltime equivalent)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

Historically, the Department’s efforts toward increasing utilization of Home- and Community-Based Services have resulted in downward pressure on the Class I Nursing Facility days trend. However, in the face of an aging population and ever-increasing demand for long-term care services, the most recent years have displayed a return to marginal annual growth in patient days.



Ex Post/In-sample Forecasts

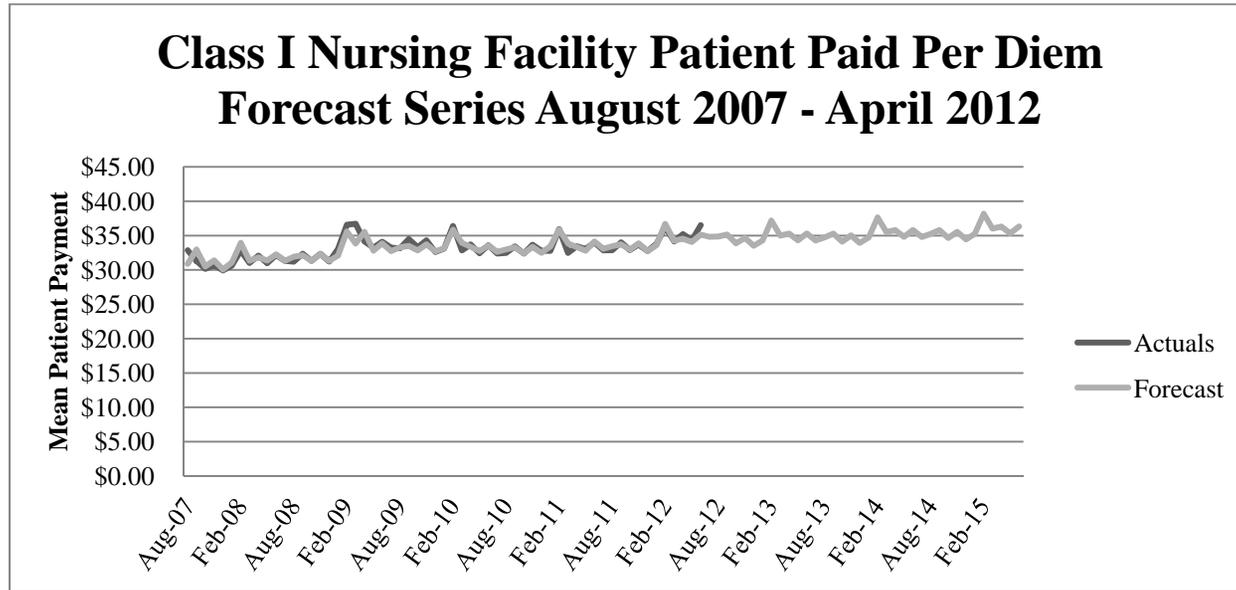
As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from May 2008 through May 2011) and compared the results to actual data reported for June 2011 through November 2011.



It is worth noting the Ex Post Forecast model underestimates FTE in the forecast period from January 2012 to June 2012. Observed patient days in FY 2011-12 make a departure from previously observed seasonality. More information is necessary to determine whether this is anomalous.

Patient Payment Forecast Model

As with the days forecast, the Department utilizes a seasonally adjusted autoregressive model to forecast patient payment.



Testing the Stationarity of the Model

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

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	P-Value
Augmented Dickey-Fuller Test Statistic	-3.398	0.00134
Conclusion: Reject that null hypothesis that there is a unit root at the 99% confidence level. An auto-regressive model can be used with this series.		

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Testing the Overall Predictive Ability of the Model

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

Nursing Facility Rate Methodology Changes

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

FY 1997-98	8% Health Care Cap and 6% Administrative Cap Implemented
FY 1998-99	No change
FY 1999-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 2000-01	No change
FY 2001-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program/Resident Centered Quality Improvement Program discontinued
FY 2002-03	Administrative Incentive Allowance removed for three months then reinstated
FY 2004-05	8% Health Care Cap reinstated
FY 2005-06	No change
FY 2006-07	8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
FY 2007-08	Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
FY 2008-09	New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.
FY 2009-10	The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the

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direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.

FY 2010-11 HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.

FY 2011-12 SB 11-125 increased the level of the provider fee to \$12.00 per non-Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.

FY 2011-12 SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2012.

FY 2012-13 HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2013.

Department Forecast Methodology Change

With the Department's November 1, 2011 Budget Request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate-setting methodology in statute. To generate the nursing facility forecast using the previous methodology, claims that were 100% patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100% patient payment impact the next year's rate. To more accurately forecast the per-diem rates, the revised forecast methodology, claims with 100% patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

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

The Department updated its methodology for calculating the nursing facility per diem for the November 2012 request. Rather than forecasting current-year per diems, the Department developed weighted-average per diem for FY 2012-13 by crosswalking prescribed by-provider per diems with a provider-days distribution for FY 2011-12. Previously, the Department forecasted per diems in aggregate; this methodology would only be accurate if the provider-days distribution were uniform. As this is not the case, the Department's new methodology addresses variance between the forecasted per diem and the observed per diem in two ways: first, the

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current year per diem is based on actual rates rather than a projection of rates, and, second, the Department uses provider days from FY 2011-12 as a proxy for provider days for FY 2012-13 rather than assume the distribution to be uniform.

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

For comparison purposes to other service categories, this exhibit lists prior-year expenditure along with the projected expenditure from page EH-3. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per-capita costs for each year. Supplemental payments made to Class I nursing facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

Totals for each aid category are used to calculate total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. At the end of FY 2005-06, the provider increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility has remained constant. Additionally, this facility received an annual cost-based rate adjustment, similar to Class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. FY 2009-10 to FY 2011-12 enrollment rates were slightly lower than in the previous years. However, for FY 2010-11 and FY 2011-12, the Department anticipates enrollment will return to the 20 client enrollment level. The estimated growth rate for FY 2012-13 reflects changes in per-diem rates based on audited cost reports from CY 2011. The estimated growth rate for FY 2013-14 is based on anticipated changes in per-diem reimbursement using information from unaudited cost reports for CY 2012. Because all clients are paid the same rate regardless of aid category, the Department anticipates change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

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

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as

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independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

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

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

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

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

Expenditure estimates for PACE for FY 2012-13, FY 2013-14, and FY 2014-15 are the product of two pieces: projected enrollment and projected cost per enrollee. As is consistent with convincing historical enrollment data suggesting linear trends for PACE enrollment, linear regression models are used to estimate future enrollment on a by-provider by-eligibility-type basis. Enrollment caps are not anticipated to limit growth for the forecast period as a result of the manner in which PACE services are provided: that is, clients are not full-time residents of PACE facilities.

The Department anticipates a new Total Longterm Care facility in northern Colorado to begin serving clients between January and March of 2013. The Department views the Total Longterm Care facility in Pueblo as a best-guess model of enrollment patterns for this facility and, for forecasting purposes, assumes that it will open in February 2013.

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Per-enrollee costs for FY 2012-13 are determined by cross-walking the actual FY 2012-13 rates for PACE services with an eligibility-type distribution estimate derived from FY 2012-13 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2012-13 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

PACE rates have been declining since FY 2008-09. The Department believes rate cuts for other services that are components of the PACE rate calculations have contributed significantly to this trend. Additionally, there has been a shift in the methodology for the calculation of institutional-to-non-institutional client splits for PACE, which has resulted in a dramatically-different view of the client population. Previously, the calculation – prepared externally – reflected a proportion of high-cost institutional clients as high as 85%. A revision to this process resulted in estimates of high-cost clients of only 50% to 55%. As the Department views this revision as representative of a level-shift in reported client distribution, this source of downward rate pressure is not expected to drive changes in PACE rates in the future. Further, the Department anticipates other components of the PACE rate calculation will demonstrate upwardly-trending behavior. To this end, the Department is projecting moderate growth in cost-per-enrollee figures for FY 2013-14 and FY 2014-15. The rate trend is the average of FY 2008-09 and FY 2009-10 cost-per-enrollee growth (3.67%) and is applied to each eligibility type separately rather than in an aggregate fashion.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.² The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as “Medicare Qualified Individual (1).” Legislation for the second group, referred to as “Medicare

² Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

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Qualified Individual (2),” comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below.³

History of Medicare Premiums

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

These premiums reflect the standard Medicare premiums paid by most Medicare recipients or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium. Additionally, some clients pay higher Part B premiums based on higher adjusted gross income, however, the Department is only required to pay the base premium cost.

During FY 2007-08, the Department made its July 2007 payment for Medicare premiums several days late. As a result, Medicare automatically deducted the balance from the Department’s Medicaid grant. As a result, from the perspective of Medicare, the Department effectively double-paid July, and the difference became a credit against the September total. As a result, the total expenditure for this line does not reflect payment for one month, because the federal funds Medicare received directly from the

³ Premium information taken from the Centers for Medicare and Medicaid Services, <http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop>

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Medicaid grant did not pass through the State's accounting system. Therefore, in order to accurately project expenditure, the Department used the actual Medicare invoice totals for FY 2007-08 instead of the actual expenditure for FY 2007-08. This ensures the projection base is not understated, which would lead to a material under-projection in the forecast.

To forecast FY 2012-13, the Department inflates the actual expenditure from the second half of FY 2011-12 by the increase caseload from FY 2011-12 to FY 2012-13. This generates the anticipated expenditure for the first half of FY 2012-13, as there will be no increases to Medicare premiums during this period. Expenditure for the second half of FY 2011-12 is calculated by inflating the estimated first half of the year's expenditure by the anticipated increase in Medicare premiums effective January 1, 2013, or 6.49%. This change in premiums is based on the average change in premiums from CY 2004 to CY 2012. Rates for CY 2013 have not yet been announced by CMS. The Department will update this component of the forecast in the February supplemental request. The total estimated expenditure for FY 2012-13 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2013-14, the Department first inflates the estimated expenditure from the second half of FY 2012-13 by the estimated caseload trend for FY 2013-14 as reported in exhibit B. This figure represents the approximate expenditure for the first half of FY 2013-14. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2013-14 is the sum of the first half and second half estimates. The forecast of FY 2014-15 expenditure utilizes the same methodology as the forecast of FY 2013-14.

Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2012-13, FY 2013-14, and FY 2014-15 calculations for the Supplemental Medicare Insurance Buy-In Program:

- Contractor to Enroll Clients in Medicare – the Department is working with a contractor on a full contingency basis to enroll Medicare eligible Medicaid clients in Medicare. This initiative is an extension of work previously done under the Department's FY 2010-11 BRI-2 "Coordination of Payments and Payment Reform" initiative. Savings generated through additional Medicare enrollments are found in Acute Care while premium payments and contractor funding are incorporated in the SMIB forecast.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost-effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2012). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost-effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB) for clients who do not qualify for the Medicare Part D benefit.

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

Contrary to previous budget submissions where the Department examined per-capita growth trends to forecast the HIBI budget, for FY 2011-12 through FY 2013-14, the Department examined total expenditure trends to estimate expenditure. The Department believes this methodology to be more accurate as per-capita growth has fluctuated significantly historically because HIBI enrollment does not bear a direct relationship to Medicaid caseload. The Department selected 9.39%, the FY 2011-12 expenditure growth rate for AND/AB clients to trend expenditure in FY 2012-13 for the Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), Eligible Children, Categorically Eligible Low-Income Adults (AFDC-A), and Baby Care Program Adults aid categories. All FY 2012-13 trend selections were held constant for FY 2013-14 and FY 2014-15.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2012-13, FY 2013-14 and FY 2014-15 calculations for the Health Insurance Buy-In Program:

- SB 10-167 “Medicaid Efficiency and Colorado False Claims Act” impacts the HIBI program in FY 2012-13 by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients

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to create cost savings for the state. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per-member per-month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline and enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

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

Summary of Service Management

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

Single Entry Points

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to 25.5-6-105, C.R.S. (2012). A single entry point agency is an agency in a local community through which persons 18 years or older, who are in need of long-term care services, can access needed long-term care services.

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home- and Community-Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and

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maintaining fiscal accountability. Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

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

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

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

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

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

Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry

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points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

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

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

For FY 2011-12, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2010-11 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For FY 2012-13, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2007-08 through FY 2010-11 for the Adults 65 and Older. For Disabled Adults 60 to 64, the Department used the year-to-date growth rate in paid HCBS utilization. For the Disabled Individuals to 59 aid category, the Department trended HCBS-paid enrollment using the average percent change in average monthly paid enrollment from FY 2006-07 through FY 2010-11. The overall HCBS utilization growth rate from FY 2006-07 to FY 2010-11 was selected to trend expenditure for the remaining aid categories: Categorically Eligible Low-Income Adults, Eligible Children, Foster Care, Non-Citizen, and Partial Dual Eligibles. The estimated FY 2011-12 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2012-13 and FY 2013-14 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2011-12 through FY 2013-14.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or

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prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases” (25.5-5-316, C.R.S. (2012)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

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

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

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

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), high risk obstetrics, and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department’s funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117(2)(d)(IV.5), C.R.S. (2012), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

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

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2012) (further described in exhibit A). The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered amount of \$63,488 is included in the FY 2009-10 request. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

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

FY 2012-13 remains at the same level as FY 2011-12. However, in FY 2013-14, the statutory authorization for this funding expires. Expenditure in the out year and any year following is expected to be \$0.

In collaboration with DPHE, the Department allocated \$500,000 in FY 2011-12 to fund an education initiative for clients with the purpose of providing instruction related to the management of chronic diseases. The Department will do so again in FY 2012-13 but does not anticipate pursuing this initiative in subsequent years due to the statutory expiration of the funding.

In FY 2011-12, The Department requested a transfer of spending authority from DPHE for the purpose of attaining federal funds to establish the Smoking Cessation Quitline for Medicaid Clients. The Department anticipates a total funds impact of \$577,316 for FY 2011-12, \$1,373,470 in FY 2012-13, and \$1,281,040 in FY 2013-14.

Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Since then, the Department contracted with only one prepaid inpatient health plan Rocky Mountain Health Plans until FY 2009-10. The Department contracted with three additional prepaid

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inpatient health plans in FY 2009-10. These include Colorado Access and Kaiser Foundation Health Plan, which are jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

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

Rocky Mountain Health Plans

Because the administrative fees remain the same in FY 2012-13 and FY 2013-14, the Department uses actual enrollment to forecast expenditure for Rocky Mountain Health Plan for FY 2013-14. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group. For this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

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

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost-avoidance payments to Rocky Mountain Health Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was made. At that time, the Department anticipated it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09 with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department has completed all CMS requirements pertaining to Rocky Mountain Health Plan and made a cost-avoidance payment to Rocky Mountain Health Plan for services rendered

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in FY 2009-10 in the latter half of FY 2011-12. Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department also made a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the year prior to it.

For FY 2012-13, FY 2013-14, and FY 2014-15, the Department assumed the cost avoidance payments would be similar in magnitude to the calculated payment for FY 2009-10 and carried that amount forward for all forecast years. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

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

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access will be completed and available to the Department in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. This program was discontinued effective June 30, 2012. However, due to the lag in payments, it is expected there will be one additional payment to be made in FY 2012-13. MDRC is currently studying the effectiveness of the program at Kaiser and will complete the evaluation for the Department at the beginning of 2013.

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Colorado Alliance & Health Independence (CAHI)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64 designed to provide a network of services that are high-quality and cost-effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. The Department is working with CAHI to determine the cost effectiveness of the program. Until the program has demonstrated cost effectiveness, the Department will not be enrolling additional clients. The FY 2012-13, FY 2013-14, and FY 2014-15 forecast assume enrollment levels that are equal to the enrollment level at the end of FY 2011-12 (225 clients).

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6 “Medicaid Value Based Care Coordination Initiative” and revised in FY 2010-11 S-6/BA-5 “Accountable Care Collaborative.” The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 “Medicaid Budget Balancing Reductions.” The Department has since expanded enrollment in the program and is projected to reach an enrollment total of 200,000 early in CY 2013. The cost savings estimated for this program are included in acute care; please see Exhibit F and Section V for more information on its impact to acute care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2012-13 include \$3,000,000 paid to the SDAC, an average PMPM of \$10.17 PMPM paid to the RCCOs, \$3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a \$2.00 monthly incentive payment divided between the providers and the RCCOs. The fees in FY 2013-14 are the same, with the exception of the average PMPM paid to RCCOs, which will be \$9.64 (incentive payments can still be earned). In the current and request years, the Department assumes the full \$2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members even though the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in FY 2012-13 and may estimate a lower PMPM depending on the average percentage of the incentive payments paid to providers. The FY 2014-15 estimate incorporates the same PMPM amounts and enrollment levels as FY 2013-14.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

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

Hospital Provider Fee Fund

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

Expansion Adults to 100%

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level (FPL). This expansion population receives the standard Medicaid benefits. Eligibility for this population under Medicaid was effective May 1, 2010.

The Department assumes the medical and mental health per-capita costs for this expansion group will be approximately 95% of those for the Medicaid Expansion Adults to 60% FPL. Per-capita cost estimates for this population have been updated to reflect the most recent projection of per-capita costs for the Expansion Adults population.

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

Adults without Dependent Children

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

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed there

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were 143,191 uninsured Adults without Dependent Children in Colorado in 2009, 49,511 of which were in the 0-10% FPL bracket. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion at 10,000.

The Department assumes the per-capita costs for this population will be a blend of the historical per capitas trended forward for the Low-Income Adults from approximately 24% to 60% of the FPL and the Disabled Individuals to 59 (AND/AB). The experiences from other states and a literature review on this population confirm this assumption. As the Department is only implementing up to 10% FPL, the Department assumes these clients will be the most high-need clients, with a lot of pent-up demand. With these assumptions, the Department assumed a blended per capita with 10% resembling the Low-Income Adults from approximately 24% to 60% of the FPL, with the other 90% resembling the Disabled Individuals to 59 (AND/AB) population., which is consistent with assumptions made in the Department's federal waiver for this population. These proportions were applied to the per capitas for the Low-Income Adults and the Disabled Individuals to 59 calculated by the Department's contractor using the historical data of both populations. To allow for potentially higher-than-anticipated costs with the rollout of a new population, the Department is requesting additional funding beyond the amount indicated in the per-capita estimates. If expenditure falls short of the requested amount, all funds will remain in the hospital provider fee cash fund.

Medicaid Buy-in Fund

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

Buy-in for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with eligibility to children with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

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

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be more likely to obtain their own insurance. The Department learned many may buy into the program to receive “wraparound” benefits, where they would receive benefits not available through their own plan.

The Department assumes the Medical Services Premiums expenditure for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department also assumes most clients in the Buy-In program will have lower utilization of many Home- and Community-Based Services (HCBS) waivers and other Long-Term Care services. The Department assumes proportionally fewer individuals with the ability to work would meet the level of care for either a waiver or nursing facility than in the current Disabled Adults to 59 population. In addition, clients who are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. In addition, the Department also assumes 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department’s HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services. Overall, the Medicaid Disabled Individuals to 59 Acute Care per capita has been adjusted based on all of the above factors, some of which act to increase and some of which act to decrease the per capita. These adjustments were applied to the total per capita rather than at the service category level.

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department’s Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals’ uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit (UPL) financing methodology accomplishes the following:

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

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The basic calculation for UPL financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

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

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

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

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

EXHIBIT L – DEPARTMENT RECOVERIES

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

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

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Recoveries made for dates of service under periods where the State received an enhanced federal match are given the same federal match as was applicable when the services were rendered. The Department previously assumed a larger percentage of recoveries would fall under periods of enhanced federal match. However, the most recent expenditure data indicates a smaller percentage of recoveries are from periods with enhanced federal match. Consequently, the Department has revised assumptions regarding federal match on recoveries accordingly.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 11 years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12-month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is data obtained from the Department’s Medicaid Management Information System (MMIS). This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community-Based Long-Term Care, Long-Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

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

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

Service Group	Old Title	New Title
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community-Based Long-Term Care	Home- and Community-Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community-Based Long-Term Care	Home- and Community-Based Services - Mentally Ill	HCBS - Mental Illness
Community-Based Long-Term Care	Home- and Community-Based Services- Children	HCBS - Disabled Children

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Service Group	Old Title	New Title
Community-Based Long-Term Care	Home-and Community-Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community-Based Long-Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community-Based Long-Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

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

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

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

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

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

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Effective with the November 1, 2012 Budget Request, the Department is reporting expenditure for Adults without Dependent Children and Disabled Buy-in eligibility types.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2011-12 final actual expenditures are included in this Budget Request for historical purpose and comparison.

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

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2011-12 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2011-12 appropriation, and the per-capita cost per client. The per-capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

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

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. In addition, on page EP-3, this exhibit displays the FY 2012-13 year-to-date expenditures through September 2011 and the cash flow pattern of actual expenditures for the first quarter of FY 2012-13 to determine a rough estimate of FY 2012-13 expenditures, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

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

V. ADDITIONAL CALCULATION CONSIDERATIONS

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

New Legislation and Impacts from FY 2012-13 Budget Cycle Requests

This section describes the impact from legislation passed during the 2012 Legislative Session and includes impacts from the Department's FY 2012-13 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

HB 12-1235 – FY 2012-13 Long Bill

The FY 2012-13 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2012 Legislative Session that impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- **Medicaid Fee-for-service Reform (R-5):** Three initiatives were included in the budget action: Behavioral Health Organization gainsharing, Federally Qualified Health Center and Rural Health Center gainsharing, and Accountable Care Collaborative gainsharing. Each of these initiatives provides financial incentives for different provider types to engage clients and care management differently to improve outcomes and generate savings. Because these changes require an investment on the part of the provider, gainsharing becomes a mechanism for compensating providers for the investment without an upfront outlay of funding by the State. Through stakeholder engagement with CMS and the provider community, the Department has revised the gainsharing proposal to facilitate an alignment of financial incentives to support the Accountable Care Collaborative care management system. All three gainsharing activities have been streamlined into a single gainsharing program wherein care management entities, behavioral health organizations, and primary care providers must work together collaboratively to produce savings through integration of behavioral health and physical health to improve total health outcomes.
- **Medicaid Budget Reductions (R-6):** This budget action encompassed 16 different policy initiatives targeted at addressing the statewide budget shortfall. The majority of the proposals are efficiency measures that align Medicaid practices with industry standards to maximize clinical efficacy while maintaining fiscal responsibility. A brief summary of the original proposals and fiscal impacts follow.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

- *Preterm Labor Prevention:* The Department is offering coverage of alpha hydroxyprogesterone caproate injections, which reduce the occurrence of preterm labor.
- *Synagis PAR Review:* The Department will be increasing review of prior authorizations for Synagis to ensure only appropriate dosages are utilized of this drug.
- *Expansion of the Physician Administered Drug Rebate Program:* The Department has expanded the list of physician-administered drugs for which it collects rebates, as well as performed outreach to providers to ensure sufficient information is provided for the Department to claim rebates.
- *Reimbursement Rate Alignment for Developmental Screenings:* Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. Previously, the rate paid for developmental and depression screenings was well above the rates paid by Medicare and commercial insurance plans for these screenings.
- *Physician Administered Drug Pricing and Unit Limits:* The Department has realigned the pricing and unit limits on three physician-administered drugs to achieve both consistency for billing and cost savings.
- *Public Transportation Utilization:* The Department has built incentives and expectations into the non-emergent medical transportation program to increase the utilization of public transportation in the Denver-metro area.
- *Home Health Therapies Cap:* The Department is limiting the number of home health visits for therapy to 48 visits per calendar year. This budget action was not approved by the General Assembly, and the Department has not included any savings for this initiative.
- *Home Health Care Cap:* The Department has limited the number of hours of skilled care a patient can receive in the home health setting to eight per day. This budget action was not approved by the General Assembly, and the Department has not included any savings for this initiative.
- *Seroquel Restrictions:* The Department has implemented policies to prevent the utilization of Seroquel for off-label use.
- *Dental Efficiencies:* The Department will clarify rules regarding eligibility for orthodontics. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion.
- *Augmentative Communication Devices:* The Department has implemented an initiative to provide access to less-costly durable medical equipment for disabled clients that require the aid of augmentative communication devices.
- *Durable Medical Equipment Preferred Provider:* The Department initiated a competitive procurement process to acquire a sole-source diabetic testing supply provider whereby the Department can leverage purchasing power to obtain significant rebates.
- *Continuation of Nursing Facility Reduction:* The Department proposes a continuation of the 1.5% rate reduction to nursing facility reimbursement current scheduled to end July 1, 2012.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

- *Ambulatory Surgical Centers:* The Department has initiated a pilot project to shift outpatient surgery utilization from the outpatient hospital setting to the less costly ambulatory surgical setting.
- *Utilization Management Vendor Funding:* The Department is requesting additional funding to expand the scope of work of the Department’s contracted utilization management vendor to perform prior authorizations for the savings initiatives in this request.
- *Pharmacy Rate Methodology Transition:* To accommodate a change in available drug pricing information, the Department is changing the reimbursement methodology for pharmaceuticals. As part of the change in reimbursement methodology, reimbursement for ingredient costs will be decreased, the dispensing fee will be increased, and net savings of \$4,000,000 total funds will be achieved. This budget action was approved with zero savings.
- *Hospital Provider Fee Financing:* The Department is utilizing hospital provider fee to offset lost federal funds associated with certification of public expenditure for outpatient hospital services. An annual amount of \$15,700,000 cash funds will be used to offset General Fund in the Medical Services Premiums line.

The following table summarizes each initiative’s fiscal impact:

FY 2012-13 R-6: Summary of Funding by Initiative

FY 2012-13	Original Requested Amount	FY 2012-13 Appropriated Amount	FY 2013-14 R-1 Requested Amount	Difference from Appropriation	Note
Policy Initiative	(\$30,199,322)	(\$21,699,706)	(\$25,979,104)	(\$4,279,398)	
Preterm Labor Prevention	(\$902,736)	(\$902,736)	(\$902,736)	\$0	
Synagis Prior Authorization Review	(\$419,772)	(\$419,772)	(\$419,772)	\$0	
Expansion of Physician Administered Drug Rebate Program	(\$2,418,276)	(\$2,418,276)	(\$2,418,276)	\$0	
Reimbursement Rate Alignment for Developmental Screenings	(\$2,092,701)	(\$2,092,701)	(\$2,092,701)	\$0	
Physician Administered Drug Pricing and Unit Limits	(\$416,472)	(\$416,472)	(\$416,472)	\$0	

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

FY 2012-13 R-6: Summary of Funding by Initiative

FY 2012-13	Original Requested Amount	FY 2012-13 Appropriated Amount	FY 2013-14 R-1 Requested Amount	Difference from Appropriation	Note
Public Transportation Utilization	(\$209,574)	(\$209,574)	(\$209,574)	\$0	
Home Health Therapies Cap	(\$382,453)	\$0	\$0	\$0	
Home Health Care Cap	(\$4,117,163)	\$0	\$0	\$0	
Seroquel Restrictions	(\$1,931,172)	(\$1,931,172)	(\$1,931,172)	\$0	
Dental Efficiency	(\$1,641,594)	(\$1,641,594)		\$1,641,594	Fiscal impact revised due to implementation delays necessary for additional stakeholder outreach.
Augmentative Communication Devices	(\$492,000)	(\$492,000)	(\$451,000)	\$41,000	Fiscal impact revised due to implementation delays.
DME Preferred Provider	(\$1,150,732)	(\$1,150,732)	(\$740,333)	\$410,399	Fiscal impact revised due to implementation delays.
Continuation of Nursing Facility Reduction ⁽¹⁾	(\$9,024,677)	(\$9,024,677)	(\$9,397,068)	(\$372,391)	Fiscal impact revised - See Exhibit H, Class I Nursing Facility Footnotes for detailed calculations
Ambulatory Surgical Centers	(\$1,000,000)	(\$1,000,000)	\$0	\$1,000,000	The Department is not expanding the pilot program as originally anticipated.
Pharmacy Rate Methodology Transition ⁽²⁾	(\$4,000,000)	\$0	(\$7,000,000)	(\$7,000,000)	Fiscal impact revised based on more complete information.
Hospital Provider Fee Financing	\$0	\$0	\$0	\$0	

(1) As this initiative requires legislation to implement, the fiscal impact listed here is duplicative of HB 12-1340 "Nursing Facility Reduction Per-Diem Rate"

(2) The JBC did not include savings for this initiative in the Long Bill. Because the survey of Colorado pharmacies was not yet complete, the Department's fiscal estimate was based on the experience of other states. The revised estimate of a \$7,000,000 impact in FY 2012-13 is based on complete survey data.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

- SB 12-060 “Improve Medicaid Fraud Prosecution”: By providing additional financial incentives for counties to identify Medicaid client fraud, this bill is expected to reduce expenditure in Medical Service Premiums by increasing the amount of client fraud recoveries. A reduction of \$54,156 is expected in FY 2012-13.
- SB 12-159 “Evaluation Children with Autism Medicaid Waiver”: This bill clarified the frequency and content of evaluations for children with autism seeking enrollment in the Medicaid autism waiver. Additional expenses for this activity are included in the Department’s forecast of Community-Based Long-Term Care services.
- HB 12-1340 “Nursing Facility Reduction Per Diem Rate”: This bill extended the 1.5% rate reduction to Class I Nursing Facility rates from FY 2011-12 that would have expired absent legislation. The estimated fiscal impact is shown in the table above, as the Department’s request for this action was included in the FY 2012-13 R-6 “Medicaid Budget Reductions Request.” Detailed calculations can be found in Exhibit H, Class I Nursing Facility Footnotes.

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

- *Client Overutilization Program Expansion (BRI-1)*: Increase enrollment by 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. The Department projects it will expand to 200 clients by January 2013 through more outreach efforts by its utilization management vendor and by completing the system change that will broaden the pool of providers who can participate. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department will continue to evaluate whether this payment is necessary to maintain at least 200 clients in the program.
- *Medicaid Reductions (BRI-5)*: This budget reduction item included a series of initiatives that were proposed to reduce Medicaid expenditure and meeting budget balancing goals. The initiatives imposed a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies, as listed below.
 - Pharmacy State Maximum Allowable Cost Expansion: Add more drugs to be placed on the SMAC list, reducing expenditure by \$1,833,334 in FY 2011-12 and annualized in FY 2012-13 to an additional reduction of \$166,666.
 - Reduce Rates for Specific Diabetes Supplies: Reduce payment for blood glucose/reagent strips from \$31.80 per box of 50 strips to the current median market price of \$18.00. This rate cut reduces expenditure by \$842,728 in FY 2011-12 and an additional \$150,066 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

- Reduce Payments for Uncomplicated Cesarean Section Deliveries: Reduce the amount paid for uncomplicated cesarean section deliveries to the amount paid for complicated vaginal deliveries, which reduces expenditure by \$6,276,004 in FY 2011-12 and an additional \$811,545 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Reduce Payments for Inpatient Renal Dialysis: Reduce the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers. This results in a reduction of \$1,418,733 in FY 2011-12 and an additional \$183,455 in FY 2012-13. The request amount also includes an adjustment to account for cash accounting.
 - Deny Hospital Readmissions within 48 Hours: Cease making a separate payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition, reducing expenditure by \$2,475,418 in FY 2011-12 and an additional \$320,094 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Prior Authorize Specific Radiology Services at Outpatient Hospitals: Require prior authorization in outpatient hospitals for MRIs, CT scans, PET scans, and SPECT scans, except for in emergency situations. This policy reduces expenditure by \$672,136 in FY 2011-12 and an additional \$3,720,409 in FY 2012-13. It is on track to be implemented in April 2012.
 - Normalize Consumer Directed Attendant Support Services Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. This results in a reduction of \$473,564 in FY 2011-12 and an additional reduction of \$1,204,144 in FY 2012-13 to community-based long-term care. The request amount was adjusted for a delay in the implementation date from July 2011 to March 2011, and it includes an adjustment to account for cash accounting.
 - Enforce Existing Limitations on Acute Home Health Services: Enforce requirement that prior authorization is needed for acute home health services beyond 60 days, reducing expenditure by \$1,131,555 in FY 2011-12 and an additional \$286,551 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
 - Reduction to Managed Care Organization: Incorporate the reductions to Medicaid fee-for-service in the rates paid to the Department's managed care organization, resulting in a reduction of \$1,906,233 in FY 2011-12 and an additional reduction of \$81,968 in FY 2012-13. The Department has adjusted its request to account for initiatives that were not appropriated and will therefore not affect the rates paid to the managed care organization.
- *Medicaid Budget Balancing Reductions (BA-9)*: In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

- Expand the Accountable Care Collaborative: Enroll 63,000 additional clients in the ACC by November 2011, for a total program enrollment of 123,000. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.
- Money Follows the Person Deinstitutionalization Efforts: Use grant funds to provide additional transitional services to move clients from nursing facilities to Community-Based Long-Term Care. The Department was unable to transition these clients due to receiving significantly less grant funds than anticipated. The clients specified in this initiative would be moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
- Limit Fluoride Application Benefit: Limit fluoride application benefit to a maximum of three applications per year, reducing expenditure by \$30,982 in FY 2011-12 and an additional \$6,101 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Limit Dental Prophylaxis Benefit: Restrict dental prophylaxis (routine dental cleaning) to two procedures per fiscal year, reducing expenditure by \$161,936 in FY 2011-12 and an additional \$31,892 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Eliminate Reimbursement for Oral Hygiene Instruction: Eliminate reimbursement for oral hygiene instruction. This results in a reduction of \$4,241,026 in FY 2011-12 and an additional \$835,251 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until March 2012, as the Department is awaiting feedback from a new utilization management contractor to appropriately implement the proposal. The Department adjusted its request accordingly. For FY 2011-12, expenditure is reduced by \$154,227, and for FY 2012-13, it is reduced by an additional \$400,840. The request amount also includes an adjustment to account for cash accounting.
- Require Specific Billing for Certain Home Health Visits: Require home health providers to specifically bill codes for brief visits in circumstances in which only a short visit is required, reducing expenditure by \$2,511,443 in FY 2011-12 and an additional \$636,809 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Provider Rate Reduction: Reduce acute care physical health provider rates by 0.75% and community-based long-term care providers by 0.5%, effective July 1, 2011. This results in a \$12,092,847 reduction in FY 2011-12 with an additional \$2,904,019 in FY 2012-13 to Acute Care, and a \$1,561,829 reduction in FY 2011-12 with an additional \$361,468 in FY 2012-13 to Community-Based Long-Term Care.

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

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount (Annualization)
State Allowable Cost Expansion	BRI-5	(\$1,833,333)	(\$1,833,334)	(\$166,666)
Reduce Rates for Diabetes Supplies	BRI-5	(\$842,727)	(\$919,340)	(\$150,066)
Reduce Payment for Uncomplicated C-Section	BRI-5	(\$6,276,004)	(\$6,846,550)	(\$811,545)
Reduce Payments for Renal Dialysis	BRI-5	(\$2,169,701)	(\$2,366,947)	(\$183,455)
Deny Payment of Hospital Readmissions 48 hrs	BRI-5	(\$2,475,418)	(\$2,700,456)	(\$320,094)
Prior Authorize Certain Radiology	BRI-5	(\$672,136)	(\$672,136)	(\$3,720,409)
Cap CDASS Wage Rates	BRI-5	(\$1,420,692)	(\$1,549,846)	(\$1,204,144)
Limit Acute Home Health Services	BRI-5	(\$1,131,555)	(\$1,234,424)	(\$286,551)
HMO Impact to Rates	BRI-5	(\$2,945,547)	(\$2,707,680)	(\$81,968)
Estimated ACC Net Savings(1)	BA-9	(\$9,537,806)	(\$4,768,903)	-
Clients Moved from Nursing Home	BA-9	(\$624,975)	(\$625,704)	\$0
Limit Fluoride Application Benefit	BA-9	(\$29,898)	(\$33,798)	(\$6,101)
Limit Dental Prophylaxis Benefit	BA-9	(\$156,274)	(\$176,658)	(\$31,892)
Limit Oral Hygiene Instruction	BA-9	(\$4,092,739)	(\$4,626,574)	(\$835,251)
Limit Physical and Occupational Therapy	BA-9	(\$446,504)	(\$504,744)	(\$416,301)
Home Health Billing Changes	BA-9	(\$2,423,629)	(\$2,739,756)	(\$636,809)
0.75% Acute Care Provider Rate Reduction	BA-9	(\$8,261,265)	(\$11,711,574)	(\$2,904,019)
0.5% CBLTC Provider Rate Reduction	BA-9	(\$1,507,220)	(\$2,260,830)	(\$361,468)
Total		(\$46,847,423)	(\$48,279,254)	(\$12,116,739)

(1) Savings from each of the ACC budget actions have been aggregated and are presented in the ACC section of the narrative.

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

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

SB 11-008 – Concerning Medicaid Eligibility for Children

This bill specifies the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children between the ages of six and 19. As of January 1, 2013, children under the age of 19 will be eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes the federal match for clients these clients will remain at the same level it would have had the clients enrolled in CHP+ instead of Medicaid, or 65%.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	2,499	\$2,833,686
FY 2013-14	16,320	\$18,317,437
FY 2014-15	18,887	\$20,745,330

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

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

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

As quality and performance incentives were previously funded after growth beyond the General Fund Cap and the provider fee was unable to fully fund all components of the supplemental payments, these quality and performance components were not always funded. Under this statute, quality and performance incentives take priority over growth beyond the General Fund cap. As a result, the provider fee is able to fully fund quality and performance incentives but can no longer fully fund growth beyond the General Fund cap.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

SB 11-177 – Concerning Pregnancy and Dropout Prevention

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

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

The Department anticipates receiving \$40,335 in FY 2012-13 and \$13,327 in FY 2013-14 to operate. While the Department had previously anticipated an expansion of the program, there have been no new providers added to the program. The Department currently assumes the program will continue to operate at current levels.

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

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

SB 11-211 – Concerning Tobacco Revenues Offsetting Medical Services

Also part of the JBC budget balancing package, this bill allows for the use of \$33,000,000 in tobacco tax funds for services in the Medical Services Premiums line. Of this amount, \$17,758,594 is from the Tobacco Education Program Fund, \$11,955,055 is from the Prevention, Early Detection, and Treatment fund, and \$3,286,351 is reappropriated funds from the Department of Public Health and Environment. The fiscal impact of this bill is accounted for in Exhibit A. This was one-time funding, and an annualization removing these funds from the FY 2012-13 base budget is seen in Exhibit A.

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

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

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

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

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

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

This bill authorized the Department to use \$15,775,670 in funds from the Primary Care fund as offset to General Fund expenditure in the Medical Services Premiums line. The fiscal impact of this bill is accounted for in Exhibit A. This was one-time funding and has been removed from the Department’s spending authority in FY 2012-13.

SB 11-250 – Concerning Eligibility for Pregnant Women

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

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	372	\$2,997,688
FY 2013-14	744	\$6,052,494
FY 2014-15	750	\$5,843,790

Federal Legislation

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

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

The Department estimates the difference in rates between July 1, 2009, and January 1, 2013, will generate an estimated \$4,950,838 total funds in FY 2012-13 and \$12,872,971 total funds in FY 2013-14, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July 1, 2009. This gap represents rate cuts that were taken since July 1, 2009, due to budget reduction measures. The Department estimates increasing rates to the July 1, 2009, level will increase expenditure by \$1,347,828 in FY 2012-13 and \$3,234,787 in FY 2013-14. These amounts will be matched by the federal government at the standard FMAP rates. The enhanced federal funding is not available in FY 2014-15. An annualization reducing expenditure to original levels can be found in Exhibit F, Acute Care.

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

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

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

FY 2013-14 BUDGET REQUEST: MEDICAL SERVICES PREMIUMS NARRATIVE

Colorado Choice Transitions (Money Follows the Person Grant)

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

The Department had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The Department anticipates approximately 100 clients will transition per calendar year beginning in January 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of \$8,188 total funds in FY 2012-13 and a reduction of \$603,033 in FY 2013-14. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Legislation

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

- *Evidence Guided Utilization Review (EGUR) (FY 2010-11 BA-12) and Prevention and Benefits for Enhanced Value (P-BEV) (BRI-1)*: This Budget Reduction Item increases FY 2010-11 expenditure by an estimated \$282,653, with an additional \$481,092 in FY 2011-12, in order to provide increased utilization review funding in order to create an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures, including fluoride treatment, and improve non-emergency medical transportation policies. Delayed implementation has shifted a portion of anticipated Medical Services Premiums savings to FY 2012-13. The Department estimates FY 2012-13 savings to be \$382,297 total funds. The revised implementation date for this initiative was November 1, 2011, when the Department began paying a new utilization management contractor.

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- *Coordinated Payment and Payment Reform (BRI-2):* This budget reduction item reduces expenditure in FY 2011-12 and FY 2012-13 for both Acute Care Services and Community-Based Long-Term Care Services. The table below demonstrates these reductions by service category.

This budget reduction item implements proposed steps toward payment coordination and payment reform. This request included four proposed initiatives which work in tandem to serve the goal of lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care. The initiatives aim to consolidate payment and billing processes, expand audits conducted by the Nursing Facilities Section, initiate a pilot audit of a Community Mental Health Center, and increase enrollment of Medicare-eligible clients into Medicare. In addition, the Department is targeting three, payment rate reform initiatives. The first, directed at Home- and Community-Based Services waivers, will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. A similar approach will be taken to investigate the potential to apply outcomes-based approach to the payment of physician payment rates. The third initiative targeted at changing the methodology of Federally Qualified Health Centers (FQHCs) payments aims to investigate the feasibility of creating an outcomes-based performance payment for FQHCs. Savings in FY 2012-13 are associated with the enrollment of Medicare eligible clients in Medicare. The Department has enlisted the services of a contractor to perform outreach to clients and to assist clients with the Medicare application project. The Department has revised savings estimates based on lower per-capita savings assumptions and lower than anticipated initiative participation rates as well as adjustments for partial delays in implementation. The estimated fiscal impact in FY 2012-13 is \$275,000.

- *Accountable Care Collaborative (S-6, BA-5):* The Department was appropriated an overall reduction in expenditure of \$514,730 in FY 2010-11, annualizing to \$10,268,779 in FY 2011-12 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning in FY 2010-11. For this request, the Department limited enrollment to 60,000 clients with the anticipation of enrolling more clients as the program becomes established. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.

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

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

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Additionally, payments of telemedicine reimbursements are contingent upon the receipt of gifts, grants, and donations in the newly created Home Health Telemedicine Cash Fund for FY 2011-12 and FY 2012-13. The bill increases Department expenditure by \$182,336 in FY 2012-13.

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

Client enrollment began late in FY 2011-12

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

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill originally reduced Department expenditure \$2,390,570 in FY 2010-11, and annualizing to \$3,699,827 in FY 2011-12, by requiring the Department to implement a number of initiatives. While the Department has been able to partially implement the components of SB 10-167, full implementation was not anticipated until spring of 2012. Consequently, a portion of the savings originally anticipated in FY 2010-11 has been shifted to FY 2011-12 and FY 2012-13. The initiatives are as follows:

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over 3 million in total) to achieve savings despite delays in implementation. The FY 2011-12 NCCI impact of \$12,500 reflects both delays in implementation and savings achieved through the manual implementing codes in FY 2010-11.

Rx Coordination of Benefits

The Rx Coordination of benefits program implements system changes that allow the Department to perform prepayment review of pharmacy claims to determine whether another party should be primary payer for the claim. A delay in system

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change implementation has resulted in a shift of savings from FY 2011-12 to FY 2012-13. Estimated savings for FY 2012-13 total \$321,990 and \$351,262 in FY 2013-14. The program was implemented August 1, 2012.

Colorado Medicaid False Claims Act:

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

Enhanced Internal Audits

Appoint an internal auditor and to ensure duplicate benefits are not being paid by other states to clients enrolled in Department programs through creating access to the Public Assistance Reporting Information System (PARIS) which will allow the Department to identify and eliminate clients receiving medical services premiums in other states.

Health Insurance Buy-In Program Expansion

Purchase private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the State by enrolling clients into individual insurance plans where enrollment is deemed cost-effective. This initiative has been delayed to implement in April 2012 to allow for contract execution. The Department has identified a vendor and began in July 2012. The vendor anticipates 90 clients will be enrolled per month until the maximum of 2,000 clients is reached.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2011-12 per-capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2012-13 through FY 2013-14.

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FY 2012-13 and FY 2013-14 Total HIBI Impact from SB 10-167		
Item	FY 2012-13	FY 2013-14
Provider Payment	\$317,955	\$315,068
Premiums Payment	\$1,365,554	\$2,443,792
Savings (Realized in Acute Care)	(\$3,340,516)	(\$5,984,276)
Total Impact	(\$1,657,007)	(\$3,225,416)

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

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

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

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

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

The Department anticipates full implementation by January 1, 2013. The Department will continue to evaluate the list of medications to determine any needed changes or additional opportunities for savings.

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Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider –in the instance of a PACE provider, the payment covers acute care and long-term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

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

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

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	Estimated Savings due to Pace Enrollments			
FY 2012-13	OAP-A	OAP-B	AND/AB	Total
Acute	(\$850,218)	(\$256,601)	(\$22,297)	(\$1,129,116)
CBLTC	(\$1,609,316)	(\$267,772)	(\$105,323)	(\$1,982,411)
Total	(\$2,459,535)	(\$524,373)	(\$127,620)	(\$3,111,528)
FY 2013-14	OAP-A	OAP-B	AND/AB	Total
Acute	(\$974,321)	(\$656,662)	(\$342,627)	(\$1,973,610)
CBLTC	(\$1,564,905)	(\$257,232)	(\$97,613)	(\$1,919,750)
Total	(\$2,539,226)	(\$913,894)	(\$440,240)	(\$3,893,360)
FY 2014-15	OAP-A	OAP-B	AND/AB	Total
Acute	(\$938,485)	(\$556,734)	(\$269,048)	(\$1,764,267)
CBLTC	(\$1,507,347)	(\$218,088)	(\$76,650)	(\$1,802,085)
Total	(\$2,445,831)	(\$774,822)	(\$345,698)	(\$3,566,352)

Managed Care Organization Reconciliations

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

HB 09-1047 – Concerning a Program for Providing Additional Therapies to Certain Persons with Disabilities Who are Eligible to Receive Medicaid

This legislation created a new HCBS waiver to allow chiropractic care, massage, and acupuncture services for clients with spinal cord injuries. The Department assumed clients would be moving from the EBD waiver to the Spinal Cord Injury (SCI) waiver and adjusted estimated enrollment by shifting 67 clients from the EBD waiver to the SCI waiver. Additional detail regarding this program can be found in the Community-Based Long-Term Care Section of the narrative.

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

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

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

This budget reduction item reduced FY 2009-10 expenditure by an estimated \$1,022,887, with an expected additional \$1,848,763 reduction in FY 2010-11, as the result of an automated prior-authorization system for pharmacy claims, as well as through changing the reimbursement rates for drugs using a state maximum allowable cost structure. The Department has adjusted savings estimates to reflect a delay in the implementation of the automated prior-authorization system. The system came online in October 2011. While the auto PA system is now operational, programming needs to be completed to fully implement the initiative. The Department estimates an annualization of \$1,217,310 in FY 2012-13.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefits package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients' care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The program began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently on track to achieve an enrollment level of 200,000 early in CY 2013. The central goals of the program are to improve health outcomes through a coordinated, client-centered system and to control costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

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

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

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

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

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

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

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. Due to attrition and replacement enrollments, it is no longer possible to isolate an original 60,000 member cohort or expansion cohort. Consequently, expenditure and savings adjustments are shown in aggregate for the program. It is of note the Department is estimating only a small increase to net savings, though adding 77,000 more clients. Because children make up a large portion of caseload in Medicaid, the greatest opportunity for ACC expansion lies within this population. As children also have relatively lower per-capita expenditure, the savings opportunity from enrollment in the ACC for this population is smaller than other populations. As a result the Department conservatively assumes net savings will increase by only a small amount relative to prior estimates. Further, RCCO rates have been adjusted to reflect the new case mix under an expanded program. As more data becomes available regarding program efficacy with children, the Department will revise this assumption in future requests.

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The chart below shows program expenditure and estimated savings for FY 2012-13, FY 2013-14, and FY 2014-15.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Program Administration (Exhibit I, PIHP)	SDAC	\$650,000	\$2,700,000	\$3,000,000	\$3,000,000
	RCCO	\$182,819	\$12,303,473	\$25,845,818	\$26,938,800
	PCMP	\$54,592	\$2,904,360	\$9,068,708	\$10,080,000
	Total Administration	\$887,411	\$17,907,833	\$37,914,526	\$40,018,800
Program Savings (Exhibit F, Acute)	Total		(\$20,616,544)	(\$43,844,251)	(\$46,478,732)
	Incremental⁽¹⁾			(\$23,227,707)	(\$2,634,481)
Net ACC Program Fiscal Impact				(\$5,929,725)	(\$6,459,932)

(1) The incremental value shown is equal to the annualization values in Exhibit F, Acute Care.