Schedule 13

Funding Request for the FY 2017-18 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-06 Delivery System and Payment Reform

Dept. Approval By: Josh Block 11/1/16

OSPB Approval By: 10/28/16

___ Supplemental FY 2016-17

X Change Request FY 2017-18

___ Budget Amendment FY 2017-18

Summary Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
Total of All Line Items Impacted by Change Request	Total	$7,523,128,643	$0	$7,459,234,975	$3,213,375	($33,540,103)
	FTE	400.3	0.0	400.6	0.0	4.6
	GF	$2,142,452,586	$0	$2,145,762,319	($200,342)	($11,049,780)
	CF	$727,601,371	$0	$700,405,967	($187,409)	($1,453,007)
	RF	$6,994,451	$0	$6,995,349	$0	$0
	FF	$4,646,080,235	$0	$4,605,628,397	$3,601,126	($21,037,316)

Line Item Information	Fund	FY 2016-17 Initial Appropriation	FY 2016-17 Supplemental Request	FY 2017-18 Base Request	FY 2017-18 Change Request	FY 2018-19 Continuation
01. Executive Director's Office, (A) General Administration - Personal Services	Total	$29,707,221	$0	$29,797,905	$0	$307,185
	FTE	400.3	0.0	400.6	0.0	4.6
	GF	$10,211,448	$0	$10,355,331	$0	$153,593
	CF	$2,994,337	$0	$2,952,905	$0	$0
	RF	$1,564,801	$0	$1,566,597	$0	$0
	FF	$14,936,635	$0	$14,923,072	$0	$153,592
01. Executive Director's Office, (A) General Administration - Health, Life, and Dental	Total	$3,434,070	$0	$3,673,458	$0	$39,636
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,230,952	$0	$1,316,506	$0	$19,818
	CF	$337,577	$0	$349,778	$0	$0
	RF	$104,755	$0	$104,635	$0	$0
	FF	$1,760,786	$0	$1,902,539	$0	$19,818

01. Executive Director's Office, (A) General Administration - Short-term Disability	**Total**	**$55,072**	**$0**	**$57,991**	**$0**	**$524**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$20,569	$0	$21,560	$0	$262
	CF	$4,588	$0	$4,796	$0	$0
	RF	$1,393	$0	$1,365	$0	$0
	FF	$28,522	$0	$30,270	$0	$262
01. Executive Director's Office, (A) General Administration - Amortization Equalization Disbursement	**Total**	**$1,434,489**	**$0**	**$1,613,687**	**$0**	**$13,764**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$535,695	$0	$600,009	$0	$6,882
	CF	$119,586	$0	$133,459	$0	$0
	RF	$36,269	$0	$37,816	$0	$0
	FF	$742,939	$0	$842,403	$0	$6,882
01. Executive Director's Office, (A) General Administration - Supplemental Amortization Equalization Disbursement	**Total**	**$1,419,546**	**$0**	**$1,613,662**	**$0**	**$13,764**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$530,115	$0	$600,009	$0	$6,882
	CF	$118,340	$0	$133,459	$0	$0
	RF	$35,891	$0	$37,791	$0	$0
	FF	$735,200	$0	$842,403	$0	$6,882
01. Executive Director's Office, (A) General Administration - Operating Expenses	**Total**	**$2,058,538**	**$0**	**$2,035,574**	**$0**	**$27,869**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$930,699	$0	$923,963	$0	$13,934
	CF	$71,522	$0	$67,439	$0	$0
	RF	$10,449	$0	$10,449	$0	$0
	FF	$1,045,868	$0	$1,033,723	$0	$13,935
01. Executive Director's Office, (A) General Administration - General Professional Services and Special Projects	**Total**	**$7,200,237**	**$0**	**$7,975,237**	**$0**	**$225,000**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,047,261	$0	$2,622,261	$0	$112,500
	CF	$1,527,500	$0	$1,227,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,625,476	$0	$4,125,476	$0	$112,500

	Total	**$6,818,264,595**	**$0**	**$6,752,893,112**	**$29,930,444**	**($32,753,794)**
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	GF	$1,942,439,768	$0	$1,945,000,281	$7,014,977	($11,075,966)
	CF	$705,708,120	$0	$678,832,273	$903,427	($1,237,656)
	RF	$5,240,893	$0	$5,240,893	$0	$0
	FF	$4,164,875,814	$0	$4,123,819,665	$22,012,040	($20,440,172)
	Total	**$653,650,029**	**$0**	**$653,658,674**	**($26,717,069)**	**($1,414,051)**
	FTE	0.0	0.0	0.0	0.0	0.0
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	GF	$181,949,404	$0	$181,920,888	($7,215,319)	($287,685)
	CF	$16,383,180	$0	$16,416,036	($1,090,836)	($215,351)
	RF	$0	$0	$0	$0	$0
	FF	$455,317,445	$0	$455,321,750	($18,410,914)	($911,015)

CF Letternote Text Revision Required?	Yes	X	No	**If Yes, see attached fund source detail.**
RF Letternote Text Revision Required?	Yes		No	X
FF Letternote Text Revision Required?	Yes		No	X
Requires Legislation?	Yes		No	X

Type of Request? Department of Health Care Policy and Financing Prioritized Request

Interagency Approval or Related Schedule 13s: None

Cost and FTE

- The Department requests an increase of $3,213,375 total funds, including a reduction of $200,342 General Fund in FY 2017-18 in order to continue the provider rate increase for select primary care codes, implement behavioral health payment reform, and account for technical adjustments for payment methodology changes.
- The Department requests a reduction of $33,540,103 total funds, including a reduction of $11,049,780 General Fund, and an increase of 4.6 FTE in FY 2018-19 in order to implement the Accountable Care Collaborative Phase II and primary care payment reform initiatives, and account for technical adjustments for payment methodology changes.

Current Program

- The Accountable Care Collaborative (ACC) Program is the core of the Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way. It is easier for members and providers to navigate and makes smarter use of every dollar spent.
- Current program successes include:
  - approximately $139 million in cumulative net costs avoided from FY 2011-12 through FY 2015-16;
  - an increase in payments tied to value;
  - lower emergency department use, hospital readmissions and high-cost imaging;
  - prevention of condition exacerbation through primary care; and
  - higher member satisfaction.

Problem or Opportunity

- The contracts for the Accountable Care Collaborative Regional Collaborative Care Organizations (RCCOs) will be reprocured for FY 2018-19, creating an opportunity to continue to strengthen the primary care system, advance the integration of physical and behavioral health care and increase payment tied to value.
- Physical and behavioral health are often connected through various comorbid conditions, but care is currently delivered through two separate, siloed systems.
- Many Department and federal initiatives share similar goals but payment mechanisms are not fully aligned.

Consequences of the Problem

- Clients who are not enrolled in the Accountable Care Collaborative may have difficulty navigating the current health care system, which is detrimental to client outcomes, especially for vulnerable populations with poor health literacy and limited access to resources.
- Disparate physical and behavioral health care systems result in worse outcomes for clients.
- Misaligned payment and incentive structures promote provider confusion and administrative burden.

Proposed Solution

- Implement the Accountable Care Collaborative Phase II in FY 2018-19, including mandatory enrollment, a focus on integrating physical and behavioral health care, and greater emphasis on value-based payments.
- Implement value-based payment components, including incentive alignment across initiatives and continuation of the primary care rate increases authorized in HB 16-1408.
- Implement behavioral health payment reform with payments tied to quality in FY 2017-18 and beyond.
- Account for technical adjustments for ongoing payment methodology changes.

Department Priority:	***R-6***
Request Detail:	***Delivery System and Payment Reform***

Summary of Incremental Funding Change for FY 2017-18	Total Funds	General Fund
Delivery System and Payment Reform	$3,213,375	($200,342)

Problem or Opportunity:

Nationwide, health care leaders, policymakers, stakeholders, and federal agencies such as the Centers for Medicare & Medicaid Services (CMS) have adjusted their focus to policies that reward integrated and value-based care in an attempt to improve health outcomes and bend the cost curve of medical care downward. Value-based purchasing, the foundation of value-based care, is defined as "any activity that a state Medicaid program is undertaking to hold a provider… accountable for the costs and quality of the care they provide."[1] The goal is to tie payments or incentives to behaviors that enhance effective care management, positive health outcomes, high quality care, and client engagement. The system transition can take many forms, including delivery system reform, improved care coordination and integration, payment reform, and incentive alignment.

Colorado has been taking steps to drive both delivery system and payment reform, to improve overall effectiveness of the system and ensure greater value-based purchasing through the Accountable Care Collaborative. The Department now has the opportunity to continue delivery system and payment reform activities through the next phase of the Accountable Care Collaborative.

This request addresses delivery system reforms through the Accountable Care Collaborative, such as the integration of physical and behavioral health, as well as value-based payment reforms associated with primary care services, vaccine stock rates, and behavioral health capitation rates. The Department is engaged in a number of other delivery system and payment reforms that are not reflected in this request, such as the consolidation of home and community based waivers and developing a conflict-free case management system.

Delivery System Reform

<u>The Accountable Care Collaborative Phase II</u>

The contracts for the Accountable Care Collaborative regional vendors, currently called Regional Collaborative Care Organizations (RCCOs), are scheduled to be reprocured for FY 2018-19 and the

[1] http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf

Department is taking this opportunity to implement major changes to evolve the program. This next iteration of the Accountable Care Collaborative, referred to as the "Accountable Care Collaborative Phase II", would advance the integration of physical and behavioral health care by creating one administrative entity responsible for managing physical and behavioral health, establishing mandatory enrollment of all Medicaid clients into the program and implementing value-based payment methodologies.

The Accountable Care Collaborative Phase II would leverage and build upon the successes of both the Accountable Care Collaborative and the Community Behavioral Health Services Program to enhance the member and provider experience, improve member health, and use state resources to their highest good in an efficient and effective system of care. Current successes of the Accountable Care Collaborative include approximately $139 million in net costs avoided from its inception in FY 2011-12 through FY 2015-16; lower rates of hospital readmissions and high-cost imaging; preventing the exacerbation of conditions through primary care use; and increased member satisfaction[2].

Integration of Physical and Behavioral Health

The Department currently has distinct systems for the delivery of physical health and behavioral health care. The coordination of physical and behavioral health presents an opportunity to improve outcomes for all members enrolled in the Accountable Care Collaborative; per the Health Home Information Resource Center brief: "More than 70 randomized controlled trials have shown collaborative care for common mental disorders such as depression to be more effective and cost-effective than usual care, across diverse practice settings and patient populations."[3]

That said, the Department anticipates the most benefit would be for members with complex behavioral health conditions with co-occurring physical health conditions. For example, a 2006 report, "Morbidity and Mortality in People with Serious Mental Illness," found that individuals "with serious mental illness (SMI) die, on average, 25 years earlier than the general population," and that the "increased mortality and morbidity are largely due to preventable conditions" such as cardiovascular disease, diabetes, respiratory disease, and infectious disease[4].

One of the most significant differences between the current Accountable Care Collaborative and the Accountable Care Collaborative Phase II would be the integration of physical and behavioral health under one administrative entity. This new entity would be called the Regional Accountable Entity (RAE) and would be responsible for promoting the population's health and functioning, coordinating care across disparate providers, interfacing with long-term services and supports (LTSS) providers, and collaborating with social, educational, and justice agencies to foster healthy communities and to address complex needs that span multiple agencies and jurisdictions. A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to all

[2] November 1, 2016 Legislative Request for Information #3 Accountable Care Collaborative Organization

[3] Unützer J, et al., (2013.) The Collaborative Care Model: An approach for integrating physical and mental health care in Medicaid health homes, *Health Home IRC*, available at: http://www.medicaid.gov/

[4] http://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

members. Having one entity would improve the member experience by creating one point of contact and clear accountability for care.

In addition to the creation of the RAEs, the Department would support increased integration of physical and behavioral health care and support increased access to behavioral health service for clients by making changes to the delivery and reimbursement of behavioral health services. For the core behavioral health services, the Department would retain a capitation payment methodology and the capitation would be paid to the RAEs, which would be responsible for optimizing mental health and wellness for all Medicaid enrollees in their region. In addition, the Department would limit the covered diagnosis requirements for capitated behavioral health benefits and reimburse more behavioral health services delivered within primary care settings for low acuity and brief episodic conditions.

Mandatory Enrollment

Client engagement is linked to improved client outcomes. There is evidence that more than client behavior influences client engagement. Health care providers and their contact with clients play a role in client engagement as well, especially in behavioral health, and can increase client compliance with treatment recommendations and adherence to treatment plans[5].

In the current Accountable Care Collaborative, new Medicaid clients are not enrolled in the Accountable Care Collaborative for one to three months following their eligibility determination, missing an opportunity to quickly affect change in the lives of all clients, especially those who are particularly vulnerable, such as those newly released from prison or jail. Navigating the complex health care system and getting physical and behavioral health needs met can be difficult for clients who are not enrolled in the Accountable Care Collaborative and lack such program supports.

All eligible full-benefit Medicaid clients[6] would be mandatorily enrolled in the Accountable Care Collaborative in Phase II, to ensure that clients are able to benefit from the program immediately upon being determined eligible for Medicaid. Clients would have their choice of primary care medical providers (PCMPs), but would not be able to dis-enroll from the Accountable Care Collaborative. Mandatory enrollment would encourage engagement in health care services and outcomes, especially for vulnerable populations such as clients receiving long-term services and supports, clients transitioning between health care settings, and populations who are served by multiple systems, such as children involved with Child Welfare, individuals newly released from jails, and those who are homeless.

Value-Based Payment

The Accountable Care Collaborative was designed to support the shift in payment within Medicaid to value-based models. For Phase II, the Department is committed to implementing innovative payment practices that reward efficiency, quality, coordination and health improvement and disincentive duplication of services, overuse of low value services, and fragmentation of care. Similar to the current Accountable Care Collaborative, the RAEs would receive an administrative per-member per-month (PMPM) payment to

[5] Bright, F. A. S., Kayes, N. M., Worrall, L., & McPherson, K. M. (2015). A conceptual review of engagement in healthcare and rehabilitation, *Disability and Rehabilitation*, 37:8, 643-654, DOI: 10.3109/09638288.2014.933899

[6] Clients in managed care programs such as the Program of All-Inclusive Care for the Elderly are not eligible for the Accountable Care Collaborative.

support health promotion activities within the region, investments for the efficient, affordable delivery of care within the region, and to ensure appropriate coordination of care for members. In the next iteration of the Accountable Care Collaborative, the Department is changing the way the PMPM is currently distributed to primary care medical providers. Instead of making a medical home payment directly to providers the Department would make the entire payment to the RAE. This would enable the RAE to design flexible funding arrangements to support primary care medical providers and other regional health care providers for participation in working to achieve the goals and objectives of the Accountable Care Collaborative. A minimum percentage of the RAE's PMPM must be distributed to the regional network of providers. The RAEs would have flexibility to negotiate with PCMPs in how they receive their funding but all PCMPs would have an option of receiving a PMPM payment, similar to the current arrangement.

The Department would pay the RAEs approximately $15.50 PMPM. This is comprised of: (1) the RCCOs' current PMPM and withhold for incentives; (2) the current primary care medical provider PMPM and withhold for incentives; and (3) an additional $1.00 PMPM to reflect the increased workload associated with increased contract requirements and more accountability for health outcomes and total cost of care in Phase II of the Accountable Care Collaborative.

The Department would continue to withhold $3.75 PMPM of the $15.50 administrative PMPM for a Pay for Performance program. RAEs would be able to earn performance payments based on meeting or exceeding targets for up to nine Key Performance Indicators that indicate progress toward program goals. Any monies not distributed for performance on Key Performance Indicators would be used to reinforce and align evolving program goals, such as funding provider participation in new state or federal initiatives aligned with the Accountable Care Collaborative or new priority performance targets for the RAEs. As with the administrative PMPM, the RAE would have responsibility for sharing incentive payments with network providers in a way that furthers the goals and objectives of the program.

Payment Reforms

Initiative Alignment

The Department has had the opportunity to observe various value-based purchasing initiatives in other states and at the federal level. The Department has also participated in numerous initiatives with a focus on increasing value-based payments, including the current Accountable Care Collaborative, CMS's Comprehensive Primary Care Initiative (CPCi) and the State Innovation Model (SIM) Initiative[7].

One of the Department's goals is to further align payment reform initiatives, such as CPCi and its next iteration, Comprehensive Primary Care Plus (CPC+), SIM, and the Accountable Care Collaborative, and those outlined under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Alignment across initiatives and across payers increases the likelihood that providers will participate and that the initiative will be successful.

[7] The SIM initiative is a CMS initiative that provides financial and technical support to states for developing and testing innovative payment and service delivery models. More information can be found at https://innovation.cms.gov/initiatives/state-innovations

Primary Care

Investing in primary care is a critical component of addressing the rising cost of health care as primary care is frequently the earliest point of intervention for conditions that get more expensive to treat the longer they go untreated; primary care is the foundation of wellness and prevention. While it is important that the State continue to invest in primary care, it is also important to continue to drive improvements and innovation in the delivery system. The Department is working with stakeholders to explore different value-based payment models that increase provider flexibility, reward performance, and align with other state and national payment reform initiatives while holding providers accountable for quality and access.

To maintain investment in primary care and create a glide-path for practices to earn reimbursement based on performance, the Department requests to continue rate increases on par with the HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA" primary care rate bump in FY 2017-18. In FY 2018-19 and beyond, primary care providers (excluding Federally Qualified Health Centers (FQHCs)) would receive regular fee-for-service (FFS) payments based on the fee schedule set prior to the primary care rate bump for primary care services. Providers that are PCMPs in the Accountable Care Collaborative Phase II and meet certain criteria and performance standards would also be eligible to earn higher reimbursement equivalent in aggregate to what they could have earned under the provider rate bump. For the highest performers, reimbursement could be higher than they would have earned at current reimbursement rates. Reimbursement would be linked to a PCMP's ability to leverage team-based care practices, enhanced care management activities, member engagement, and quality improvement strategies to deliver more efficient, cost effective care and to improve client health. The Department would continue to work with stakeholders to develop the payment methodology in an effort to ensure that the model achieves the desired goals.

As referenced above, PCMPs would also receive payment from the RAEs to help ensure they are able to overcome obstacles that would otherwise prevent them from achieving their quality goals. Providers would work with their RAE to determine the best methodology for these payments.

Though FQHCs provide primary care under the Accountable Care Collaborative, their payments are currently paid above federally required reimbursement and they do not have incentives built into their rates. The current payment structure creates an opportunity to tie a portion of FQHC payments to quality and outcomes in order to align with other primary care providers in the Accountable Care Collaborative. Similar to work with primary care, the Department would work with FQHCs through a technical support grant from the National Academy for State Health Policy (NASHP) to develop a monthly payment model for FQHC services that would allow FQHCs greater flexibility in the provision of services to better meet the needs of clients and ultimately drive down the cost of care. The additional flexibility provided under this model would be coupled with accountability for quality and access similar to other primary care payment models.

Vaccine Stock Rates

Many of the vaccine stock rates used by the Department are outdated and result in inefficient reimbursement for providers. When a new vaccine enters the market, the rate for that immunization is set equal to the retail price from a price list published by Center for Disease Control (CDC), but the rate is not adjusted on an ongoing basis after its initial setting. The CDC Vaccine Price List provides the current private sector vaccine prices and is recognized as a transparent methodologic basis for vaccine rates by the American Academy of

Pediatrics as well as the Academy of Family Physicians[8]. Private sector prices are those reported by vaccine manufacturers annually to the CDC and serve as a benchmark for vaccine prices.

Currently, after the rates are set, they remain unchanged year-over-year, even as the costs of the vaccine stocks change as drugs enter or leave the market. Upon review of current rates, many immunizations are above the retail price published by the CDC and some are below the retail price. When an immunization patent expires, the price for that immunization generally decreases in order to stay competitive with the generic version of that immunization. Without a benchmark to annually adjust rates, the Department continues to pay the higher, brand-name cost for the immunization, resulting in over-reimbursement to providers. Conversely, without a benchmark to set rates, the Department is unable to adjust prices to keep up with smaller inflationary price increases, resulting in under-reimbursing providers in some circumstances. The inconsistency of vaccine stock rates results in a lack of transparency for providers and, overall, overpayment to providers for the cost of vaccine stock. To address this, the Department would set reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the CDC. In doing so, the Department would increase transparency in the immunization rate setting process for providers and more accurately reimburse providers for the cost of vaccine stock. The CDC Vaccine Price List provides the private sector vaccine prices, which are reported by vaccine manufacturers annually to the CDC and serve as a strong benchmark by which to base rates. The Department would update immunizations rates annually to account for changes in the retail price published by the CDC.

Behavioral Health

The behavioral health capitation rates decreased significantly in FY 2016-17, in part due to a change in pricing methodology of the behavioral health encounter data to comply with new federal managed care regulations[9]. The Department anticipates that there will be a further reduction in rates in FY 2017-18, as described in the Technical Adjustments section below.

To mitigate these reductions and ensure that providers have adequate flexibility to address the complex needs of the Coloradans they serve, the Department proposes to pay an offsetting increase over the capitation rate for BHOs (and, later, RAEs) as an incentive payment for improved performance beginning in FY 2017-18. This additional increase would be paid as incentive payments for community mental health centers (CMHCs) and BHOs meeting innovation and quality goals.

The incentive payment would reward performance and quality, such as rewarding growth of behavioral health treatment capacity in the primary care setting while also creating alignment with other payment reform initiatives. This methodology change would also help mitigate the expected rate reductions in FY 2017-18 and allow BHOs and, later, RAEs more flexibility to implement innovative behavioral health programs based on evidence-based practices.

[8] http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
[9] The new regulations are based on significant changes to 42 CFR Parts 431, 433, 438, 440, 457, and 495.

Colorado received a planning grant[10] for certified community behavioral health clinics (CCBHCs), designed to fund Colorado's preparation for participation in a demonstration program[11] under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA). While Colorado is not guaranteed for selection in the CCBHC demonstration program, CMS expects all states that received a planning grant to submit an application to participate in the two-year demonstration. If selected for the demonstration, Colorado would have the opportunity to earn an enhanced 65% federal medical assistance percentage (FMAP) for standard match clients for qualifying services provided by CCBHCs.

The Department assumes that, if it is selected for participation in the demonstration program, this would result in General Fund savings that would offset a portion of the cost of paying incentive payments over the capitation rate. The Department would ensure that the net impact of the savings from the enhanced match, the rate reduction, and the increase for incentive payments would be budget neutral or budget negative.

Technical Adjustments

The Department has included two technical adjustments in this request for the impacts of ongoing payment reform work in FY 2017-18 and forward.

Reimbursement Methodology Change for Outpatient Services

On October 31, 2016, the Department switched to the Enhanced Ambulatory Patient Grouping (EAPG) system, a form of bundled payment, for reimbursement for outpatient hospital services. Previously, outpatient hospital services were paid as a percent of cost. This payment reform aligns with inpatient hospital services' Diagnosis-Related Group (DRG) payment methodology and removes the need to pay outpatient hospital services at an inflated rate and reconcile retroactively. This will result in savings during the interim when the Department pays for these services appropriately up front but still receives reconciliation payments from hospitals for overpayments in previous fiscal years. The Department has been unable to make this methodology change until the implementation of the new MMIS. While the Department expects this methodology change to be budget neutral in the long term, it is budget negative in the short term while the Department continues to receive reconciliations for past overpayments. The savings for FY 2016-17 forward are accounted for in this request.

Federal Managed Care Regulations Impact on Behavioral Health Capitation Rates

The Department anticipates a drop of approximately 4% in behavioral health capitation rates from FY 2016-17 to FY 2017-18 due to new federal managed care regulations. In FY 2017-18, federal regulations require the Department to set an actuarially certified rate point, rather than negotiating a rate within the actuarially certified rate range. The Department expects this point to be lower than the FY 2016-17 rate by approximately 4%, since the FY 2016-17 rate is near the top of the rate range. Therefore, the Department expects another reduction in the behavioral health capitation rate in FY 2017-18, and the effects of that reduction are accounted for in this request.

[10] http://www.samhsa.gov/section-223/about
[11] http://www.samhsa.gov/section-223

Proposed Solution:

The Department requests an increase of $3,213,375 total funds, including a reduction of $200,342 General Fund in FY 2017-18 and a reduction of $33,540,103 total funds, including a reduction of $11,049,780 General Fund and an increase of 4.6 FTE in FY 2018-19 and future years in order to implement the Accountable Care Collaborative Phase II and associated payment reform. In FY 2017-18, the requested funding would be used to prepare for implementation of the Accountable Care Collaborative Phase II, continue the primary care provider rate increase approved in HB 16-1408, as well as develop behavioral health care incentives to reward innovation and value-based care. In FY 2018-19, the requested funding would be used to implement the Accountable Care Collaborative Phase II as well as value-based payment reform within primary care and federally qualified health centers (FQHCs).

The Department has broken down the components of the requested funding below.

Delivery System Reform

FY 2017-18

The Accountable Care Collaborative Phase II

During FY 2017-18, the Department would continue to prepare for the implementation of the Accountable Care Collaborative Phase II. This work includes activities such as meeting with stakeholders, working with CMS on waiver authority for the program, and drafting the vendor contracts. Any transition costs needed as the new RAE vendors become fully operational are included in a separate request, FY 2017-18 R-11 "Vendor Transitions."

FY 2018-19

The Accountable Care Collaborative Phase II

The Department intends to implement the Accountable Care Collaborative Phase II on July 1, 2018. The Accountable Care Collaborative Phase II has multiple components including the integration of physical and behavioral health under one administrative entity, implementing mandatory enrollment for all eligible clients and changing the Regional Accountable Entities' PMPM to promote value-based care. The Department anticipates that this portion of the request would result in a reduction of $68,581,872 total funds, including a reduction of $21,901,670 General Fund, due to improved clinical outcomes as a result of increased integrated and coordinated care. The Department's request includes 4.6 FTE in FY 2018-19, annualizing to 5.0 FTE in FY 2019-20, as described in the 'Assumptions and Calculations' section and appendix A of this request.

Payment Reform

Primary Care

For FY 2017-18, the Department requests $54,085,240 total funds, $18,772,007 General Fund[12] to continue the primary care rate increases authorized in HB 16-1408 into FY 2017-18, trended forward for expected caseload growth. For FY 2018-19, the Department requests $58,062,151 total funds, $20,231,923 General Fund, for primary care rate reform. A half-month of expected claims runout from the request to continue the

[12] HB 16-1408 appropriated funding from the Children's Basic Health Plan Trust fund for this purpose; the Department is requesting General Fund for FY 2017-18. In addition, this figure is adjusted for actual utilization of these codes in FY 2015-16, trended by caseload growth.

primary rate increase in HB 16-1408 in FY 2017-18 would increase this amount by $2,351,532 total funds, $819,398 General Fund for a total of $60,413,683 total funds, $21,051,321 General Fund.

Continued funding of the primary care rate increases authorized in HB 16-1408 would allow primary care providers and the Department to continue to work together to develop a value-based payment model for primary care to be implemented for FY 2018-19. The Department has been working with primary care stakeholders since the end of the 2016 legislative session and would continue this collaboration through FY 2017-18 leading up to implementation. Further, by leveraging this opportunity to engage in primary care payment reform, Colorado physicians would make progress towards meeting MACRA payment reform targets. This would allow physicians to receive not just increased Medicaid reimbursement, but also increased Medicare reimbursement.

The Department would work closely with stakeholders to develop and implement a primary care alternative payment methodology to replace the temporary primary care rate bump authorized under the Affordable Care Act Section 1202 and in HB 16-1408 This would align with other national payment reform initiatives, and increase the amount of payments tied to quality.

Vaccine Stock Rates

The Department requests a reduction of $994,353 total funds, including a reduction of $250,958 General Fund in FY 2017-18, and a reduction of $1,022,420 total funds, including a reduction of $255,171 General Fund in FY 2018-19, in order to annually set reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the CDC. Going forward, the Department would update immunizations rates annually to account for changes in the retail price published by the CDC.

Behavioral Health

The Department requests to pay incentive payments in addition to the capitation rate for behavioral health services, as authorized under 42 CFR § 483.6(c)(5)(iii), beginning in FY 2017-18. This additional funding would be paid as incentive payments for CMHCs and BHOs meeting innovation and quality goals. The Department does not anticipate a payment for this purpose in FY 2017-18, as payments attributable to a given fiscal year would be made in the following fiscal year.

The Department requests $26,717,069 total funds, $7,215,319 General Fund, in FY 2018-19 to pay incentive payments from the rate reduction in FY 2017-18.

The Department also requests $225,000 total funds, $112,500 General Fund, in one-time funding in FY 2018-19 for contractor costs for actuarial equivalency certification and rate rebasing for the CCBHC demonstration and would include analysis, certification, and answering follow-up questions with CMS, as well as actuarial work for rebasing rates due to programmatic changes. The requested funding is based on contracts with similar scope.

Technical Adjustments

The Department requests a reduction of $49,877,512 total funds, including a reduction of $18,795,541 General Fund, in FY 2017-18, and a reduction of $51,291,563 total funds, including a reduction of $17,272,079 General Fund, in FY 2018-19, to account for technical adjustments of ongoing rate reform work,

specifically the change in outpatient hospital services reimbursement methodology to an EAPG methodology and the expected 4% reduction in behavioral health capitation rates.

Program Evaluation

In addition to the continuation of the delivery system and payment reform initiatives, the Department requests $150,000 total funds, $75,000 General Fund in FY 2019-20 to hire a contractor to evaluate the effectiveness of each of the initiatives. The contractor would produce a report that studies whether the desired outcomes were achieved and would make recommendations on how to increase the effectiveness of the reforms. The Department requests that this funding be appropriated each year thereafter, to allow for annual program evaluations.

Anticipated Outcomes:

The components of this request focus on strengthening the primary care system, advancing the integration of physical and behavioral care and increasing payment tied to value. These activities strongly align with the Department's mission of improving health care access and outcomes for the people the Department serves while demonstrating sound stewardship of financial resources.

Delivery System Reform

The Accountable Care Collaborative Phase II

Integration of Physical and Behavioral Health Care

An integrated physical and behavioral health care system would help clients receive the care they need to optimize their health and well-being. Studies have shown that especially clients with complex physical and behavioral health conditions face obstacles which prevent them from receiving appropriate care. Inappropriate or inadequate care can worsen preventable conditions and result in higher cost care, poor client experience and decreases in health outcomes. Integrating the administration of physical and behavioral health care would potentially create savings opportunities and improve health outcomes and client experience. This aligns with State Innovation Model (SIM) Initiative and work that other payers in Colorado are advancing.

This initiative falls under the Department Performance Plan goals of creating an integrated delivery system for improving client outcomes and containing costs.

Mandatory Enrollment

Mandatorily enrolling all full-benefit Medicaid clients in the Accountable Care Collaborative Phase II would immediately connect clients with a PCMP if they do not already have one, and would give clients access to the full benefits of the Accountable Care Collaborative program. Client engagement has been shown to make health care service delivery more effective and is crucial to high-quality care, improving outcomes and preventing waste of resources[13].

This aligns with the Department Performance Plan's customer-focused strategies, specifically improving health outcomes and member experience, and the goal of member engagement.

[13] Graffigna, G., Barello, S., & Triberti, S. (2015, November). Patient Engagement: A Consumer-Centered Model to Innovate Healthcare. Retrieved from http://www.degruyter.com/view/product/466090

Value-Based Payment
The RAEs would be responsible for making payments directly to the PCMPs which allows for more flexible funding arrangements to support primary care medical providers and other regional health care providers for participation in working to achieve the goals and objectives of the Accountable Care Collaborative. Implementing this approach would allow the RAE to reward efficiency, quality, coordination and health improvement. This approach would also support providers in providing appropriate and cost-effective care, improve health outcomes, and enhance member and provider satisfaction. Finally, this would disincentivize duplication of services, overuse of low value services, and fragmentation of care.

This falls under the Department Performance Plan's goals of improving benefit and program design and payment methodology, and supports sustaining effective external relationships with providers.

Payment Reform
Initiative Alignment
Alignment across initiatives at both the State and federal level would drive multiple positive outcomes for providers. Aligned incentives reduce administrative burden for providers, create an opportunity for providers to leverage multiple streams of funding including federal initiatives, and furthers providers' ability to achieve practice transformation goals. Experts suggest a need for federal government and states "to align on a broad set of payment reform goals" and that aligning with Medicare reform initiatives can help ensure that state initiatives are sustainable.[14]

This falls under the Department Performance Plan's goals of improving benefit and program design and payment methodology, as well as supporting an integrated delivery system, and supports sustaining effective external relationships with providers.

Primary Care and Behavioral Health
Tying a greater proportion of payments to value for non-FQHC primary care providers, FQHCs and CMHCs would allow the Department to pay providers at rates that maintain access to care and, at the same time, reward innovation and quality and contribute to lower costs. Clearly defined and aligned objectives would incentivize providers to provide care that would improve health outcomes and lower costs.

This meets the Department Performance Plan's goals of improved benefit and program design, payment methodology, and cost containment and aligns with the strategies of improving health outcomes, member experience, and lower per capita costs, sustaining effective external relationships with providers, and ensuring sound stewardship of financial resources.

Assumptions and Calculations:

Please see Appendix A for detailed descriptions of the 5 FTE requested to support implementation of the Accountable Care Collaborative Phase II and payment reform initiatives, and appendix B for more information on calculations.

[14] http://www.nashp.org/sites/default/files/Aligning.Federal.State_.Payment.Reform.pdf

Delivery System Reform

The Accountable Care Collaborative Phase II

Integration of Physical and Behavioral Health

The Department assumes that a source of new savings in the Accountable Care Collaborative Phase II would come from the integration of physical and behavioral health. Many studies and reports propose the opportunity for significant savings in this arena, especially for clients with physical and behavioral health conditions. However, very little statistical evidence currently exists to determine what to expect with this integration of care.

A 2001 study[15], rated "fair" due to large loss to follow-up in a literature review[16] on the subject, suggests that patients with serious and persistent mental illness (SPMI) in an integrated care clinic cost approximately $1,533 less for total care than patients with SPMI treated in a general medicine clinic. The study suggests that while primary costs were estimated at $1,582 per patient in the integrated clinic, versus $398 per patient in the general medicine clinic, this increase was offset by a reduction in inpatient costs from $2,673 per patient in the general medicine clinic to $410 per patient in the integrated care clinic. These findings are supported in the significant improvement to client outcomes found in a 2010 study[17], as well, which was rated as "good" in the same literature review, though it did not investigate changes to costs. The literature review was referenced as an integration resource by the Substance Abuse and Mental Health Services Administration (SAMHSA)[18].

It is difficult to determine what components make up the decrease in costs of $1,533 for clients in the integrated care clinic, so instead calculated the offset between inpatient savings and primary care costs, for a total decrease of $1,079. In order to remain conservative, due to the age and small sample size of the study, the Department used half of this estimated cost savings to calculate savings due to whole-person, integrated care for individuals with SPMI. The study relied on 6- and 12-month follow up data, so the Department divided by 12 for an estimated monthly savings per client of $44.96.

Another study from 2003[19], rated "good" in the same literature review referenced above, suggests that integrating substance abuse treatment and primary care resulted in a reduction in total medical costs of $231.09 per member month for clients treated in integrated care versus a matched sample of clients treated in independent care. Depending on whether clients had substance abuse-related medical conditions, at least one medical condition in addition to substance use disorder, or at least one psychiatric condition, total medical

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[15] Druss, B. G., Rohrbaugh, R. M., Levinson, C. M., Rosenheck, R. A. (2001). Integrated Medical Care for Patients with Serious Psychiatric Illness: A Randomized Trial. *Archives of General Psychiatry*. 58(9): 861-868. doi:10.1001/archpsyc.58.9.861

[16] Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund. Retrieved from: http://www.milbank.org/uploads/documents/papers/Integrating-Primary-Care-Report.pdf

[17] Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral, and Evaluation (PCARE) Study. *The American Journal of Psychiatry.* 167(2):151-159. doi: 10.1176/appi.ajp.2009.09050691

[18] http://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health

[19] Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care. *Medical Care*. 41(3): 357-367. doi:10.1097/00005650-200303000-00004

savings estimates ranged up to $343.67 per member month, primarily due to a reduction in inpatient hospital use as well as emergency room use.

To remain conservative, the Department chose the savings estimate of $231.09 and divided it by three due to the age of the study and lack of clarity around milder cost reductions for the control population in the study, for a total monthly savings estimate of $77.03 per client.

To estimate the populations that would achieve savings, the Department trended forward FY 2014-15 data for clients with SPMI and clients with substance use disorder (SUD) by half of actual and estimated caseload growth from FY 2015-16 forward. The Department assumes that the penetration rate of these clients enrolling in the Accountable Care Collaborative Phase II would be similar to the penetration rate of the populations of elderly and individuals with disabilities (discussed further under Mandatory Enrollment) due to their medical complexity. The Department also assumes that only 75% of these clients enrolled in the Accountable Care Collaborative Phase II would be receiving integrated, coordinated care. Therefore savings would only be attributable to this percentage of Accountable Care Collaborative Phase II enrollees estimated to have these conditions. The Department has accounted for estimated clients with comorbidities between SUD and SPMI under the expected savings for clients with SUD.

The Department assumes that there would be a six-month delay from the start of the Accountable Care Collaborative Phase II before beginning to see savings to accommodate for time lag related to first visit and claims submission Please see tables 4.1 through 4.5 of Appendix B for more detailed information on these calculations.

Mandatory Enrollment and Value-Based Payment

The Department estimates savings separately for three distinct client groups in the Accountable Care Collaborative: Elderly and Individuals with Disabilities, Adults without Disabilities, and Children without Disabilities[20]. The Department assumes a higher penetration rate as a result of the change to mandatory enrollment. Clients in the Program of All-Inclusive Care for the Elderly, would not be eligible for the Accountable Care Collaborative Phase II and would therefore not be mandatorily enrolled into the program. Please see tables 6.1 through 6.3 of Appendix B for more detailed information on these calculations.

The Department calculated the difference in expected enrollment in the Accountable Care Collaborative Phase II with the higher penetration rate and expected enrollment in the current Accountable Care Collaborative with the lower penetration rate, for an incremental new enrollment estimate due to the Accountable Care Collaborative Phase II. This incremental enrollment would drive both costs and savings, and so the Department calculates both separately.

Costs stem from the additional expense of PMPM payments made to RAEs for these new clients. The Department assumes that the total PMPM would increase by $1.00 in the Accountable Care Collaborative Phase II, so the change in cost would be due to a combination of factors. These factors include the current

[20] More information can be found in the November 1, 2015 Legislative Request for Information #7 Accountable Care Collaborative Organization located at: https://www.colorado.gov/pacific/sites/default/files/Legislative%20Request%20For%20Information%20-%20Accountable%20 Care%20Collaborative%20%20-%20November%201,%202015.pdf

PMPM of approximately $14.50 on average (combining the current PMPMs for RCCOs and PCMPs) multiplied by the incremental increase in enrollment estimates, or the incremental cost due to new enrollment; the $1.00 PMPM increase multiplied by the enrollment estimates for the current Accountable Care Collaborative, or the incremental cost due to the change in PMPM; and the $1.00 PMPM increase multiplied by the incremental increase in enrollment estimates, or the compounded effect of the change in PMPM and the change in enrollment expectations. Please see tables 3.1 and 3.2 of Appendix B for more detailed information on these calculations.

The Department did not adjust its savings estimates for each population, in order to remain conservative in its estimates. Little cost savings information exists on the effect of integrated care coordination on relatively healthy populations, rather than specific, medically complex subpopulations such as those with SPMI or SUD diagnoses discussed above. Because savings assumptions are held constant between the current Accountable Care Collaborative and the Accountable Care Collaborative Phase II for the enrolled population, the Department calculates incremental savings due to new enrollment in the Accountable Care Collaborative Phase II as new enrollment for each savings category multiplied by estimated savings per capita for that category. To account for mandatory enrollment and all eligible Medicaid clients enrolling into the Accountable Care Collaborative Phase II within the first month of program implementation, the Department assumes that there would be a six-month delay before realizing savings in order to account for factors such as the time for patients to have their first visits and billing lag. The Department believes this represents a conservative lower bound for estimated savings due to incremental enrollment in the Accountable Care Collaborative Phase II over the current Accountable Care Collaborative. Please see Table 5.1 of Appendix B for more detailed information on these calculations.

Payment Reform

Primary Care

Primary Care (non-Federally Qualified Health Centers) Medical Providers

In order to calculate a base amount for the request to continue the primary care rate increase of HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA", the Department adds an adjustment for updated actual utilization rates for FY 2015-16 to the total amount appropriated for the increase in HB 16-1408. The Department assumes the Primary Care Sustainability Cash Fund would only be available for the primary care rate increase in HB 16-1408, and that any continuation thereafter would be funded with General Fund. To achieve an equivalent General Fund impact, the Department trends the estimated General Fund impact for FY 2016-17 forward by expected growth in caseload and calculates the corresponding cash and federal funds amounts based on expected utilization by eligibility for FY 2017-18 forward.

The Department calculates half a month of claims runout in FY 2018-19 for the request to continue the primary care rate increase into FY 2017-18. Otherwise, for FY 2018-19 forward, the Department would design an alternative payment model, with stakeholder feedback, that targets the General Fund calculation trended forward by caseload growth and anticipates payout as incentive payments. The Department would continue to work on the operational details of these payments, including timing and reimbursement mechanism. This methodology would ensure that the payment reform would be equivalent to the primary care payment increase currently appropriated by the General Assembly, with the benefit of tying payment to

quality and outcomes. Please see tables 7.1 through 7.3 of Appendix B for more detailed information on these calculations.

Federally Qualified Health Centers

The Department would lower the current payment to FQHCs at the alternate payment methodology (APM) rate to the payment at the prospective payment system (PPS) rate, but would offer the difference back to FQHCs as incentive payments tied to quality outcomes. The Department assumes that the FQHCs would achieve their full incentive payments, and so the Department expects this change to be budget neutral.

Vaccine Stock Rates

Tables 8.2 and 8.5 of Appendix B summarize the total estimated savings to vaccine stock by setting reimbursement for vaccine stock equal to the retail price published annually by the CDC. Tables 8.3 and 8.6 of Appendix B show FY 2017-18 and FY 2018-19 forecasted expenditure broken out by eligibility categories for vaccine stock under current rates, based on FY 2015-16 actual expenditure trended forward by estimated caseload growth. Tables 8.4 and 8.7 of Appendix B show FY 2017-18 and FY 2018-19 estimated expenditure broken out by eligibility categories for vaccine stock with rates set equal to the CDC price list trended forward by estimated caseload growth. The Department assumes utilization of vaccine stock would be unchanged if rates are set equal to the CDC price list.

Tables 8.11 and 8.12 of Appendix B show the projected FY 2017-18 impact to expenditure for individual vaccines due to the change in methodology, with the ten vaccinations with the highest expenditure shown separately. As an example, the most commonly used vaccination, the tetanus vaccination, is currently priced $37.24 over the retail rate from the CDC and would result in a projected $1,123,386 less expenditure in FY 2017-18 if set equal to the CDC rate.

Behavioral Health

The Department currently pays BHOs different capitation rates depending on the population. This would continue for the RAEs in the Accountable Care Collaborative Phase II. In order to calculate the amount of incentive payments, the Department estimates each of the populations with a different capitation rate separately, trended forward by expected caseload growth from the February 2016 S-2 "Behavioral Health Community Programs" budget request's FY 2017-18 estimates.

Federal regulations allow incentive payments up to 5% over capitation rates for behavioral health, but the Department only expects a 4% reduction in rates in FY 2017-18 (discussed further under Technical Adjustments). The Department assumes that each fiscal year's incentive payments would be paid out in the following fiscal year, to allow time to verify achievement of quality goals. Due to budget neutrality assumptions and design, these calculations are shown in detail in the tables calculating the impact of the rate reduction for the previous fiscal year, multiplied by -1. This represents the total cost of incentive payments for behavioral health tied to value. Please see Table 9.1 of Appendix B for more detailed information on these calculations.

Technical Adjustments

To calculate savings due to the continued receipt of reconciliation payments from hospitals for overpayments for outpatient services in previous fiscal years, after the Department has switched to an EAPG payment

methodology for these services, the Department calculated the average reconciliations for past time periods where the Department assumes reconciliation has fully taken place and trended this average forward by the average growth rate of reconciliations between fiscal years. To remain conservative, the Department has held the FY 2017-18 savings expectations constant through each of the fiscal years in this request. The Department assumes, based on historical information, that the majority of reconciliations take place for fiscal years approximately 4 to 7 years in the past. Therefore, the Department does not expect higher FMAP due to expansion in FY 2013-14 to appear in the reconciliations until approximately FY 2018-19.

To calculate savings due to the reduction of the behavioral health capitation rate in FY 2017-18 because of new federal managed care regulations, the Department assumes that the FY 2017-18 rates would have otherwise remained constant at the FY 2016-17 rate, with a small positive growth trend for rates in FY 2018-19, and calculates 4% of the capitation for each population forward for each fiscal year. The Department multiplies this amount by -1 and then multiplies by expected caseload for each population to calculate the estimated savings due to this reduction.

Please see tables 10.1 through 10.5 of Appendix B for more detailed information on these calculations.

Appendix A: FTE Descriptions

Position Name	Position Classification	Number of FTE	Description
Primary Care Payment Reform Analyst	Rate/Financial Analyst IV	1.0	This position would be tasked with transitioning the primary care fee schedule from the current static fee schedule to a dynamic fee schedule that is provider specific and changes frequently due to provider performance. The position would evaluate fee levels under the value-based purchasing models to ensure incentive payments remain within budget and that the Department pays the appropriate level of incentive to encourage behavior change and performance. Transitioning from a single fee schedule for primary care physicians to a model that adjusts based on provider specific performance is a major increase in the operational oversight required and rate policy analysis needed for the primary care benefit.
Program Evaluation Analyst	Analyst IV	1.0	The proposed position would measure and evaluate the performance and quality outcomes of the behavioral health integration efforts and the practice supports and program interventions implemented through the Accountable Care Collaborative Phase II. Position would conduct evaluations on a multitude of interventions in the Accountable Care Collaborative, specifically related to physical and behavioral health interventions, to ensure interventions are making the intended changes. Starting in FY 2019-20, position would also oversee and monitor the work of the contractor hired to evaluate the effectiveness of each of the initiatives. Position would provide recommendations for changes to the Accountable Care Collaborative based on evaluation activities.
Integrated Care Specialist	Analyst IV	1.0	This position would provide additional expertise in behavioral health and the integration of behavioral health and primary care to reflect the changed program oversight needs. As the current BHO program is run in 5 regions, additional staff are required to effectively monitor the behavioral health component for the 7 contracts of the Accountable Care Collaborative Phase II. Position responsibilities would include contract management and program oversight. In addition, this position would review audited and other financial reports to monitor the cost-effectiveness and value of integrated care services.

Position Name	Position Classification	Number of FTE	Description
Integrated Care Specialist - Communications	Administrator III	1.0	This position would provide additional expertise in behavioral health and the integration of behavioral health and primary care to reflect the changed program oversight needs. As the current BHO program is run in 5 regions, additional staff are required to effectively monitor the behavioral health component for the 7 contracts of the Accountable Care Collaborative Phase II. Position responsibilities would include contract management and program oversight. In addition, this position would provide communication expertise to support communicating with providers, clients, advocates, media, and national organizations regarding the integrated care policies and outcomes of the Accountable Care Collaborative.
Accountable Care Collaborative Client, Provider, and Special Populations Relations Specialist	Administrator III	1.0	This position would be responsible for managing client and provider complaints as well as with serving as a liaison for special populations. Transition across delivery system design can be confusing, creating higher work load as clients, providers, and other agency partners learn the new processes and systems. Position would ensure collaboration with other agencies to address systemic barriers to care and services and the role as client and provider liaison would ensure understanding of barriers at both the systemic and individual level. Position would work with the RAEs to ensure appropriate and necessary focus on high-risk, high-cost populations such as individuals receiving LTSS, children in the child welfare system, individuals with criminal justice involvement, and individuals experiencing housing insecurity.
	Total FTE	**5.0**	

Table 1.1 FY 2016-17 Cost Estimates with Fund Splits, by Appropriation (INFORMATIONAL ONLY)								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**		**Federal Funds**	**Notes/Calculations**
					Hospital Provider Fee	**BCCP Cash Fund**		
A	(1) EDO; (A) General Administration, Personal Services	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
C	(1) EDO; (A) General Administration, Short-term Disability	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
F	(1) EDO; (A) General Administration, Operating Expenses	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0	Table 2.1 Row G
H	(2) Medical Services Premiums	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Table 2.1 Row B + Table 2.1 Row D + Table 2.1 Row E + Table 2.1 Row H + Table 2.1 Row I + Table 2.1 Row K + Table 2.1 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$0	0.0	$0	$0	$0	$0	Table 2.1 Row J + Table 2.1 Row M
J	Total Costs	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Sum Row A through Row I

Table 1.2 FY 2017-18 Cost Estimates with Fund Splits, by Appropriation

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	(1) EDO; (A) General Administration, Personal Services	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
C	(1) EDO; (A) General Administration, Short-term Disability	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
F	(1) EDO; (A) General Administration, Operating Expenses	$0	0.0	$0	$0	$0	$0	No FY 2017-18 Impact
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$0	0.0	$0	$0	$0	$0	Table 2.2 Row G
H	(2) Medical Services Premiums	$29,930,444	0.0	$7,014,977	$889,558	$13,869	$22,012,040	Table 2.2 Row B + Table 2.2 Row D + Table 2.2 Row E + Table 2.2 Row H + Table 2.2 Row I + Table 2.2 Row K + Table 2.2 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	($26,717,069)	0.0	($7,215,319)	($1,090,537)	($299)	($18,410,914)	Table 2.2 Row J + Table 2.2 Row M
J	Total Costs	$3,213,375	0.0	($200,342)	($200,979)	$13,570	$3,601,126	Sum Row A through Row I

Table 1.3 FY 2018-19 Cost Estimates with Fund Splits, by Appropriation

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	(1) EDO; (A) General Administration, Personal Services	$307,185	4.6	$153,593	$0	$0	$153,592	From FTE Calculations
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$39,636	0.0	$19,818	$0	$0	$19,818	From FTE Calculations
C	(1) EDO; (A) General Administration, Short-term Disability	$524	0.0	$262	$0	$0	$262	From FTE Calculations
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$13,764	0.0	$6,882	$0	$0	$6,882	From FTE Calculations
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$13,764	0.0	$6,882	$0	$0	$6,882	From FTE Calculations
F	(1) EDO; (A) General Administration, Operating Expenses	$27,869	0.0	$13,934	$0	$0	$13,935	From FTE Calculations
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$225,000	0.0	$112,500	$0	$0	$112,500	Table 2.3 Row G
H	(2) Medical Services Premiums	($32,753,794)	0.0	($11,075,966)	($1,237,653)	($3)	($20,440,172)	Table 2.3 Row B + Table 2.3 Row D + Table 2.3 Row E + Table 2.3 Row H + Table 2.3 Row I + Table 2.3 Row K + Table 2.3 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	($1,414,051)	0.0	($287,685)	($215,140)	($211)	($911,015)	Table 2.3 Row J + Table 2.3 Row M
J	Total Costs	($33,540,103)	4.6	($11,049,780)	($1,452,793)	($214)	($21,037,316)	Sum Row A through Row I

Table 1.4 FY 2019-20 Cost Estimates with Fund Splits, by Appropriation

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	(1) EDO; (A) General Administration, Personal Services	$335,135	5.0	$167,567	$0	$0	$167,568	From FTE Calculations
B	(1) EDO; (A) General Administration, Health, Life, and Dental	$39,636	0.0	$19,818	$0	$0	$19,818	From FTE Calculations
C	(1) EDO; (A) General Administration, Short-term Disability	$570	0.0	$285	$0	$0	$285	From FTE Calculations
D	(1) EDO; (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$15,015	0.0	$7,508	$0	$0	$7,507	From FTE Calculations
E	(1) EDO; (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$15,015	0.0	$7,508	$0	$0	$7,507	From FTE Calculations
F	(1) EDO; (A) General Administration, Operating Expenses	$4,750	0.0	$2,375	$0	$0	$2,375	From FTE Calculations
G	(1) EDO; (A) General Administration, General Professional Services and Special Projects	$150,000	0.0	$75,000	$0	$0	$75,000	Table 2.4 Row G
H	(2) Medical Services Premiums	($145,847,884)	0.0	($47,815,357)	($6,029,611)	($16,721)	($91,986,195)	Table 2.4 Row B + Table 2.4 Row D + Table 2.4 Row E + Table 2.4 Row H + Table 2.4 Row I + Table 2.4 Row K + Table 2.4 Row L
I	(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	($405,343)	0.0	($106,321)	($263,157)	$0	($35,865)	Table 2.4 Row J + Table 2.4 Row M
J	Total Costs	($145,693,106)	5.0	($47,641,617)	($6,292,768)	($16,721)	($91,742,000)	Sum Row A through Row I

Table 2.1 FY 2016-17 Cost Estimates with Fund Splits, by Component (INFORMATIONAL ONLY)								
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**		**Federal Funds**	**Notes/Calculations**
					Hospital Provider Fee	**BCCP Cash Fund**		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
F	*Payment Reform*							
G	Administrative Costs - Contractor Costs	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
H	Primary Care Rate Increase Continuation	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
I	Vaccine Stock Rate Methodology Change	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
J	Behavioral Health Incentive Payments	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	No FY 2016-17 Impact
L	Outpatient Hospital Services Methodology Change	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Table 10.1 Row A
M	Behavioral Health Capitation Rate Reduction	$0	0.0	$0	$0	$0	$0	Table 10.1 Row B
N	Total Costs	($15,440,295)	0.0	($7,720,148)	$0	$0	($7,720,147)	Sum Row B through Row M

Definitions:
PMPM - Per Member Per Month

Table 2.2 FY 2017-18 Cost Estimates with Fund Splits, by Component

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$0	0.0	$0	$0	$0	$0	Table 3.1 Row H
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$0	0.0	$0	$0	$0	$0	From FTE Calculations
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	$0	0.0	$0	$0	$0	$0	Table 5.1 Row AA
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	$0	0.0	$0	$0	$0	$0	Table 4.1 Row C
F	*Payment Reform*							
G	Payment Reform Administrative Costs - Contractor Costs	$0	0.0	$0	$0	$0	$0	See Narrative
H	Primary Care Rate Increase Continuation	$54,085,240	0.0	$18,846,157	$922,457	$13,869	$34,302,757	Table 7.4 Row C
I	Vaccine Stock Rate Methodology Change	($994,353)	0.0	($250,958)	($32,899)	$0	($710,496)	Table 8.1 Row A
J	Behavioral Health Incentive Payments	$0	0.0	$0	$0	$0	$0	Table 9.1 Row A
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	See Narrative
L	Outpatient Hospital Services Methodology Change	($23,160,443)	0.0	($11,580,222)	$0	$0	($11,580,221)	Table 10.2 Row A
M	Behavioral Health Capitation Rate Reduction	($26,717,069)	0.0	($7,215,319)	($1,090,537)	($299)	($18,410,914)	Table 10.2 Row B
N	Total Costs	$3,213,375	0.0	($200,342)	($200,979)	$13,570	$3,601,126	Sum Row B through Row M

Table 2.3 FY 2018-19 Cost Estimates with Fund Splits, by Component

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$45,343,338	0.0	$17,599,750	$1,778,624	$839	$25,964,125	Table 3.1 Row H
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$402,742	4.6	$201,371	$0	$0	$201,371	From FTE Calculations
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	($55,567,996)	0.0	($24,079,004)	($2,247,134)	($1,500)	($29,240,358)	Table 5.1 Row AA
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	($58,759,956)	0.0	($15,623,787)	($1,914,619)	($14,762)	($41,206,788)	Table 4.2 Row C
F	*Payment Reform*							
G	Payment Reform Administrative Costs - Contractor Costs	$225,000	0.0	$112,500	$0	$0	$112,500	See Narrative
H	Payment Reform Primary Care Incentives	$60,413,683	0.0	$21,051,321	$1,184,492	$15,420	$38,162,450	Table 7.5 Row C
I	Vaccine Stock Rate Methodology Change	($1,022,420)	0.0	($255,171)	($39,016)	$0	($728,233)	Table 8.1 Row B
J	Behavioral Health Incentive Payments	$26,717,069	0.0	$7,215,319	$1,090,537	$299	$18,410,914	Table 9.1 Row B
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	See Narrative
L	Outpatient Hospital Services Methodology Change	($23,160,443)	0.0	($9,769,075)	$0	$0	($13,391,368)	Table 10.3 Row A
M	Behavioral Health Capitation Rate Reduction	($28,131,120)	0.0	($7,503,004)	($1,305,677)	($510)	($19,321,929)	Table 10.3 Row B
N	Total Costs	($33,540,103)	4.6	($11,049,780)	($1,452,793)	($214)	($21,037,316)	Sum Row B through Row M

Table 2.4 FY 2019-20 Cost Estimates with Fund Splits, by Component

Row	Item	Total Funds	FTE	General Fund	Cash Funds		Federal Funds	Notes/Calculations
					Hospital Provider Fee	BCCP Cash Fund		
A	*Delivery System Reform*							
B	Accountable Care Collaborative Phase II PMPM Costs	$44,094,310	0.0	$17,012,125	$1,852,378	$808	$25,228,999	Table 3.1 Row H
C	Accountable Care Collaborative Phase II Administrative Costs - FTE	$410,121	5.0	$205,061	$0	$0	$205,060	From FTE Calculations
D	Accountable Care Collaborative Phase II Savings Due to Enrollment	($105,604,954)	0.0	($45,807,852)	($4,346,903)	($2,910)	($55,447,289)	Table 5.1 Row AA
E	Accountable Care Collaborative Phase II Savings Due to Physical-Behavioral Health Care Coordination	($119,183,550)	0.0	($31,689,953)	($4,962,730)	($29,942)	($82,500,925)	Table 4.3 Row C
F	*Payment Reform*							
G	Payment Reform Administrative Costs - Contractor Costs	$150,000	0.0	$75,000	$0	$0	$75,000	See Narrative
H	Payment Reform Primary Care Incentives	$59,055,014	0.0	$20,577,889	$1,477,023	$15,323	$36,984,779	Table 7.6 Row C
I	Vaccine Stock Rate Methodology Change	($1,048,261)	0.0	($262,303)	($49,379)	$0	($736,579)	Table 8.1 Row C
J	Behavioral Health Incentive Payments	$28,131,120	0.0	$7,503,004	$1,305,677	$510	$19,321,929	Table 9.1 Row C
K	Federally Qualified Health Center Payment Reform	$0	0.0	$0	$0	$0	$0	See Narrative
L	Outpatient Hospital Services Methodology Change	($23,160,443)	0.0	($7,645,263)	$0	$0	($15,515,180)	Table 10.4 Row A
M	Behavioral Health Capitation Rate Reduction	($28,536,463)	0.0	($7,609,325)	($1,568,834)	($510)	($19,357,794)	Table 10.4 Row B
N	Total Costs	($145,693,106)	5.0	($47,641,617)	($6,292,768)	($16,721)	($91,742,000)	Sum Row B through Row M

Definitions:
PMPM - Per Member Per Month

Table 3.1 Accountable Care Collaborative Phase II PMPM Cost Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Incremental Member Month Estimates for Accountable Care Collaborative Phase II	0	2,004,963	1,892,397	Table 6.1 Row Y * 12
B	Current Accountable Care Collaborative Member Month Estimates	13,634,688	14,266,404	14,762,160	Table 6.3 Row Y * 12
C	Additional PMPM for Accountable Care Collaborative Phase II	$0.00	$1.00	$1.00	Table 3.2 Row H
D	Current Accountable Care Collaborative PMPM	$14.50	$14.50	$14.50	Table 3.2 Row F
E	Cost Due to Change in Enrollment	$0	$29,071,970	$27,439,753	Row A * Row D
F	Cost Due to Change in PMPM	$0	$14,266,404	$14,762,160	Row B * Row C
G	Compounded Cost	$0	$2,004,963	$1,892,397	Row A * Row C
H	Total Cost	$0	$45,343,338	$44,094,310	Row E + Row F + Row G

Definitions:

PMPM - Per Member Per Month

Table 3.2 Accountable Care Collaborative Phase II Difference in PMPM					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Current Accountable Care Collaborative PMPM				
B	*Base RCCO PMPM*	$9.00	$9.00	$9.00	Average across RCCOs, from current contracts
C	*RCCO Incentive PMPM*	$1.50	$1.50	$1.50	From current contracts
D	*Base PCMP PMPM*	$3.00	$3.00	$3.00	From current contracts
E	*PCMP Incentive PMPM*	$1.00	$1.00	$1.00	From current contracts
F	Total Current Accountable Care Collaborative PMPM	$14.50	$14.50	$14.50	Row B + Row C + Row D + Row E
G	Accountable Care Collaborative Phase II PMPM	$14.50	$15.50	$15.50	See Narrative
H	Difference in PMPM	$0.00	$1.00	$1.00	Row G - Row F

Definitions:

PMPM - Per Member Per Month; RCCO - Regional Collaborative Care Organization; PCMP - Primary Care Medical Provider

Table 4.1 FY 2017-18 Fund Splits for Savings to Acute Care for Integration of Physical and Behavioral Health Care						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Savings for the Integration of Care for Medicaid Clients with SPMI	$0	$0	$0	$0	Table 4.4 Row G
B	Estimated Savings for the Integration of Care for Medicaid Clients with SUD	$0	$0	$0	$0	Table 4.5 Row G
C	Total Estimated Savings for the Integration of Physical and Behavioral Health Care	$0	$0	$0	$0	Row A + Row B

Table 4.2 FY 2018-19 Fund Splits for Savings to Acute Care for Integration of Physical and Behavioral Health Care						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Savings for the Integration of Care for Medicaid Clients with SPMI	($16,566,157)	($5,448,968)	($418,886)	($10,698,303)	Table 4.4 Row G
B	Estimated Savings for the Integration of Care for Medicaid Clients with SUD	($42,193,799)	($10,174,819)	($1,510,495)	($30,508,485)	Table 4.5 Row G
C	Total Estimated Savings for the Integration of Physical and Behavioral Health Care	($58,759,956)	($15,623,787)	($1,929,381)	($41,206,788)	Row A + Row B

Table 4.3 FY 2019-20 Fund Splits for Savings to Acute Care for Integration of Physical and Behavioral Health Care						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Estimated Savings for the Integration of Care for Medicaid Clients with SPMI	($33,601,679)	($11,052,321)	($1,060,804)	($21,488,554)	Table 4.4 Row G
B	Estimated Savings for the Integration of Care for Medicaid Clients with SUD	($85,581,871)	($20,637,632)	($3,931,868)	($61,012,371)	Table 4.5 Row G
C	Total Estimated Savings for the Integration of Physical and Behavioral Health Care	($119,183,550)	($31,689,953)	($4,992,672)	($82,500,925)	Row A + Row B

Definitions:

SPMI - Serious and Persistent Mental Illness; SUD - Substance Use Disorder

Table 4.4 Estimated Savings for Individuals with Serious and Persistent Mental Illness					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Estimated Number of Medicaid Clients with SPMI	91,955	93,252	94,572	See Narrative
B	Estimated Penetration Rate of Accountable Care Collaborative Phase II	0.00%	87.81%	87.81%	Table 6.2 Row B
C	Estimated Percent of Accountable Care Collaborative Phase II Enrollees with SPMI Receiving Coordinated Care	0.00%	75.00%	75.00%	See Narrative
D	Estimated Number of Medicaid Clients with SPMI Receiving Integrated Care	0	61,413	62,283	Row A * Row B * Row C
E	Estimated Savings Per Month Per Client Due to Integration of Care	($44.96)	($44.96)	($44.96)	Half of estimate based on research[1]
F	Number of Months with Savings Due to Integration of Care	0	6	12	Based on start date of July 1, 2018 and estimated 6-month delay before savings
G	Total Estimated Savings for Integration of Care for Medicaid Clients with SPMI	$0	($16,566,157)	($33,601,679)	Row D * Row E * Row F

Definitions:
SPMI - Serious and Persistent Mental Illness
Footnotes:
1. Druss, B. G., Rohrbaugh, R. M., Levinson, C. M., Rosenheck, R. A. Integrated Medical Care for Patients with Serious Psychiatric Illness: A Randomized Trial. *Archives of General Psychiatry* . 2001; 58(9): 861-868. doi:10.1001/archpsyc.58.9.861

Table 4.5 Estimated Savings for Individuals with Substance Use Disorder					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Estimated Number of Medicaid Clients with SUD	136,694	138,622	140,584	See Narrative
B	Estimated Penetration Rate of Accountable Care Collaborative Phase II	0.00%	87.81%	87.81%	Table 6.2 Row B
C	Estimated Percent of Accountable Care Collaborative Phase II Enrollees with SUD Receiving Coordinated Care	0.00%	75.00%	75.00%	See Narrative
D	Estimated Number of Medicaid Clients with SUD Receiving Integrated Care	0	91,293	92,585	Row A * Row B
E	Estimated Savings Per Month Per Client Due to Integration of Care	($77.03)	($77.03)	($77.03)	A third of estimate based on research[1]
F	Number of Months with Savings Due to Integration of Care	0	6	12	Based on start date of July 1, 2018 and estimated 6-month delay before savings
G	Total Estimated Savings for Integration of Care for Medicaid Clients with SUD	$0	($42,193,799)	($85,581,871)	Row D * Row E * Row F

Definitions:
SUD - Substance Use Disorder
Footnotes:
1. Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care. *Medical Care* . 2003; 41(3): 357-367. doi:10.1097/00005650-200303000-00004

Table 5.1 Savings to Acute Care for New Enrollment					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Elderly and Individuals with Disabilities Populations				
B	*Standard FMAP General Fund Populations*	0	55,427	54,678	Table 6.1 Row B
C	*Standard FMAP Hospital Provider Fee Populations*	0	3,743	3,566	Table 6.1 Row F
D	*Enhanced FMAP Non-Newly Eligible Populations*	0	894	928	Table 6.1 Row N
E	Total Elderly and Individuals with Disabilities	0	60,064	59,172	Row B + Row C + Row D
F	Estimated Cost Savings Per Month	($145.65)	($141.28)	($137.04)	Based on estimates in the November 2015 LRFI #7 ACC Organization
G	Estimated Number of Months with Savings	0	6	12	Assumes 6-month delay in achieving savings
H	Subtotal Elderly and Individuals with Disabilities Savings	$0	($50,914,911)	($97,308,462)	Row E * Row F * Row G
I	Adult Populations				
J	*Standard FMAP General Fund Populations*	0	24,081	18,440	Table 6.1 Row C
K	*Standard FMAP Hospital Provider Fee Populations*	0	1,867	1,465	Table 6.1 Row G
L	*Enhanced FMAP Expansion Populations*	0	57,560	56,201	Table 6.1 Row K
M	*Enhanced FMAP BCCP Program Population*	0	94	94	Table 6.1 Row S
N	*Enhanced FMAP Title XXI-funded Populations*	0	654	655	Table 6.1 Row W
O	Total Adults	0	84,257	76,854	Row J + Row K + Row L + Row M + Row N
P	Estimated Cost Savings Per Month	($7.86)	($7.62)	($7.39)	Based on estimates in the November 2015 LRFI #7 ACC Organization
Q	Estimated Number of Months with Savings	0	6	12	Assumes 6-month delay in achieving savings
R	Subtotal Adults Savings	$0	($3,852,632)	($6,817,737)	Row O * Row P * Row Q
S	Children Populations				
T	*Standard FMAP General Fund Populations*	0	926	0	Table 6.1 Row D
U	*Standard FMAP Hospital Provider Fee Populations*	0	17,924	18,694	Table 6.1 Row H
V	*Enhanced FMAP Title XXI-funded Populations*	0	3,910	2,979	Table 6.1 Row X
W	Total Children	0	22,760	21,673	Row T + Row U + Row V
X	Estimated Cost Savings Per Month	($6.04)	($5.86)	($5.69)	Based on estimates in the November 2015 LRFI #7 ACC Organization
Y	Estimated Number of Months with Savings	0	6	12	Assumes 6-month delay in achieving savings
Z	Subtotal Children Savings	$0	($800,453)	($1,478,755)	Row W * Row X * Row Y
AA	Total Estimated Savings	$0	($55,567,996)	($105,604,954)	Row H + Row R + Row Z

Definitions:

FMAP - Federal Medical Assistance Percentage; LRFI - Legislative Request for information; ACC - Accountable Care Collaborative; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.1 Population Breakout of Difference in Enrollment Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Standard FMAP General Fund Populations	0	80,434	73,118	Row B + Row C + Row D
B	*Elderly and Individuals with Disabilities*	*0*	*55,427*	*54,678*	*Table 6.2 Row F - Table 6.3 Row B*
C	*Adults*	*0*	*24,081*	*18,440*	*Table 6.2 Row G - Table 6.3 Row C*
D	*Children*	*0*	*926*	*0*	*Table 6.2 Row H - Table 6.3 Row D*
E	Standard FMAP Hospital Provider Fee Populations	0	23,534	23,725	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*0*	*3,743*	*3,566*	*Table 6.2 Row J - Table 6.3 Row F*
G	*Adults*	*0*	*1,867*	*1,465*	*Table 6.2 Row K - Table 6.3 Row G*
H	*Children*	*0*	*17,924*	*18,694*	*Table 6.2 Row L - Table 6.3 Row H*
I	Enhanced FMAP Expansion Populations	0	57,560	56,201	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.2 Row N - Table 6.3 Row J*
K	*Adults*	*0*	*57,560*	*56,201*	*Table 6.2 Row O - Table 6.3 Row K*
L	*Children*	*0*	*0*	*0*	*Table 6.2 Row P - Table 6.3 Row L*
M	Enhanced FMAP Non-Newly Eligible Populations	0	894	928	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*0*	*894*	*928*	*Table 6.2 Row R - Table 6.3 Row N*
O	*Adults*	*0*	*0*	*0*	*Table 6.2 Row S - Table 6.3 Row O*
P	*Children*	*0*	*0*	*0*	*Table 6.2 Row T - Table 6.3 Row P*
Q	Enhanced FMAP BCCP Program Population	0	94	94	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.2 Row V - Table 6.3 Row R*
S	*Adults*	*0*	*94*	*94*	*Table 6.2 Row W - Table 6.3 Row S*
T	*Children*	*0*	*0*	*0*	*Table 6.2 Row X - Table 6.3 Row T*
U	Enhanced FMAP Title XXI-funded Populations	0	4,564	3,633	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.2 Row Z - Table 6.3 Row V*
W	*Adults*	*0*	*654*	*655*	*Table 6.2 Row AA - Table 6.3 Row W*
X	*Children*	*0*	*3,910*	*2,979*	*Table 6.2 Row AB - Table 6.3 Row X*
Y	**Total Difference in Enrollment Estimates**	**0**	**167,080**	**157,700**	**Row A + Row E + Row I + Row M + Row Q + Row U**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.2 Population Breakout of Accountable Care Collaborative Phase II Enrollment Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Accountable Care Collaborative Phase II Enrollment Percentage of Medicaid Caseload Estimates				
B	*Elderly and Individuals with Disabilities*	*54.12%*	*87.81%*	*87.81%*	*Percent of Medicaid population eligible for the Accountable Care Collaborative Phase II, based on FY 2015-16 actuals*
C	*Adults*	*83.29%*	*90.99%*	*90.99%*	*Percent of Medicaid population eligible for the Accountable Care Collaborative Phase II, based on FY 2015-16 actuals*
D	*Children*	*87.34%*	*92.75%*	*92.75%*	*Percent of Medicaid population eligible for the Accountable Care Collaborative Phase II, based on FY 2015-16 actuals*
E	Standard FMAP General Fund Populations	648,497	753,320	771,345	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*54,802*	*112,935*	*115,026*	*Table 6.4 Row B * Row B*
G	*Adults*	*157,202*	*188,761*	*190,954*	*Table 6.4 Row C * Row C*
H	*Children*	*436,493*	*451,624*	*465,365*	*Table 6.4 Row D * Row D*
I	Standard FMAP Hospital Provider Fee Populations	30,646	55,890	57,930	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*2,760*	*6,948*	*7,288*	*Table 6.4 Row F * Row B*
K	*Adults*	*8,207*	*10,689*	*10,948*	*Table 6.4 Row G * Row C*
L	*Children*	*19,679*	*38,253*	*39,694*	*Table 6.4 Row H * Row D*
M	Enhanced FMAP Expansion Populations	392,957	472,557	482,836	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.4 Row J * Row B*
O	*Adults*	*392,957*	*472,557*	*482,836*	*Table 6.4 Row K * Row C*
P	*Children*	*0*	*0*	*0*	*Table 6.4 Row L * Row D*
Q	Enhanced FMAP Non-Newly Eligible Populations	1,861	2,841	2,965	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*1,861*	*2,841*	*2,965*	*Table 6.4 Row N * Row B*
S	*Adults*	*0*	*0*	*0*	*Table 6.4 Row O * Row C*
T	*Children*	*0*	*0*	*0*	*Table 6.4 Row P * Row D*
U	Enhanced FMAP BCCP Program Population	0	94	94	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.4 Row R * Row B*
W	*Adults*	*0*	*94*	*94*	*Table 6.4 Row S * Row C*
X	*Children*	*0*	*0*	*0*	*Table 6.4 Row T * Row D*
Y	Enhanced FMAP Title XXI-funded Populations	62,263	71,245	72,709	Row Z + Row AA + Row AB
Z	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*Table 6.4 Row V * Row B*
AA	*Adults*	*1,156*	*1,865*	*1,924*	*Table 6.4 Row W * Row C*
AB	*Children*	*61,107*	*69,380*	*70,786*	*Table 6.4 Row X * Row D*
AC	**Total Accountable Care Collaborative Phase II Enrollment Estimates**	**1,136,224**	**1,355,947**	**1,387,880**	**Row E + Row I + Row M + Row Q + Row U + Row Y**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.3 Population Breakout of Current Accountable Care Collaborative Enrollment Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Standard FMAP General Fund Populations	648,497	672,886	698,227	Row B + Row C + Row D
B	*Elderly and Individuals with Disabilities*	*54,802*	*57,508*	*60,348*	*November 2016 forecast Medical Services Premiums, trended forward*
C	*Adults*	*157,202*	*164,680*	*172,514*	*November 2016 forecast Medical Services Premiums, trended forward*
D	*Children*	*436,493*	*450,698*	*465,365*	*November 2016 forecast Medical Services Premiums, trended forward*
E	Standard FMAP Hospital Provider Fee Populations	30,646	32,356	34,205	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*2,760*	*3,205*	*3,722*	*November 2016 forecast Medical Services Premiums, trended forward*
G	*Adults*	*8,207*	*8,822*	*9,483*	*November 2016 forecast Medical Services Premiums, trended forward*
H	*Children*	*19,679*	*20,329*	*21,000*	*November 2016 forecast Medical Services Premiums, trended forward*
I	Enhanced FMAP Expansion Populations	392,957	414,997	426,635	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
K	*Adults*	*392,957*	*414,997*	*426,635*	*November 2016 forecast Medical Services Premiums, trended forward*
L	*Children*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
M	Enhanced FMAP Non-Newly Eligible Populations	1,861	1,947	2,037	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*1,861*	*1,947*	*2,037*	*November 2016 forecast Medical Services Premiums, trended forward*
O	*Adults*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
P	*Children*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
Q	Enhanced FMAP BCCP Program Population	0	0	0	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
S	*Adults*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
T	*Children*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
U	Enhanced FMAP Title XXI-funded Populations	62,263	66,681	69,076	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 forecast Medical Services Premiums, trended forward*
W	*Adults*	*1,156*	*1,211*	*1,269*	*November 2016 forecast Medical Services Premiums, trended forward*
X	*Children*	*61,107*	*65,470*	*67,807*	*November 2016 forecast Medical Services Premiums, trended forward*
Y	**Total Current Accountable Care Collaborative Enrollment Estimates**	**1,136,224**	**1,188,867**	**1,230,180**	**Row A + Row E + Row I + Row M + Row Q + Row U**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 6.4 Population Breakout of Medicaid Caseload Estimates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Standard FMAP General Fund Populations	810,645	822,992	833,138	Row B + Row C + Row D
B	*Elderly and Individuals with Disabilities*	*126,275*	*128,613*	*130,994*	*November 2016 "Medical Services Premiums" Request, trended forward*
C	*Adults*	*202,741*	*207,453*	*209,863*	*November 2016 "Medical Services Premiums" Request, trended forward*
D	*Children*	*481,629*	*486,926*	*492,281*	*November 2016 "Medical Services Premiums" Request, trended forward*
E	Standard FMAP Hospital Provider Fee Populations	56,459	60,903	63,129	Row F + Row G + Row H
F	*Elderly and Individuals with Disabilities*	*6,901*	*7,913*	*8,300*	*November 2016 "Medical Services Premiums" Request, trended forward*
G	*Adults*	*11,205*	*11,747*	*12,032*	*November 2016 "Medical Services Premiums" Request, trended forward*
H	*Children*	*38,353*	*41,243*	*42,797*	*November 2016 "Medical Services Premiums" Request, trended forward*
I	Enhanced FMAP Expansion Populations	497,701	519,351	530,647	Row J + Row K + Row L
J	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
K	*Adults*	*497,701*	*519,351*	*530,647*	*November 2016 "Medical Services Premiums" Request, trended forward*
L	*Children*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
M	Enhanced FMAP Non-Newly Eligible Populations	2,991	3,122	3,259	Row N + Row O + Row P
N	*Elderly and Individuals with Disabilities*	*2,991*	*3,122*	*3,259*	*November 2016 "Medical Services Premiums" Request, trended forward*
O	*Adults*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
P	*Children*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
Q	Enhanced FMAP BCCP Program Population	179	103	103	Row R + Row S + Row T
R	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
S	*Adults*	*179*	*103*	*103*	*November 2016 "Medical Services Premiums" Request, trended forward*
T	*Children*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
U	Enhanced FMAP Title XXI-funded Populations	73,878	76,853	78,433	Row V + Row W + Row X
V	*Elderly and Individuals with Disabilities*	*0*	*0*	*0*	*November 2016 "Medical Services Premiums" Request, trended forward*
W	*Adults*	*1,988*	*2,050*	*2,114*	*November 2016 "Medical Services Premiums" Request, trended forward*
X	*Children*	*71,890*	*74,803*	*76,319*	*November 2016 "Medical Services Premiums" Request, trended forward*
Y	**Total Medicaid Caseload Estimates**	**1,441,853**	**1,483,324**	**1,508,709**	**Row A + Row E + Row I + Row M + Row Q + Row U**

Definitions:
FMAP - Federal Medical Assistance Percentage; BCCP - Breast and Cervical Cancer Prevention and Treatment Program; Title XXI - Title XXI of the Social Security Act (Child Health Plan *Plus*)

Table 7.1 Primary Care Payment Reform Total Funds Summary						
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Total Impact of Initiative**	**Notes/Calculations**
A	FY 2017-18 Continuation of HB 16-1408 Primary Care Rate Increase	$54,085,240	$2,351,532	$0	$56,436,772	Table 7.2 Row I annualized for cash flow
B	FY 2018-19 Estimated Increase to Primary Care Funding with Payment Reform	$0	$58,062,151	$0	$58,062,151	Table 7.2 Row I
C	FY 2019-20 Estimated Increase to Primary Care Funding with Payment Reform	$0	$0	$59,055,014	$59,055,014	Table 7.2 Row I
D	Total Estimated Cost of Primary Care Rate Increase	$54,085,240	$60,413,683	$59,055,014		Row A + Row B + Row C

Table 7.2 Primary Care Payment Reform Fund Splits						
Row	**Item**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Percent of Fund Use					
B	*General Fund*	34.53%	34.85%	34.85%	34.85%	Based on expected utilization by eligibility of selected primary care codes.
C	*Cash Funds*	0.93%	1.73%	2.00%	2.53%	Based on expected utilization by eligibility of selected primary care codes.
D	*Federal Funds*	64.54%	63.42%	63.16%	62.63%	Based on expected utilization by eligibility of selected primary care codes.
E	Estimated Caseload Growth	N/A	4.76%	2.88%	1.71%	Growth between fiscal years in Table 6.4 Row Y
F	*General Fund*	$18,772,007	$19,665,555	$20,231,923	$20,577,889	FY 2016-17: Table 7.3 Row D General Fund; Else: (Previous year Row F) * Row E
G	*Cash Funds*	$506,879	$977,036	$1,159,202	$1,492,346	FY 2016-17: Table 7.3 Row D Cash Funds; Else: Row I * Row C
H	*Federal Funds*	$35,080,038	$35,794,181	$36,671,026	$36,984,779	FY 2016-17: Table 7.3 Row D Federal Funds; Else: Row I * Row D
I	**Primary Care Payment Reform Impact**	**$54,358,924**	**$56,436,772**	**$58,062,151**	**$59,055,014**	**FY 2016-17: Table 7.3 Row D Total Funds; Else: Row F / Row B**

Table 7.3 FY 2016-17 HB 16-1408 Fund Splits						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Percent of Fund Use	100.00%	34.53%	0.93%	64.54%	Estimated fund splits based on changes in FMAP
B	HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA" Primary Care Rate Increase	$55,694,236	$20,000,000	$556,859	$35,137,377	HB 16-1408, with General Fund in place of the Primary Care Provider Sustainability Fund
C	Impact of Update for Actual Utilization in FY 2015-16	($1,335,312)	($1,227,993)	($49,980)	($57,339)	Adjustment to expected expenditure based on actual utilization of these codes in FY 2015-16
D	Cost of the HB 16-1408 Primary Care Rate Increase without Immunization	$54,358,924	$18,772,007	$506,879	$35,080,038	Row B + Row C

Definitions:
FMAP - Federal Medical Assistance Percentage

Table 8.1 Vaccine Stock Rate Methodology Change Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	FY 2017-18 Estimated Impact to Vaccine Stock Costs	($994,353)	($250,958)	($32,899)	($710,496)	Table 8.2 Row E
B	FY 2018-19 Estimated Impact to Vaccine Stock Costs	($1,022,420)	($255,171)	($39,016)	($728,233)	Table 8.5 Row E
C	FY 2019-20 Estimated Impact to Vaccine Stock Costs	($1,048,261)	($262,303)	($49,379)	($736,579)	Table 8.8 Row E

Table 8.2 FY 2017-18 Vaccine Stock Fund Splits - Request Amount						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	($445,715)	$0	($24,514)	($421,201)	Table 8.3 Row A - Table 8.4 Row A
B	Children[1]	$4,492	$1,805	$0	$2,687	Table 8.3 Row B - Table 8.4 Row B
C	Elderly and Individuals with Disabilities	$27,107	$14,597	($1,043)	$13,553	Table 8.3 Row C - Table 8.4 Row C
D	All Other Adults	($580,237)	($267,360)	($7,342)	($305,535)	Table 8.3 Row D - Table 8.4 Row D
E	**Total Cost**	**($994,353)**	**($250,958)**	**($32,899)**	**($710,496)**	Row A + Row B + Row C + Row D

Table 8.3 FY 2017-18 Vaccine Stock Fund Splits - Estimated Costs with Vaccine Stock Rates Set Equal to CDC Price List						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,180,071	$0	$174,904	$3,005,167	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$354,255	$173,689	$0	$180,566	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$725,691	$348,977	$13,869	$362,845	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$1,740,909	$805,283	$40,811	$894,815	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,000,926**	**$1,327,949**	**$229,584**	**$4,443,393**	Row A + Row B + Row C + Row D

Table 8.4 FY 2017-18 Vaccine Stock Fund Splits - Estimated Costs at Current Vaccine Stock Rates						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,625,786	$0	$199,418	$3,426,368	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$349,763	$171,884	$0	$177,879	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$698,584	$334,380	$14,912	$349,292	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$2,321,146	$1,072,643	$48,153	$1,200,350	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,995,279**	**$1,578,907**	**$262,483**	**$5,153,889**	Row A + Row B + Row C + Row D

Footnotes:

1. Vaccine stock for children ages 0-18 are reimbursed through the Vaccines for Children program, and therefore total expenditure for children is lower than other categories.

Table 8.5 FY 2018-19 Vaccine Stock Fund Splits - Request Amount						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	($463,418)	$0	($30,122)	($433,296)	Table 8.6 Row A - Table 8.7 Row A
B	Children[1]	$4,692	$1,887	$0	$2,805	Table 8.6 Row B - Table 8.7 Row B
C	Elderly and Individuals with Disabilities	$28,315	$15,353	($1,196)	$14,158	Table 8.6 Row C - Table 8.7 Row C
D	All Other Adults	($592,009)	($272,411)	($7,698)	($311,900)	Table 8.6 Row D - Table 8.7 Row D
E	**Total Cost**	**($1,022,420)**	**($255,171)**	**($39,016)**	**($728,233)**	Row A + Row B + Row C + Row D

Table 8.6 FY 2018-19 Vaccine Stock Fund Splits - Estimated Costs with Vaccine Stock Rates Set Equal to CDC Price List						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,303,893	$0	$214,753	$3,089,140	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$364,494	$178,669	$0	$185,825	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$752,308	$360,252	$15,902	$376,154	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$1,801,139	$832,691	$42,786	$925,662	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,221,834**	**$1,371,612**	**$273,441**	**$4,576,781**	Row A + Row B + Row C + Row D

Table 8.7 FY 2018-19 Vaccine Stock Fund Splits - Estimated Costs at Current Vaccine Stock Rates						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,767,311	$0	$244,875	$3,522,436	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$359,802	$176,782	$0	$183,020	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$723,993	$344,899	$17,098	$361,996	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$2,393,148	$1,105,102	$50,484	$1,237,562	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$7,244,254**	**$1,626,783**	**$312,457**	**$5,305,014**	Row A + Row B + Row C + Row D

Footnotes:
1. Vaccine stock for children ages 0-18 are reimbursed through the Vaccines for Children program, and therefore total expenditure for children is lower than other categories.

Table 8.8 FY 2019-20 Vaccine Stock Fund Splits - Request Amount						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	($473,566)	$0	($40,253)	($433,313)	Table 8.9 Row A - Table 8.10 Row A
B	Children[1]	$4,796	$1,926	$0	$2,870	Table 8.9 Row B - Table 8.10 Row B
C	Elderly and Individuals with Disabilities	$29,032	$15,771	($1,255)	$14,516	Table 8.9 Row C - Table 8.10 Row C
D	All Other Adults	($608,523)	($280,000)	($7,871)	($320,652)	Table 8.9 Row D - Table 8.10 Row D
E	**Total Cost**	**($1,048,261)**	**($262,303)**	**($49,379)**	**($736,579)**	Row A + Row B + Row C + Row D

Table 8.9 FY 2019-20 Vaccine Stock Fund Splits - Estimated Costs with Vaccine Stock Rates Set Equal to CDC Price List						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,376,249	$0	$286,981	$3,089,268	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$371,969	$182,305	$0	$189,664	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$773,460	$370,051	$16,679	$386,730	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$1,846,457	$853,601	$43,753	$949,103	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$6,368,135**	**$1,405,957**	**$347,413**	**$4,614,765**	Row A + Row B + Row C + Row D

Table 8.10 FY 2019-20 Vaccine Stock Fund Splits - Estimated Costs at Current Vaccine Stock Rates						
Row	**Eligibility Categories**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Expansion Adults	$3,849,815	$0	$327,234	$3,522,581	Includes: MAGI Adults and Parents/Caretakers 69% to 133%
B	Children[1]	$367,173	$180,379	$0	$186,794	Includes: Eligible Children, Foster Children, and SB 11-008 Eligible Children
C	Elderly and Individuals with Disabilities	$744,428	$354,280	$17,934	$372,214	Includes: OAP-A, OAP-B, AND/AB, Partial Duals, and Disabled Buy-In
D	All Other Adults	$2,454,980	$1,133,601	$51,624	$1,269,755	Includes: Parents/Caretakers 0-68%, MAGI Pregnant Adults, and SB 11-250 Pregnant Adults
E	**Total Cost**	**$7,416,396**	**$1,668,260**	**$396,792**	**$5,351,344**	Row A + Row B + Row C + Row D

Footnotes:
1. Vaccine stock for children ages 0-18 are reimbursed through the Vaccines for Children program, and therefore total expenditure for children is lower than other categories.

Table 8.11 FY 2017-18 Vaccine Stock Total Expenditure Comparison

Procedure Code	Description[1]	FY 2017-18 Projected Utilization	FY 2017-18 Projected Expenditure Under Current Rates	FY 2017-18 Projected Expenditure Using CDC Price List	Difference
90715	Tetanus Shot	30,247	$2,439,663	$1,316,277	($1,123,386)
90378	Respiratory Syncytial Virus Prevention	445	$592,000	$614,966	$22,966
90746	Hepatitis B Vaccine	6,757	$488,397	$414,581	($73,816)
90649	Human Papillomavirus Vaccine	2,798	$447,042	$498,404	$51,362
90670	Pneumococcal Conjugate Vaccine	2,824	$394,829	$451,672	$56,843
90732	Influenza Virus Vaccine	3,727	$281,496	$294,690	$13,194
90686	Influenza Virus Vaccine	17,802	$277,585	$329,899	$52,314
90658	Influenza Virus Vaccine	18,937	$267,872	$273,500	$5,628
90651	Human Papillomavirus Vaccine	1,527	$241,458	$272,027	$30,569
90632	Hepatitis A Vaccine	3,125	$241,026	$209,564	($31,462)
	All Other Vaccines	35,050	$1,323,910	$1,325,345	$1,435
	Total of All Vaccines	**123,239**	**$6,995,278**	**$6,000,925**	**($994,353)**

Footnotes:
1. Vaccines that treat the same virus vary by brand, intended age range, as well as other factors

Table 8.12 FY 2017-18 Vaccine Stock Per Unit Expenditure Comparison

Procedure Code	Description[1]	FY 2017-18 Projected Utilization	FY 2017-18 Projected Price Per Unit Under Current Rates	FY 2017-18 Projected Price Per Unit Using CDC Price List	Difference
90715	Tetanus Shot	30,247	$80.66	$43.42	($37.24)
90378	Respiratory Syncytial Virus Prevention	445	$1,331.06	$1,379.60	$48.54
90746	Hepatitis B Vaccine	6,757	$72.28	$61.22	($11.06)
90649	Human Papillomavirus Vaccine	2,798	$159.75	$177.70	$17.95
90670	Pneumococcal Conjugate Vaccine	2,824	$139.80	$159.57	$19.77
90732	Influenza virus Vaccine	3,727	$75.54	$78.90	$3.36
90686	Influenza virus Vaccine	17,802	$15.59	$18.49	$2.90
90658	Flu Vaccine	18,937	$14.15	$14.41	$0.26
90651	Human Papillomavirus Vaccine	1,527	$158.09	$177.70	$19.61
90632	Hepatitis A Vaccine	3,125	$77.13	$66.91	($10.22)
	All Other Vaccines	35,050	$37.77	$37.73	($0.04)

Footnotes:
1. Vaccines that treat the same virus vary by brand, intended age range, as well as other factors

Table 9.1 Behavorial Health Incentive Payment Fund Split Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	FY 2017-18 Estimated Cost of Behavioral Health Incentive Payments	$0	$0	$0	$0	The Department would not pay out incentive payments until after the fiscal year closes, so does not anticipate payments in FY 2017-18
B	FY 2018-19 Estimated Cost of Behavioral Health Incentive Payments	$26,717,069	$7,215,319	$1,090,836	$18,410,914	Table 10.2 Row B * -1
C	FY 2019-20 Estimated Cost of Behavioral Health Incentive Payments	$28,131,120	$7,503,004	$1,306,187	$19,321,929	Table 10.3 Row B * -1

Table 10.1 FY 2016-17 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($15,440,295)	($7,720,148)	$0	($7,720,147)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	$0	$0	$0	$0	
C	Total Impact of Behavioral Health Payment Reform	($15,440,295)	($7,720,148)	$0	($7,720,147)	Row A + Row B

Table 10.2 FY 2017-18 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($23,160,443)	($11,580,222)	$0	($11,580,221)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	($26,717,069)	($7,215,319)	($1,090,836)	($18,410,914)	Table 10.5 Row AC
C	Total Impact of Behavioral Health Payment Reform	($49,877,512)	($18,795,541)	($1,090,836)	($29,991,135)	Row A + Row B

Table 10.3 FY 2018-19 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($23,160,443)	($9,769,075)	$0	($13,391,368)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	($28,131,120)	($7,503,004)	($1,306,187)	($19,321,929)	Table 10.5 Row AC
C	Total Impact of Behavioral Health Payment Reform	($51,291,563)	($17,272,079)	($1,306,187)	($32,713,297)	Row A + Row B

Table 10.4 FY 2019-20 Technical Adjustments Summary						
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Notes/Calculations**
A	Savings from EAPG Methodology for Outpatient Services	($23,160,443)	($7,645,263)	$0	($15,515,180)	See Narrative, Pages 8-9
B	Savings from Expected 4% Reduction in Capitation Rates	($28,536,463)	($7,609,325)	($1,569,344)	($19,357,794)	Table 10.5 Row AC
C	Total Impact of Behavioral Health Payment Reform	($51,696,906)	($15,254,588)	($1,569,344)	($34,872,974)	Row A + Row B

Definitions:

EAPG - Enhanced Ambulatory Patient Grouping

Table 10.5 Technical Adjustment: Behavorial Health Payment Reform 4% Reduction in Capitation Rates					
Row	**Item**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Notes/Calculations**
A	Population of Elderly Individuals on Medicaid	44,137	44,870	45,539	See Narrative
B	Behavioral Health Per Capita	$222.72	$225.36	$225.36	See Narrative
C	4% of Behavioral Health Per Capita	($8.91)	($9.01)	($9.01)	Row B * .04 * -1
D	Savings for Elderly Individuals	($393,261)	($404,279)	($410,306)	Row A * Row C
E	Population of Individuals with Disabilities on Medicaid	89,039	91,656	93,755	See Narrative
F	Behavioral Health Per Capita	$1,671.84	$1,709.16	$1,709.16	See Narrative
G	4% of Behavioral Health Per Capita	($66.87)	($68.37)	($68.37)	Row F * .04 * -1
H	Savings for Individuals with Disabilities	($5,954,038)	($6,266,521)	($6,410,029)	Row E * Row G
I	Population of Non-Expansion Adults on Medicaid	216,113	221,353	224,112	See Narrative
J	Behavioral Health Per Capita	$345.84	$353.76	$353.76	See Narrative
K	4% of Behavioral Health Per Capita	($13.83)	($14.15)	($14.15)	Row J * .04 * -1
L	Savings for Non-Expansion Adults on Medicaid	($2,988,843)	($3,132,145)	($3,171,185)	Row I * Row K
M	Population of Expansion Parents on Medicaid	108,821	116,361	125,235	See Narrative
N	Behavioral Health Per Capita	$189.96	$194.28	$194.28	See Narrative
O	4% of Behavioral Health Per Capita	($7.60)	($7.77)	($7.77)	Row N * .04 * -1
P	Savings for Expansion Parents	($827,040)	($904,125)	($973,076)	Row M * Row O
Q	Population of Expansion Adults on Medicaid	391,871	406,112	408,671	See Narrative
R	Behavioral Health Per Capita	$634.32	$648.96	$648.96	See Narrative
S	4% of Behavioral Health Per Capita	($25.37)	($25.96)	($25.96)	Row R * .04 * -1
T	Savings for Expansion Adults	($9,941,767)	($10,542,668)	($10,609,099)	Row Q * Row S
U	Population of Children on Medicaid	571,582	582,667	591,092	See Narrative
V	Behavioral Health Per Capita	$236.04	$241.44	$241.44	See Narrative
W	4% of Behavioral Health Per Capita	($9.44)	($9.66)	($9.66)	Row V * .04 * -1
X	Savings for Children	($5,395,734)	($5,628,563)	($5,709,949)	Row U * Row W
Y	Population of Foster Care on Medicaid	20,290	20,305	20,305	See Narrative
Z	Behavioral Health Per Capita	$1,498.80	$1,542.60	$1,542.60	See Narrative
AA	4% of Behavioral Health Per Capita	($59.95)	($61.70)	($61.70)	Row Z * .04 * -1
AB	Savings for Foster Care	($1,216,386)	($1,252,819)	($1,252,819)	Row Y * Row AA
AC	Total Estimated Cost of 4% Increase to Capitation Rates	($26,717,069)	($28,131,120)	($28,536,463)	Row D + Row H + Row L + Row P + Row T + Row X + Row AB

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in Year 1 as 0.9166 FTE to account for the pay-date shift. This applies to personal services costs only; operating costs are not subject to the pay-date shift.

Expenditure Detail		FY 2018-19		FY 2019-20	
Personal Services:					
Classification Title	Monthly Salary	FTE		FTE	
Rate/Financial Analyst IV	$5,005	0.9	$55,051	1.0	$60,060
PERA			$5,588		$6,096
AED			$2,753		$3,003
SAED			$2,753		$3,003
Medicare			$798		$871
STD			$105		$114
Health-Life-Dental			$7,927		$7,927
Subtotal Position 1, 1.0 FTE		**0.9**	**$74,975**	**1.0**	**$81,074**
Classification Title	Monthly Salary	FTE		FTE	
Analyst IV	$5,005	2.7	$165,153	3.0	$180,180
PERA			$16,763		$18,288
AED			$8,258		$9,009
SAED			$8,258		$9,009
Medicare			$2,395		$2,613
STD			$314		$342
Health-Life-Dental			$23,782		$23,782
Subtotal Position 2, 3.0 FTE		**2.7**	**$224,923**	**3.0**	**$243,223**
Classification Title	Monthly	FTE		FTE	
Administrator IV	$5,005	0.9	$55,051	1.0	$60,060
PERA			$5,588		$6,096
AED			$2,753		$3,003
SAED			$2,753		$3,003
Medicare			$798		$871
STD			$105		$114
Health-Life-Dental			$7,927		$7,927
Subtotal Position 3, 1.0 FTE		**0.9**	**$74,975**	**1.0**	**$81,074**
Subtotal Personal Services		4.6	**$374,873**	5.0	**$405,371**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	4.6	$2,292	5.0	$2,500
Telephone Expenses	$450	4.6	$2,062	5.0	$2,250
PC, One-Time	$1,230	5.0	$6,150		
Office Furniture, One-Time	$3,473	5.0	$17,365		
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$27,869**		**$4,750**
TOTAL REQUEST		4.6	**$402,742**	5.0	**$410,121**
	General Fund:		*$201,371*		*$205,061*
	Cash funds:		*$0*		*$0*
	Reappropriated Funds:		*$0*		*$0*
	Federal Funds:		*$201,371*		*$205,061*