

Schedule 13

Funding Request for the FY 2016-17 Budget Cycle

Department of Health Care Policy and Financing

Request Title

R-03 CHP+

Dept. Approval By: Josh Block

[Signature] 11/2/15 X

Supplemental FY 2015-16

Change Request FY 2016-17

Base Reduction FY 2016-17

OSPB Approval By:

[Signature] 10/28/15

Budget Amendment FY 2016-17

Summary Information	Fund	FY 2015-16		FY 2016-17	FY 2017-18	
		Initial	Supplemental	Base Request	Change	
		Appropriation	Request		Request	Continuation
Total		\$166,723,024	\$0	\$166,724,351	(\$17,605,016)	(\$10,596,184)
FTE		\$0	0.0	\$0	0.0	0.0
Total of All Line Items Impacted by Change Request	GF	\$2,525,718	\$0	\$2,525,718	(\$25,277)	(\$1,904,512)
	CF	\$29,111,476	\$0	\$29,219,879	(\$11,208,331)	(\$10,118,625)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$135,085,830	\$0	\$134,978,754	(\$6,371,408)	\$1,426,953

Line Item Information	Fund	FY 2015-16		FY 2016-17	FY 2017-18	
		Initial	Supplemental	Base Request	Change	
		Appropriation	Request		Request	Continuation
Total		\$0	\$0	\$0	\$0	\$0
FTE		0.0	0.0	0.0	0.0	0.0
05. Indigent Care Program - Children's Basic Health Plan Administration	GF	\$0	\$0	\$0	\$0	\$0
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0

Total		\$166,723,024	\$0	\$166,724,351	(\$17,605,016)	(\$10,596,184)
FTE		0.0	0.0	0.0	0.0	0.0
05. Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	GF	\$2,525,718	\$0	\$2,525,718	(\$25,277)	(\$1,904,512)
	CF	\$29,111,476	\$0	\$29,219,879	(\$11,208,331)	(\$10,118,625)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$135,085,830	\$0	\$134,978,754	(\$6,371,408)	\$1,426,953

Letternote Text Revision Required? Yes No **If Yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and CORE Fund Number: FF: Title XXI
CF: See Exhibit C2

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes No **Not Required:**

Schedule 13s from Affected Departments: N/A

Other Information:



Department of Health Care Policy and Financing
Children's Basic Health Plan

FY 2015-16, FY 2016-17, and FY 2017-18 Budget Request

November 2015

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CHILDREN'S BASIC HEALTH PLAN

The following is a description of the budget projection for the Children's Basic Health Plan.

Changes from February 2015 Forecast

- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for children was 53,832, which is 929, or 1.70%, under what was forecasted in February 2015. Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for prenatal is 693, which is 31, or 4.29% under what was forecasted in February 2015. This has resulted in a decreased caseload forecast for all forecast years and a lower estimated expenditure in FY 2015-16 than previously forecasted in February 2015.
- The CHP+ program makes reconciliation payments for manual enrollments that are not part of the capitation payments. These payments decreased significantly in FY 2014-15. In FY 2013-14, the Department paid \$18.4 million in reconciliation payments for manual enrollments. In FY 2014-15, this type of expenditure dropped to \$3.6 million. These payments are expected to remain at this lower level. This resulted in a much lower expenditure in FY 2014-15 than projected in February 2015, and a much lower projected expenditure in FY 2015-16.
- Rates for children's medical capitation payments decreased by 5% for children to 205% FPL and 9% for children 206%-260% FPL. This has resulted in a lower projected expenditure for FY 2015-16.

Points of Interest

- Beginning in January 2013, Medicaid eligibility expanded to include children ages 6 to 18 up to 133% Federal Poverty Level (FPL) per SB 11-008 and prenatal clients up to 185% FPL per SB 11-250. Senate bills 11-008 and 11-250 led to a significant decrease in caseload for CHP+ and the effects were previously reported as a bottom line adjustments in caseload.
- The Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) began in October 2013. States are required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in Health Care Exchanges, as well as Medicaid and federal CHIP programs. The changes from the implementation of MAGI were previously reported as bottom line adjustments and are now considered a part of the base caseload. As expected, the implementation of MAGI has resulted in a decrease in caseload.
- Continuous eligibility was implemented for Medicaid Eligible Children and CHP+ Children in March 2014. The Department has forecasted aggressive growth trends to account for the anticipated increase in member months.
- Beginning in January 2013, systems issues created duplicate payments for CHP+ clients in the State Managed Care Network. The magnitude of these duplication errors has waned considerably.

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- In FY 2013-14, prenatal capitations for some clients within 201%-259% FPL experienced systems issues. The issues have been tied to individual income rating codes that represent the following FPL brackets; 185%-200%, 201%-213%, and 214%-225%. This issue was resolved in FY 2014-15.
- After January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Hospital Provider Fee (HB 09-1293). The Department is working to identify a discrete FPL for all CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- The contracted rates for prenatal clients in FY 2015-16 are unchanged from the contracted rates in FY 2014-15.
- In FY 2013-14, a budget amendment was passed to expand dental services in CHP+ in order to bring the program into compliance with the CHIPRA Legislation of 2009. This has resulted in a substantial increase in rates for dental services in FY 2014-15.
- In FY 2014-15, the Department had submitted an estimate for the implementation of HB 09-1353, removing the five year bar on legal immigrant children and pregnant women. The five year bar had been removed for Medicaid eligible pregnant adults, but not for Medicaid Eligible Children and CHP+ clients. The Department's estimate in FY 2013-14 assumed implementation in FY 2014-15. After further review, the Department has decided that the implementation this bill for Medicaid eligible children and CHP+ clients cannot be done until FY 2015-16.
- The Department began paying a disallowance in FY 2014-15 due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-250% FPL range. Payment details can be found on page R-3.C2-6.

History and Background Information

Children's Basic Health Plan (CBHP), also known as Children's Health Plan *Plus* (CHP+), provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 260% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. CHP+ offers a defined benefit package that uses privatized administration.

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

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration. The Department will submit a separate supplemental request to true up its most recent estimates for FY 2015-16 in February 2016.

The eligible CHP+ populations are:

- Children to 205% FPL (Medical and Dental)
- Children 206%-260% FPL (Medical and Dental)
- Prenatal to 205% FPL
- Prenatal 206%-260% FPL

CBHP CAPITATION PAYMENTS

The CBHP Capitation Payments line item reflects the appropriation that funds CBHP services throughout Colorado through managed care providers contracted by the Department. CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor.

The dental vendor contract was re-bid for FY 2007-08, and a new contract was executed with Delta Dental. As part of the re-bid process, Delta Dental was able to offer an increased benefits package. These changes included increasing the cap on dental benefits from \$500 to \$600 per year, removing the age limit on sealants and fluoride varnishes, and increasing the cap on fluoride varnishes from one to two per year. In FY 2013-14, there was a budget amendment passed (BA-11) to align the CHP+ oral health care benefits with the CHIPRA legislation of 2009. CHP+ dental coverage had been lacking periodontic care, orthodontic care, prosthodontic care, and the required coverage of all medically necessary oral health care. Such services were added to the scope of coverage and the dental program's annual maximum was increased from \$600 to \$1000. These changes in the oral health care benefits led to significant increases in the dental rates for FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they were paid 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. This change in reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative trend in the children's per capita cost in FY 2010-11.

Analysis of Historical Expenditure Allocations across Eligibility Categories

Historical expenditure allocations across eligibility categories reflects the expenditures reported in the Colorado Financial Reporting System (COFRS). Beginning July 1, 2014, the Department will transition from COFRS to Colorado Operations Resource Engine (CORE). Historical expenditure through FY 2013-14 is from COFRS, historical expenditure from FY 2014-15 is from CORE.

Description of Transition to New Methodology

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department has moved to a capitation trend forecast model beginning with the FY 2014-15 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends for each eligibility category, rather than a weighted rate for all categories, future expenditures are forecasted per the characteristics of a specific eligibility category: the actuarially agreed-upon capitation rate and caseload for the nine categories rather than the previous three (children's medical, children's dental, and prenatal). In addition to viewing the nine eligibility categories separately, the Department has divided up the categories further to analyze each group that has a specific rate. This grouping separates by age as well as FPL. The different age groups apply only to children: 0-1, 2-5, and 6-18. The same FPL brackets apply to both children and prenatal: under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-259%. These individual analyses are then aggregated in the FPL brackets 0%-205% and 206%-260%. The age groups are each considered separately. By tying forecasted capitation rates directly to each category, the methodology may provide more accurate estimates of expenditures by eligibility category as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to health maintenance organizations and the state managed care network.

In estimating the future per capitas, the Department has also started incorporating claims distribution and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C8 (page R-3.12)

Additionally, the Department has incorporated an incurred but not reported methodology similar to the Medicaid Behavioral Health Program Request submitted by the Department. The Department is adjusting its request to capture the reality that some CBHP claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year for Medicaid Children's Basic Health Plan. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT C1 - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 1, 2013 Budget Request, the Department will include Exhibit C1 which presents a concise summary of spending authority affecting Children's Basic Health Plan. In this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit C2. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from exhibit C2 (pages R-3.C2-1 through R-3.C2-3). The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT C2 - CALCULATION OF FUND SPLITS

Exhibit C2 details fund splits for all Children's Basic Health Plan budget lines for the current fiscal year Supplemental and the out-year Budget Request. Capitation expenditures are split between traditional clients and expansion clients. The State share for the traditional clients (0%-205% FPL) is funded from the CBHP Trust fund and the State share for expansion clients (206%-260% FPL) is funded from Hospital Provider Fee funds (HB 09-1293).

The enhanced CHP+ FMAP was raised from 65% to 65.71% in October 2014. The average for the State Fiscal Year 2014-15 was 65.53%. Per the Patient Protection and Affordable Care Act (Sec. 2101 (a)), the enhanced CHP+ FMAP will be raised 23 percentage points from October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The projected FMAP for FY 2015-16 is 82.80% and the projected FMAP for FY 2016-17 is 88.5%. Due to this 23 percentage point increase, the Department forecasts that the CBHP Trust Fund will be sufficient for the State share of CHP+ expenditures beginning in FY 2015-16. The total amount attributed to the General Fund in FY 2015-16, FY 2016-17, and FY 2017-18 is due to the disallowance payments, discussed above.

EXHIBIT C3 - CHILDREN'S BASIC HEALTH PLAN SUMMARY

Exhibit C3 presents a summary of Children's Basic Health Plan caseload and capitation expenditures itemized by eligibility category and a summary of the bottom line adjustments to expenditure, as well as expenditures for CBHP Administration. The net capitation

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payments include the impacts of the reconciliations for manual enrollments. Exhibit C6 illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT C4 - CBHP CASELOAD

Exhibit C4 contains the caseload history for each of the eligibility categories broken down by poverty level (0%-205% and 206%-260%) and also broken down by age group for children's categories (ages 0-1, 2-5, and 6-18). Each of the tables that comprise Exhibit C4 is described below. Forecast details for CHP+ caseload can be found starting on page R-3.22 of this narrative.

Children's Basic Health Plan Caseload by Fiscal Year

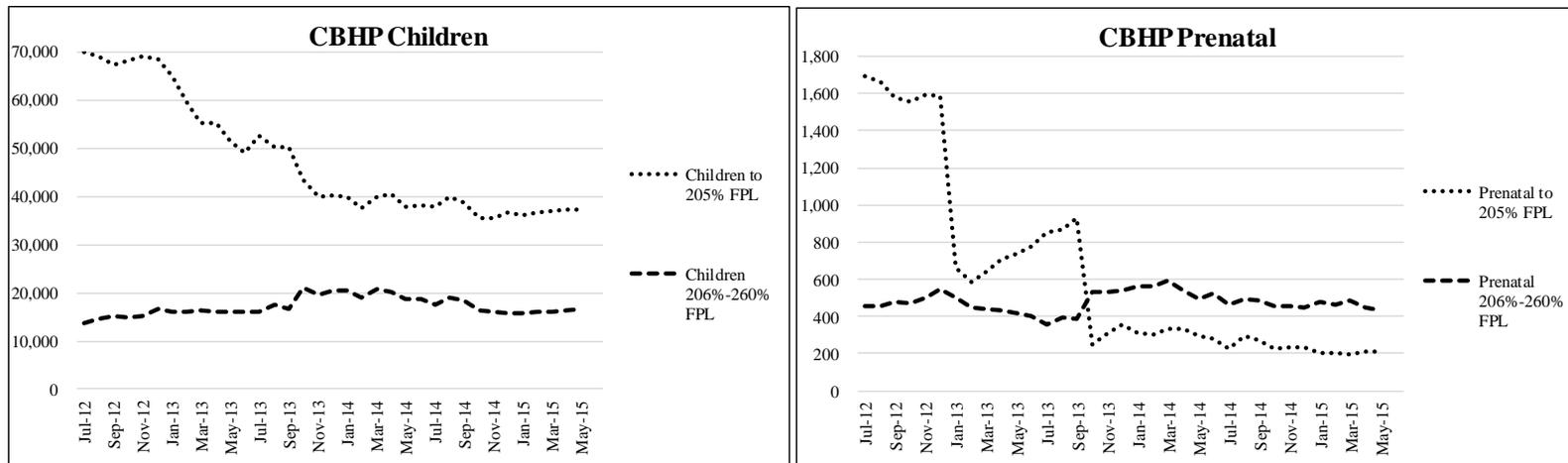
Caseload for the Children's Basic Health Plan is displayed in one table showing caseload by all CHP+ eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are used in numerous exhibits throughout the Children's Basic Health Plan Exhibits and narrative. Caseload numbers for children are used twice, once for medical and once for dental.

Caseload forecast by fiscal year shows the final estimated caseload, caseload adjustments, and base caseload. Caseload adjustments in this request include the estimates for the Welcome-Mat Effect (formerly referred to as EBNE) and the estimates for the implementation of HB 09-1353 (which removes the 5 year bar on legal immigrant children and pregnant women).

Children's Basic Health Plan Caseload by Month

These tables show the actual caseload by month as reported in the JBC monthly report for the three most recent fiscal years. As can be seen in the graphs shown below and on page R-3.C4-5, caseload steadily decreased for populations under 205% FPL from January 2013 through January 2014, due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion, and only slightly increasing for populations above 205% FPL. The most recent months seem to have remained steady.

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Children's Basic Health Plan Per Capita Historical Summary

Medicaid Children's Basic Health Plan per capita is displayed in one table. The table displays per capita by all CBHP eligibility categories, children categories are displayed twice to show medical and dental per capita. Figures for fiscal years up to the present fiscal year are actual per capita, while the current fiscal year and the request year per capita are estimates. Calculated per capita in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all expenditure adjustments for the given fiscal year. Forecasted per capita without bottom line adjustments can be found in exhibit C6, pages R-3.C6-1 through R-3.C6-3. Calculations are described in exhibits C6 through C10 (pages R-3.10 through R-3.16).

The final per capita for Children's Medical and Dental expenditures increased greatly for all FPL categories in FY 2013-14. This is due to a large increase in reconciliation payments for manual enrollments. In FY 2012-13, the Department paid approximately \$8.5 million for reconciliation payments for manual enrollments. In FY 2013-14, these payments increased to \$18.4 million. This resulted in a large increase in final per capita for all children's expenditure categories, and a subsequent decrease in FY 2014-15.

For prenatal clients to 205% FPL, the actual per capita in FY 2013-14 decreased by 0.61%. This is due to a systems issue with capitation payments beginning in January 2014, discussed above. These capitation issues were seen in clients within 186%-200%, 201%-213%, and 214%-225%. This issue was resolved in FY 2014-15.

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Children's Basic Health Plan Historical Expenditures Summary

The history of expenditures shows total capitation expenditures for all CBHP eligibility categories. Medical and dental expenditures are listed separately. Actual expenditures through FY 2013-14 by eligibility category are available from the Colorado Financial Reporting System (COFRS) and actual expenditures for FY 2013-14 are also reported in exhibit C3-Expenditure Summary, page R-3.C3-1. Actual expenditure from FY 2014-15 and forward are from the Colorado Operations Resource Engine (CORE). This exhibit also includes a similar summary of expenditure for all forecast years.

EXHIBIT C5 - CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES

Traditional Population Expenditures and Funding

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the 2015 Tobacco MSA Payment Forecast and the actual expenditures from prior years. Calculations can be seen in exhibit C5, page R-3.C5-2.

As described above for exhibit C2, the CHP+ Federal Match increases by 23 percentage points in October 2015. After this increased match, the Department forecasts that the CHP Trust Fund will have sufficient revenue to cover the expenditures of the CHP+ population under 205% FPL. This results in \$0 General Fund expenditure for capitation payments. These calculations are shown on page R-3.C5-2.

Expansion Population Expenditures and Funding

HB 09-1293 established a funding mechanism for a series of expansion clients. The set of expansion clients that are funded through the bill are children and prenatal clients with income 206%-260% FPL. These populations also receive the enhanced CHP+ Federal Match. Services for these clients are funded through the Hospital Provider Fee Cash Fund. This exhibit shows expenditures for the expansion population in isolation and provides additional detail to the calculation of fund splits.

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Children's Health Plan Plus Enrollment Fees

Clients above 157% FPL owe an enrollment fee prior to accessing benefits. There is a fee for enrolling either one child, or more than one child. This exhibit shows the assumptions and calculations used to predict the collected enrollment fees. The amount accrued in enrollment fees is exempt from the federal match, so this amount is subtracted from the estimated CHP+ expenditures that can receive a federal match for fund split calculations seen in exhibits C2 and C5 (pages R-3.C2-1 through R-3.C2-3, R-3.C5-2, and R-3.C5-4).

EXHIBIT C6 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit C6 provides capitation expenditure calculations for the current fiscal year and the request year.

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

The forecasted capitation rate is derived from exhibits C8 through C10 and will be presented in more detail below. The caseload is the same as displayed in exhibit C4.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown in the exhibits starting on page R-3.C6-1.

After calculating total expenditure for capitations, the anticipated reconciliation payments for manual enrollments for each fiscal year are estimated and added to total expenditure. The sum of expenditure for capitation payments and reconciliation payments for manual

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enrollments is the total CBHP Capitation Payments summarized in exhibit C3. Following the addition of projected reconciliation payments for manual enrollments are any applicable bottom-line impacts to expenditure. Details are discussed below in exhibit C7.

Actuarially Certified Capitation Rates

Capitated rates for the health maintenance organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit C6. The methodology for determining the forecasted capitation rate is the subject of exhibits C8 through C10.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Page R-3.C6-4 presents the percentage of claims paid in a twelve-month period that come from that same period and those which come from previous periods.

EXHIBIT C7 - CHILDREN'S BASIC HEALTH PLAN BOTTOM LINE IMPACTS TO EXPENDITURE

Reconciliation payments for manual enrollments

As mentioned above, the Department makes reconciliation payments for clients that were manually enrolled. These are projected by applying growth rates from projected caseload (exhibit C4) and rate inflation (exhibit C9) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year.

Payments to Federally Qualified Health Centers (FQHC's)/ Rural Health Centers (RHC's)

The Department began making reconciliation payments to FQHC's/RHC's in FY 2013-14, this was referred to as CHP+ PPS Implementation in the February 2014 request. Services at FQHC's and RHC's are now taken into consideration in the rate setting process
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as of FY 2014-15, but there are still reconciliation payments to be made. In FY 2014-15, the Department paid \$6,216,390 in reconciliation payments to FQHC's and RHC's. This includes a payment that required a good cause waiver. Approval for the good cause waiver was received from CMS in April 2015, and the payments were made in June 2015. The Department estimates a total of \$6,423,983 will need to be made in FY 2015-16. After this, services provided by FQHC's/RHC's should be fully accounted for in the rate setting process and reconciliation payments should not be needed for these services.

EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the health maintenance organizations (HMO's) and State Managed Care Network (SMCN) to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the CBHP Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last seven years of claims and caseload data. Page R-3.C8-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The Department did experience a significant amount of duplicate claims through calendar year 2013, but these duplicate claims have been removed from this analysis. Details on the selected retroactivity adjustment can be found on page R-3.C8-1.

Claims Distribution Adjustment Multiplier

To derive the claims distribution adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last seven years of data were examined.

As presented on page R-3.C8-2, for each eligibility category, the amount paid divided by claims was compared to the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual HMO or SMCN). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. Details on the selected claims distribution adjustment for each eligibility can be found on page R-3.C8-2.

EXHIBIT C9 - CBHP CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual health maintenance organization or state managed care network) was examined. Exhibit C9 presents historical data as well as the forecasted weighted rates. Rates are first presented by poverty level and age group, and then aggregated by poverty level for all ages.

The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit C10.

Based on the Department's calculations and rate-setting process and input from the health maintenance organizations, the Department's actuaries certify a capitation rate range for each HMO, SMCN, and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across several factors. First, the rate is weighted within an eligibility category. Within an eligibility category, the rate is weighted by the health maintenance organizations' and state managed care network's proportion of claims processed within that eligibility category, the proportion attributable to each FPL category (0%-100%, 101%-150%, 150%-200%, and above 200%), and for children the proportion for each age range (ages 0-1, 2-5, and 6-18). Next, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can

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be increasing or decreasing independently of any one capitation rate, the weighted CBHP total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit C9 presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit C6 in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years. Below is a table showing the actual weighted rate for FY 2014-15, and the projected weighted rates through FY 2017-18.

Fiscal Year	Children Medical to 205% FPL	Children Medical 206%-259% FPL	Children Dental to 205% FPL	Children Dental 206%-259% FPL	Prenatal to 205% FPL	Prenatal 206%-259% FPL	Weighted CBHP Total
FY 2014-15 Actuals	\$151.22	\$154.78	\$18.45	\$18.02	\$980.09	\$970.08	\$180.83
FY 2015-16 Estimated Rate	\$143.22	\$140.41	\$19.28	\$18.89	\$980.13	\$970.08	\$172.39
% Change from FY 2014-15	-5.29%	-9.28%	4.50%	4.83%	0.00%	0.00%	-4.67%
FY 2016-17 Estimated Rate	\$146.77	\$141.67	\$19.91	\$19.54	\$1,005.81	\$993.85	\$176.31
% Change from FY 2015-16	2.48%	0.90%	3.27%	3.44%	2.62%	2.45%	2.28%
FY 2017-18 Estimated Rate	\$149.30	\$142.99	\$20.56	\$20.19	\$1,026.83	\$1,013.43	\$178.83
% Change from FY 2016-17	1.72%	0.93%	3.26%	3.33%	2.09%	1.97%	1.97%

EXHIBIT C10 - FORECAST MODEL COMPARISONS

Exhibit C10 produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in exhibit C6. Pages R-3.C10-1 and R-3.C10-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in exhibit C8.

On page R-3.C10-2, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into page S-3A/BA-3.C10-1. Based on the point estimates, the adjustments presented in Exhibit C8 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of exhibit C6.

Final Forecasts

Page R-3.C10-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page R-3.C10-2 (see below).

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The forecasted rate is then adjusted by the claims distribution adjustment multiplier, calculated on page R-3.C8-2. The multiplier is applied to account for the distribution of clients amongst the different HMO's and the SMCN. The average amount paid may not perfectly reflect the estimated claims distribution. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From exhibit C8, page R-3.C8-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for exhibit C8, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in exhibit C6. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page R-3.C10-2.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

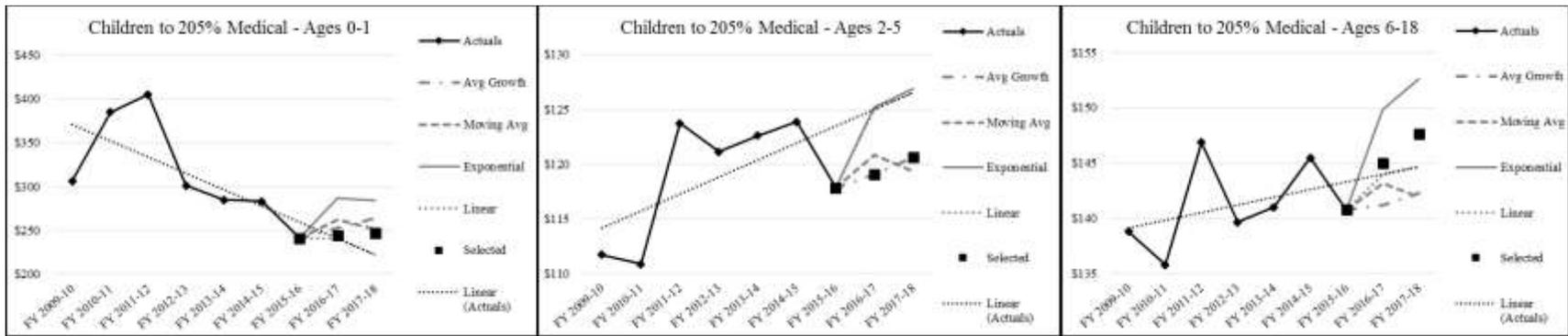
Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with

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FY 2008-09 the Department has experienced unusual trends for the CBHP capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. The tables beginning on the next page show the trends selected for the current and request years by eligibility category.

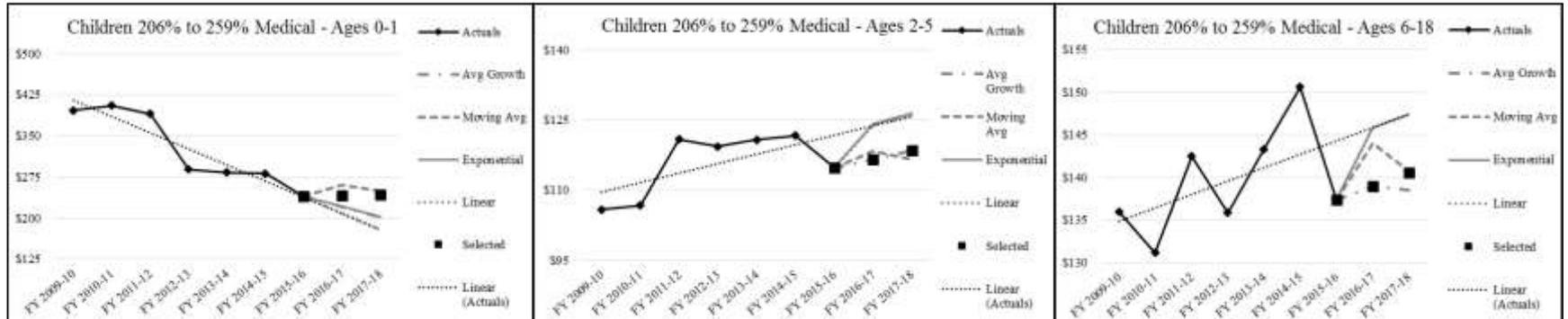
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Rate Trends for Children Medical to 205% FPL			
Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Children to 205% FPL Medical Ages 0-1	1.23% Exponential Growth Model	1.23% Trend selected for FY 2016-17	Rates for clients' ages 0-1 decreased in FY 2015-16, but remained relatively flat in FY 2013-14 and FY 2014-15. The trend selected is only slightly positive.
Children to 205% FPL Medical Ages 2-5	1.03% Average Growth Model	1.32% Average Growth Model	Rates for clients ages 2-5 decreased in FY 2015-16. The trend selected is comparable to the growth rates seen in FY 2013-14 and FY 2014-15.
Children to 205% FPL Medical Ages 6-18	3.00% Exponential Growth Model	1.85% Exponential Growth Model	Rates for clients ages 6-18 decreased in FY 2015-16. In prior years the rates have been volatile. The trend selected is comparable to the growth seen in FY 2014-15.



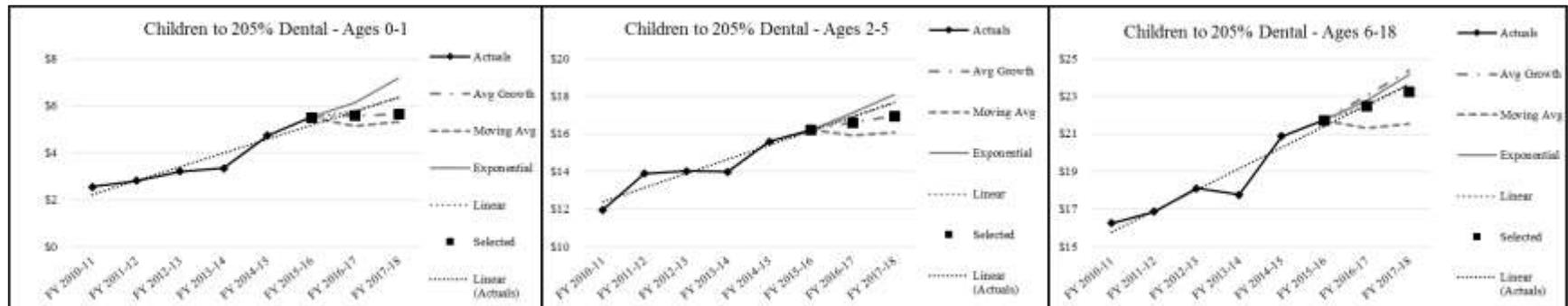
FY 2016-17 BUDGET REQUEST: CHILDREN'S BASIC HEALTH PLAN NARRATIVE

Rate Trends for Children Medical 206% to 259% FPL			
Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Children 206% to 259% FPL Medical Ages 0-1	0.62% Average of Average Growth Model and Two Period Moving Average	0.62% Trend selected for FY 2016-17	Rates for clients ages 0-1 decreased in FY 2015-16, but remained relatively flat in FY 2013-14 and FY 2014-15. The trend selected is only slightly positive.
Children 206% to 259% FPL Medical Ages 2-5	1.52% Average Growth Model	1.65% Average Growth Model	Rates for clients ages 2-5 decreased in FY 2015-16. The trend selected is comparable to the growth rates seen in FY 2013-14 and FY 2014-15.
Children 206% to 259% FPL Medical Ages 6-18	1.16% Average Growth Model	1.16% Trend selected for FY 2016-17	Rates for clients ages 6-18 decreased in FY 2015-16. In prior years the rates have been volatile. The trend selected is slightly positive.



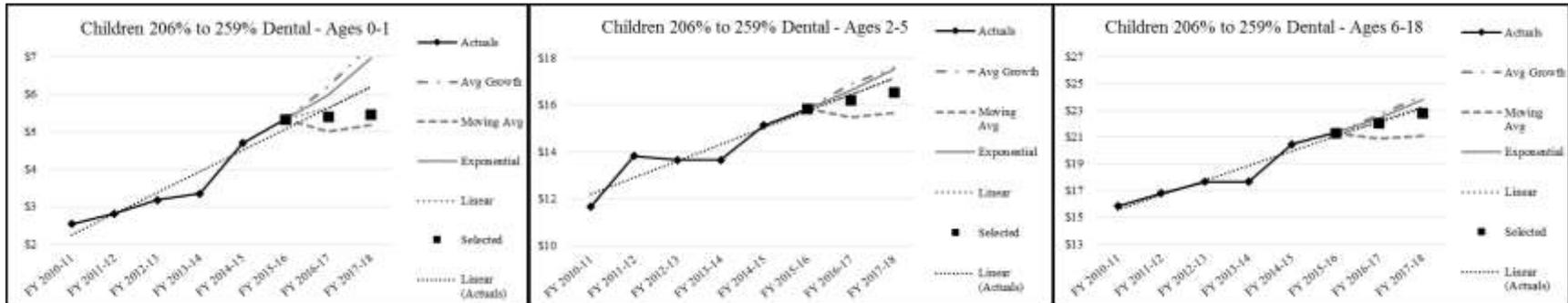
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Rate Trends for Children Dental to 205% FPL			
Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Children to 205% FPL Dental Ages 0-1	1.27% Average Growth Model	1.27% Trend selected for FY 2016-17	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children to 205% FPL Dental Ages 2-5	2.40% Average Growth Model	2.05% Average Growth Model	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children to 205% FPL Dental Ages 6-18	3.44% Linear Growth Model	3.44% Trend selected for FY 2016-17	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.



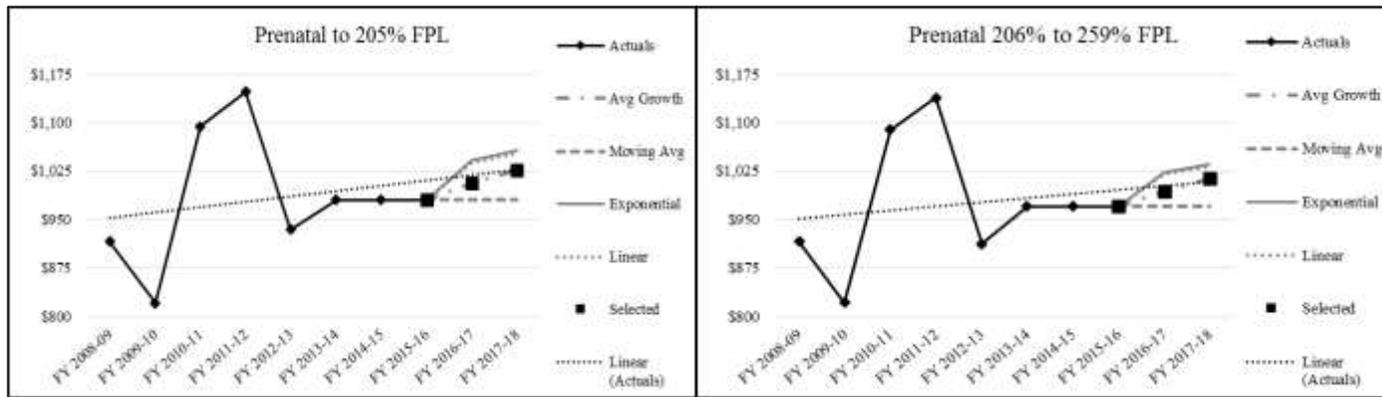
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Rate Trends for Children Dental 206% to 259% FPL			
Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	Justification
Children 206% to 259% FPL Dental Ages 0-1	1.27% Trend selected for Children 0%-205% FPL	1.27% Trend selected for Children 0%-205% FPL	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children 206% to 259% FPL Dental Ages 2-5	2.40% Trend selected for Children 0%-205% FPL	2.05% Trend selected for Children 0%-205% FPL	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.
Children 206% to 259% FPL Dental Ages 6-18	3.36% Linear Growth Model	3.36% Trend selected for FY 2016-17	The sharp increase seen in FY 2014-15 is due to an expansion in dental benefits for CHP+. There was another increase in FY 2015-16. The Department expects these increases to slow now that the new benefit package has been available for two years.



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Rate Trends for Prenatal			
Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Prenatal to 205% FPL	2.62% Average Growth Model	2.09% Average Growth Model	Rates for prenatal clients did not change from FY 2013-14 to FY 2014-15. The trend selected is from the percent change seen from FY 2012-13 to FY 2013-14.
Prenatal 206%-259% FPL	2.45% Average Growth Model	1.97% Average Growth Model	This population is still relatively new. Trends are identical to what was selected for prenatal clients to 205% FPL.



CBHP CASELOAD

Length of Stay

CBHP caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The Department has started tracking the average length of stay for each eligibility category to further the understanding the behavior of the CHP+ clients. Results for FY 2013-14 (shaded) is subject to change as there may not be sufficient run out to capture the true length of stay for all clients. The Department anticipates an increase in the average length of stay as continuous eligibility for Medicaid Eligible Children and CHP+ Children was implemented March 1st, 2014.

		CHP Children 0%-205%	CHP Children 206%-259%	CHP Prenatal 0%-205%	CHP Prenatal 206%-259%
FY 2009-10	Avg. LOS Mo's	14.50	15.60	7.72	6.48
	% > 12 Mo's	51.66%	49.72%	3.03%	1.08%
FY 2010-11	Avg. LOS Mo's	11.55	12.83	6.96	6.82
	% > 12 Mo's	40.92%	51.30%	1.94%	1.68%
FY 2011-12	Avg. LOS Mo's	9.18	11.26	6.35	6.38
	% > 12 Mo's	32.86%	49.21%	1.41%	0.91%
FY 2012-13	Avg. LOS Mo's	8.41	11.32	5.16	6.34
	% > 12 Mo's	26.55%	42.53%	0.78%	0.63%
FY 2013-14	Avg. LOS Mo's	9.31	11.45	5.18	6.60
	% > 12 Mo's	23.19%	32.41%	1.16%	3.48%

CBHP Caseload Models

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data from July 2007 to June 2015. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The Department is now using the software EViews 6 to estimate these models.

Trend and Seasonality Model

CBHP caseload is a non-stationary series with a positive trend and many of the categories experience some level of seasonality. One of the models used incorporates a time trend and monthly seasonal dummy variables.

ARIMA Model

ARIMA models, once referred to as Box-Jenkins models, rely on the past behavior of the series being forecasted. Relying on the past behavior of a series mandates that a series be stationary. Most of the eligibilities in Medicaid caseload have a positive growth trend (non-stationary) and require differencing to be made stationary.

Trend Stationary and Difference Stationary

Series that are stationary have a constant mean, caseload series frequently do not have this characteristic and often have a trending mean. Two popular models used for non-stationary series with a trending mean are trend stationary and difference stationary. The trend stationary serves as an effective model if the series has a deterministic trend. The difference stationary model proves effect should the trend be stochastic. Differencing the dependent variable gives a stationary series. The basic forms of the two models are listed below.

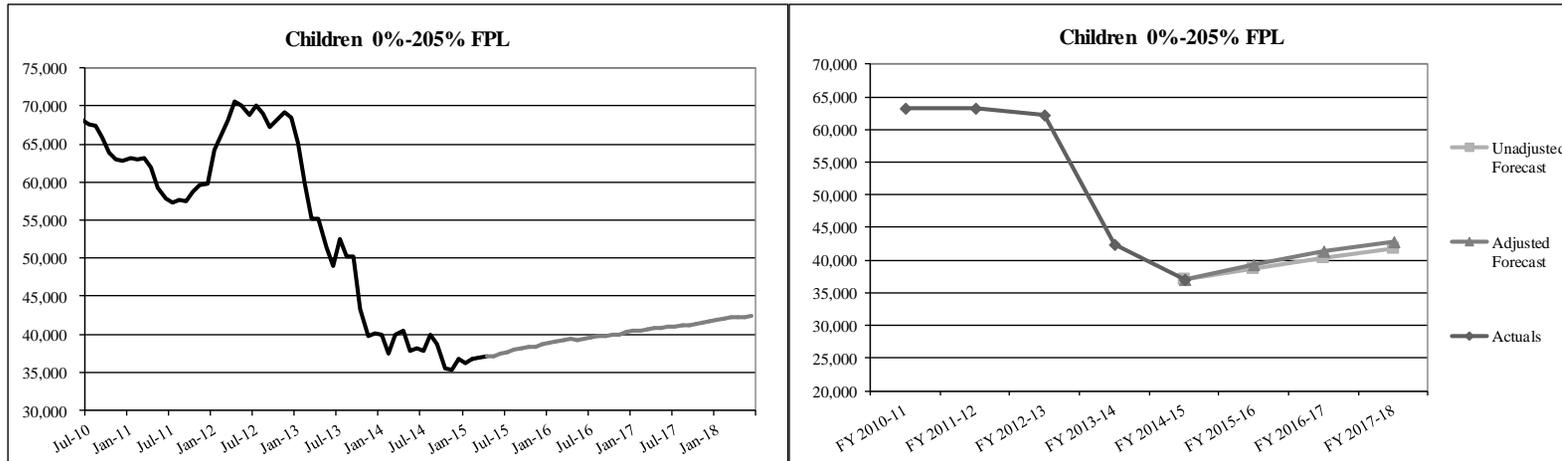
- Trend Stationary: $\log(y) = c + \text{trend} + \varepsilon$
- Difference Stationary: $\text{differenced}(\log(y)) = c + \varepsilon$

Model Selection

Models are created for each individual group that receives a separate rate. These groups are separated by FPL for both children and prenatal: under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. Children's groups are also separated by age: age groups 0-1, 2-5, and 6-18. A model is selected to forecast each group. After several different forecasts are produced, the Department normally chooses one for each category and then aggregated to the FPL categories for children and prenatal; under 205% and 206%-260%. When selecting a model, the Department closely analyzes the historical data as well as the goodness of fit of the model.

CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST

Children's Caseload Projections (Exhibit C4)



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Children 0%-205% FPL is 37,104, which is lower than what was forecasted in the February 2015 forecast. This has resulted in lower forecast trends for this November 2015 request. The selected trend would result in average monthly growth of 282 per month. This is comparable to the average monthly growth seen over the last 6 months, which is 285 per month.
- This population includes the subpopulation created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201% and 205% FPL.
 - This population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.

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- There is one bottom-line adjustment to the Children to 205% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This five year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16.

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Children 0%-205% FPL: Historical Caseload and Projections			
	Actuals	Monthly Change	% Change
Jun-13	48,895	-	-
Jul-13	52,548	3,653	7.47%
Aug-13	50,183	(2,365)	-4.50%
Sep-13	50,143	(40)	-0.08%
Oct-13	43,294	(6,849)	-13.66%
Nov-13	39,834	(3,460)	-7.99%
Dec-13	40,151	317	0.80%
Jan-14	39,925	(226)	-0.56%
Feb-14	37,491	(2,434)	-6.10%
Mar-14	39,972	2,481	6.62%
Apr-14	40,436	464	1.16%
May-14	37,893	(2,543)	-6.29%
Jun-14	38,258	365	0.96%
Jul-14	37,832	(426)	-1.11%
Aug-14	39,858	2,026	5.36%
Sep-14	38,675	(1,183)	-2.97%
Oct-14	35,543	(3,132)	-8.10%
Nov-14	35,405	(138)	-0.39%
Dec-14	36,771	1,366	3.86%
Jan-15	36,177	(594)	-1.62%
Feb-15	36,686	509	1.41%
Mar-15	36,909	223	0.61%
Apr-15	37,175	266	0.72%
May-15	37,114	(61)	-0.16%

	Caseload	% Change	Level Change
FY 2007-08	57,796		
FY 2008-09	61,582	6.55%	3,786
FY 2009-10	68,589	11.38%	7,007
FY 2010-11	63,244	-7.79%	(5,345)
FY 2011-12	63,217	-0.04%	(27)
FY 2012-13	62,260	-1.51%	(957)
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,104	-12.72%	(5,407)
FY 2015-16	38,722	4.36%	1,618
FY 2016-17	40,294	4.06%	1,572
FY 2017-18	41,749	3.61%	1,455

HB 09-1353 Adjustment			
FY 2014-15			-
FY 2015-16			634
FY 2016-17			991
FY 2017-18			1,026

November 2015 Projections After Adjustments			
FY 2014-15	37,104	-12.72%	(5,407)
FY 2015-16	39,356	4.36%	2,252
FY 2016-17	41,285	4.06%	1,929
FY 2017-18	42,775	3.61%	1,490

Actuals		
	Monthly Change	% Change
6-month average	285	0.80%
12-month average	(65)	-0.12%
18-month average	(151)	-0.32%
23-month average	(512)	-1.07%

February 2015 Forecast		
Forecasted June 2015 Level		39,321

Base trend from May 2015 level		
FY 2015-16	37,114	0.02%
		9

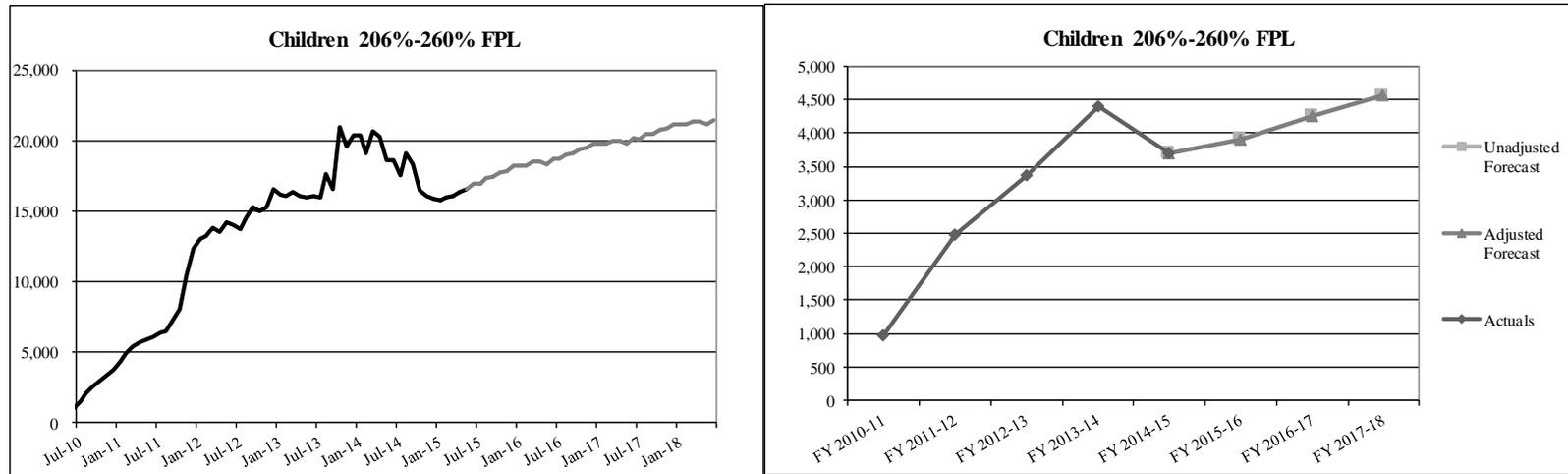
February 2015 Projection Before Adjustments			
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,803	-11.07%	(4,708)
FY 2015-16	39,496	4.48%	1,693
FY 2016-17	41,317	4.61%	1,821

HB 09-1353 Adjustment		
FY 2013-14		-
FY 2014-15		-
FY 2015-16		634
FY 2016-17		991

February 2015 Projection After Adjustments			
FY 2013-14	42,511	-31.72%	(19,749)
FY 2014-15	37,803	-11.07%	(4,708)
FY 2015-16	40,130	6.16%	2,327
FY 2016-17	42,308	5.43%	2,178

Monthly Average Growth Comparisons		
February 2015 Forecast	89	0.28%
FY 2014-15 Actuals	(104)	-0.22%
FY 2014-15 1st Half	(248)	-0.56%
FY 2014-15 2nd Half	69	0.19%
FY 2015-16 Forecast	282	0.72%
February 2015 Forecast	124	0.31%
FY 2016-17 Forecast	58	0.14%

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- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Children 206%-260% FPL is 16,728 which is lower than what was forecasted in February 2015. This November 2015 forecast has adjusted accordingly. Three of the last four months saw monthly growth of 200 or more. The projected average monthly growth for FY 2015-16 is 209 per month.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206% and 259% of the federal poverty level.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustments to the Children 206%-259% FPL caseload. It is the projected impact from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

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Children 206%-260% FPL: Historical Caseload and Projections			
	Actuals	Monthly Change	% Change
Jun-13	16,047	-	-
Jul-13	15,933	(114)	-0.71%
Aug-13	17,642	1,709	10.73%
Sep-13	16,564	(1,078)	-6.11%
Oct-13	20,972	4,408	26.61%
Nov-13	19,542	(1,430)	-6.82%
Dec-13	20,377	835	4.27%
Jan-14	20,324	(53)	-0.26%
Feb-14	19,050	(1,274)	-6.27%
Mar-14	20,690	1,640	8.61%
Apr-14	20,255	(435)	-2.10%
May-14	18,554	(1,701)	-8.40%
Jun-14	18,613	59	0.32%
Jul-14	17,496	(1,117)	-6.00%
Aug-14	19,106	1,610	9.20%
Sep-14	18,350	(756)	-3.96%
Oct-14	16,449	(1,901)	-10.36%
Nov-14	16,027	(422)	-2.57%
Dec-14	15,851	(176)	-1.10%
Jan-15	15,780	(71)	-0.45%
Feb-15	15,980	200	1.27%
Mar-15	16,068	88	0.55%
Apr-15	16,327	259	1.61%
May-15	16,573	246	1.51%

February 2015 Forecast			
Forecasted June 2015 Level			18,059

Base trend from May 2015 level			
FY 2015-16	16,573	-0.85%	(142)

	Caseload	% Change	Level Change
FY 2009-10	136		
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	15,575	40.96%	4,526
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	16,728	-12.16%	(2,315)
FY 2015-16	17,989	7.54%	1,261
FY 2016-17	19,559	8.73%	1,570
FY 2017-18	20,924	6.98%	1,365

HB 09-1353 Adjustment			
FY 2014-15			-
FY 2015-16			311
FY 2016-17			502
FY 2017-18			537

November 2015 Projections After Adjustments			
FY 2014-15	16,728	-12.16%	(2,315)
FY 2015-16	18,300	7.54%	1,572
FY 2016-17	20,061	8.73%	1,761
FY 2017-18	21,461	6.98%	1,400

Actuals		
	Monthly Change	% Change
6-month average	91	0.57%
12-month average	(165)	-0.83%
18-month average	(165)	-0.78%
23-month average	23	0.42%

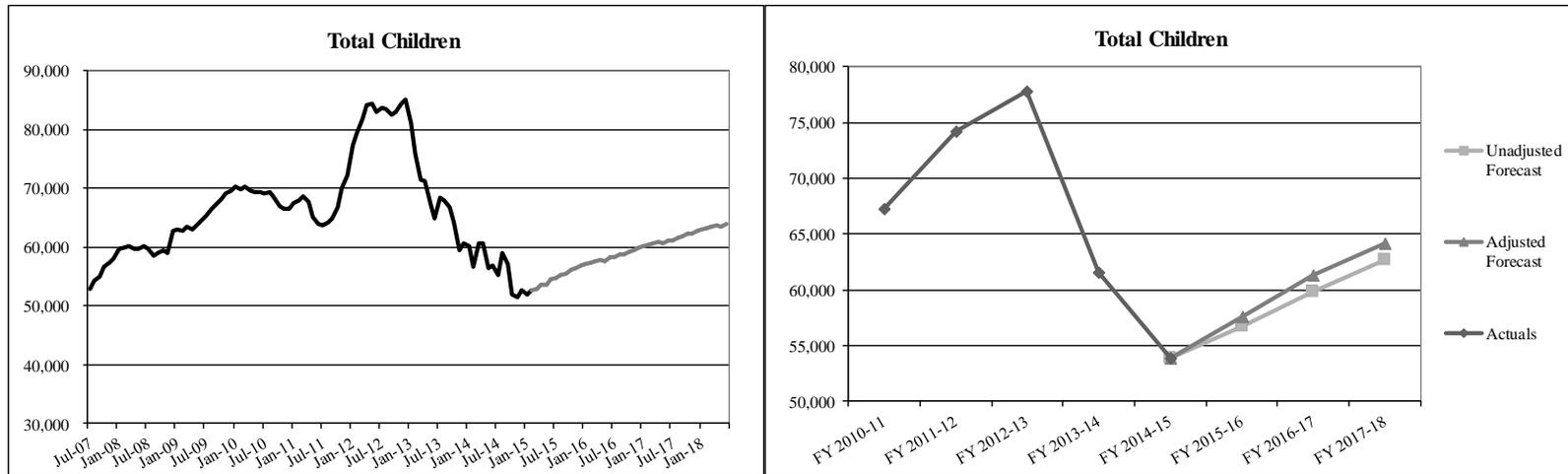
February 2015 Projection Before Adjustments			
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	17,176	-9.80%	(1,867)
FY 2015-16	18,140	5.61%	964
FY 2016-17	19,132	5.47%	992

HB 09-1353 Adjustment			
FY 2013-14			-
FY 2014-15			-
FY 2015-16			311
FY 2016-17			502

February 2015 Projection After Adjustments			
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	17,176	-9.80%	(1,867)
FY 2015-16	18,451	7.42%	1,275
FY 2016-17	19,634	6.41%	1,183

Monthly Average Growth Comparisons		
February 2015 Forecast	(46)	-0.13%
FY 2014-15 Actuals	(185)	-0.94%
FY 2014-15 1st Half	(460)	-2.46%
FY 2014-15 2nd Half	144	0.90%
FY 2015-16 Forecast	209	1.16%
February 2015 Forecast	60	0.33%
FY 2016-17 Forecast	94	0.47%

FY 2016-17 BUDGET REQUEST: CHILDREN'S BASIC HEALTH PLAN NARRATIVE



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Children was 53,832, which was 929 clients, or 1.70% under the February 2015 forecast. Forecasts have been reduced for this February 2015 estimate.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- As described above, there is one bottom-line adjustment to the CHP+ children's caseload. It is the projected impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This five year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

FY 2016-17 BUDGET REQUEST: CHILDREN'S BASIC HEALTH PLAN NARRATIVE

Total Children: Historical Caseload and Projections							
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change
Jun-13	64,942	-	-	FY 2007-08	57,796		
Jul-13	68,481	3,539	5.45%	FY 2008-09	61,582	6.55%	3,786
Aug-13	67,825	(656)	-0.96%	FY 2009-10	68,725	11.60%	7,143
Sep-13	66,707	(1,118)	-1.65%	FY 2010-11	67,267	-2.12%	(1,458)
Oct-13	64,266	(2,441)	-3.66%	FY 2011-12	74,266	10.40%	6,999
Nov-13	59,376	(4,890)	-7.61%	FY 2012-13	77,835	4.81%	3,569
Dec-13	60,528	1,152	1.94%	FY 2013-14	61,554	-20.92%	(16,281)
Jan-14	60,249	(279)	-0.46%	FY 2014-15	53,832	-12.55%	(7,722)
Feb-14	56,541	(3,708)	-6.15%	FY 2015-16	56,711	5.35%	2,879
Mar-14	60,662	4,121	7.29%	FY 2016-17	59,853	5.54%	3,142
Apr-14	60,691	29	0.05%	FY 2017-18	62,673	4.71%	2,820
May-14	56,447	(4,244)	-6.99%				
Jun-14	56,871	424	0.75%				
Jul-14	55,328	(1,543)	-2.71%				
Aug-14	58,964	3,636	6.57%				
Sep-14	57,025	(1,939)	-3.29%				
Oct-14	51,992	(5,033)	-8.83%				
Nov-14	51,432	(560)	-1.08%				
Dec-14	52,622	1,190	2.31%				
Jan-15	51,957	(665)	-1.26%				
Feb-15	52,666	709	1.36%				
Mar-15	52,977	311	0.59%				
Apr-15	53,502	525	0.99%				
May-15	53,687	185	0.35%				

February 2015 Projection Before Adjustments			
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	54,979	-10.68%	(6,575)
FY 2015-16	57,636	4.83%	2,657
FY 2016-17	60,449	4.88%	2,813

HB 09-1353 Adjustment			
FY 2013-14			-
FY 2014-15			-
FY 2015-16			945
FY 2016-17			1,493
FY 2017-18			1,563

November 2015 Projections After Adjustments			
FY 2014-15	53,832	-12.55%	(7,722)
FY 2015-16	57,656	5.35%	3,824
FY 2016-17	61,346	5.54%	3,690
FY 2017-18	64,236	4.71%	2,890

February 2015 Projection After Adjustments			
FY 2013-14	61,554	-20.92%	(16,281)
FY 2014-15	54,979	-10.68%	(6,575)
FY 2015-16	58,581	6.55%	3,602
FY 2016-17	61,942	5.74%	3,361

Actuals			
	Monthly Change	% Change	
6-month average	376	0.72%	
12-month average	(230)	-0.35%	
18-month average	(316)	-0.48%	
23-month average	(489)	-0.74%	

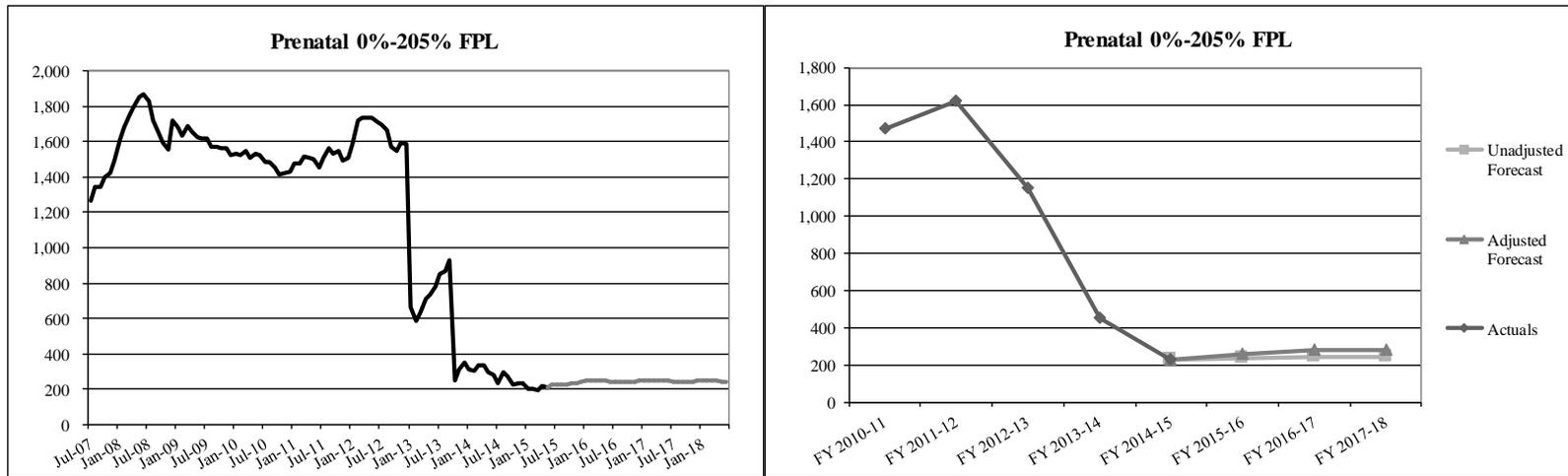
Monthly Average Growth Comparisons			
February 2015 Forecast	42	0.14%	
FY 2014-15 Actuals	(289)	-0.45%	
FY 2014-15 1st Half	(708)	-1.17%	
FY 2014-15 2nd Half	213	0.41%	
FY 2015-16 Forecast	491	0.86%	
February 2015 Forecast	185	0.32%	
FY 2016-17 Forecast	152	0.25%	

February 2015 Forecast			
Forecasted June 2015 Level		57,380	

Base trend from May 2015 level			
FY 2015-16	53,687	-0.25%	(133)

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Prenatal Caseload Projections (Exhibit C4)



- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Prenatal clients 0%-205% was 228, which is lower than what was forecasted in February 2015. This November 2015 forecast has decreased accordingly.
- Along with the children’s expansion to 205% FPL, this population includes the subpopulation that was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this subpopulation have family incomes between 201 and 205% of the federal poverty level.
 - Similar to children, this population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213% FPL. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-259% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustment to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

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Prenatal 0%-205% FPL: Historical Caseload and Projections			
	Actuals	Monthly Change	% Change
Jun-13	778	-	-
Jul-13	850	72	9.25%
Aug-13	869	19	2.24%
Sep-13	928	59	6.79%
Oct-13	246	(682)	-73.49%
Nov-13	313	67	27.24%
Dec-13	354	41	13.10%
Jan-14	310	(44)	-12.43%
Feb-14	300	(10)	-3.23%
Mar-14	333	33	11.00%
Apr-14	332	(1)	-0.30%
May-14	298	(34)	-10.24%
Jun-14	276	(22)	-7.38%
Jul-14	229	(47)	-17.03%
Aug-14	296	67	29.26%
Sep-14	273	(23)	-7.77%
Oct-14	224	(49)	-17.95%
Nov-14	233	9	4.02%
Dec-14	232	(1)	-0.43%
Jan-15	205	(27)	-11.64%
Feb-15	200	(5)	-2.44%
Mar-15	195	(5)	-2.50%
Apr-15	214	19	9.74%
May-15	212	(2)	-0.93%

	Caseload	% Change	Level Change
FY 2007-08	1,571		
FY 2008-09	1,665	5.98%	94
FY 2009-10	1,550	-6.91%	(115)
FY 2010-11	1,470	-5.16%	(80)
FY 2011-12	1,616	9.93%	146
FY 2012-13	1,148	-28.96%	(468)
FY 2013-14	451	-60.71%	(697)
FY 2014-15	228	-49.45%	(223)
FY 2015-16	239	4.82%	11
FY 2016-17	245	2.51%	6
FY 2017-18	243	-0.82%	(2)

HB 09-1353 Adjustment			
FY 2014-15			-
FY 2015-16			22
FY 2016-17			35
FY 2017-18			35

November 2015 Projections After Adjustments			
FY 2014-15	228	-49.45%	(223)
FY 2015-16	261	4.82%	33
FY 2016-17	280	2.51%	19
FY 2017-18	278	-0.82%	(2)

Actuals		
	Monthly Change	% Change
6-month average	(4)	-1.37%
12-month average	(7)	-2.09%
18-month average	(6)	-1.51%
23-month average	(25)	-2.40%

February 2015 Forecast		
Forecasted June 2015 Level		273

Base trend from May 2015 level		
FY 2015-16	212	-6.64%
		(15)

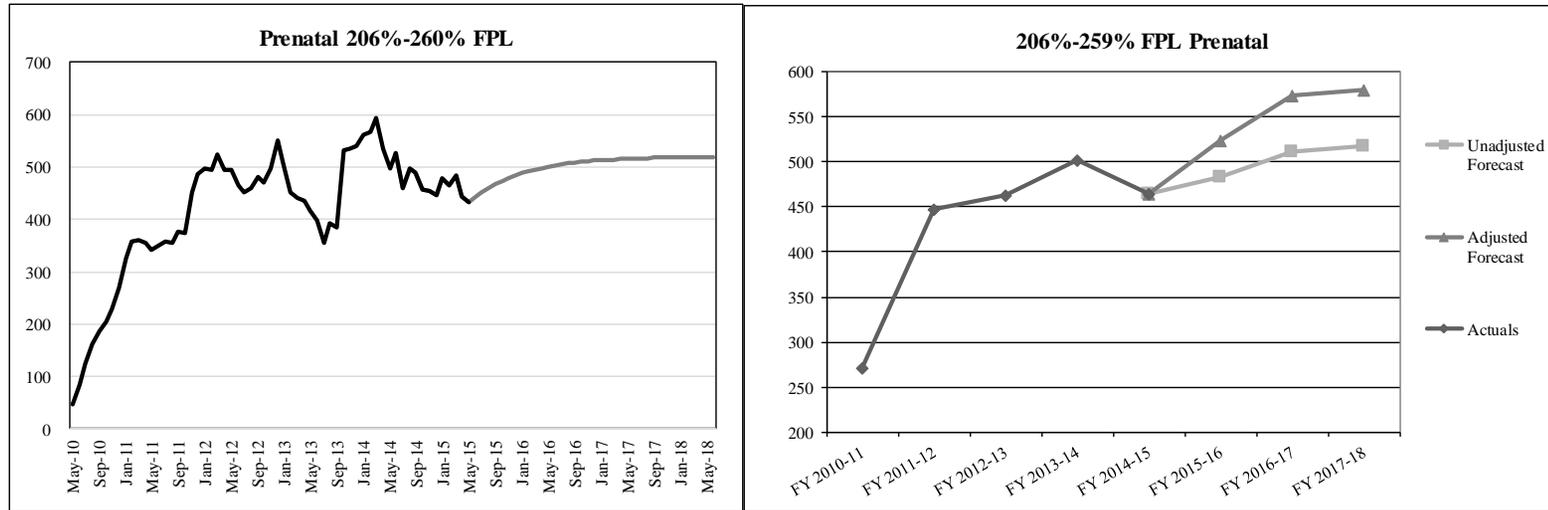
February 2015 Projection Before Adjustments			
FY 2013-14	451	-60.71%	(697)
FY 2014-15	252	-44.12%	(199)
FY 2015-16	286	13.49%	34
FY 2016-17	297	3.85%	11

HB 09-1353 Adjustment			
FY 2013-14			-
FY 2014-15			-
FY 2015-16			22
FY 2016-17			35

February 2015 Projection After Adjustments			
FY 2013-14	451	-60.71%	(697)
FY 2014-15	252	-44.12%	(199)
FY 2015-16	308	22.22%	56
FY 2016-17	332	7.79%	24

Monthly Average Growth Comparisons		
February 2015 Forecast	(0)	0.56%
FY 2014-15 Actuals	(6)	-1.61%
FY 2014-15 1st Half	(7)	-1.65%
FY 2014-15 2nd Half	(4)	-1.55%
FY 2015-16 Forecast	6	2.42%
February 2015 Forecast	5	1.63%
FY 2016-17 Forecast	(2)	-0.80%

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- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ Prenatal 206%-259% FPL was 464, which is lower than what was forecasted in February 2015. This November 2015 forecast has decreased accordingly.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206% and 259% of the federal poverty level.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the five year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

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206%-259% FPL Prenatal: Historical Caseload and Projections			
	Actuals	Monthly Change	% Change
Jun-13	399	-	-
Jul-13	354	(45)	-11.28%
Aug-13	393	39	11.02%
Sep-13	385	(8)	-2.04%
Oct-13	533	148	38.44%
Nov-13	534	1	0.19%
Dec-13	540	6	1.12%
Jan-14	561	21	3.89%
Feb-14	566	5	0.89%
Mar-14	593	27	4.77%
Apr-14	536	(57)	-9.61%
May-14	496	(40)	-7.46%
Jun-14	527	31	6.25%
Jul-14	460	(67)	-12.71%
Aug-14	496	36	7.83%
Sep-14	488	(8)	-1.61%
Oct-14	457	(31)	-6.35%
Nov-14	455	(2)	-0.44%
Dec-14	446	(9)	-1.98%
Jan-15	478	32	7.17%
Feb-15	465	(13)	-2.72%
Mar-15	485	20	4.30%
Apr-15	444	(41)	-8.45%
May-15	433	(11)	-2.48%

	Caseload	% Change	Level Change
FY 2008-09	-		
FY 2009-10	11		
FY 2010-11	272	2372.73%	261
FY 2011-12	448	64.71%	176
FY 2012-13	463	3.35%	15
FY 2013-14	502	8.42%	39
FY 2014-15	464	-7.57%	(38)
FY 2015-16	483	4.09%	19
FY 2016-17	512	6.00%	29
FY 2017-18	518	1.17%	6

HB 09-1353 Adjustment			
FY 2014-15			-
FY 2015-16			41
FY 2016-17			61
FY 2017-18			62

November 2015 Projections After Adjustments			
FY 2014-15	464	-7.57%	(38)
FY 2015-16	524	12.93%	60
FY 2016-17	573	9.35%	49
FY 2017-18	580	1.22%	7

Actuals		
	Monthly Change	% Change
6-month average	(4)	-0.69%
12-month average	(5)	-0.93%
18-month average	(6)	-0.98%
23-month average	1	0.81%

February 2015 Projection Before Adjustments			
FY 2013-14	502	8.42%	39
FY 2014-15	476	-5.18%	(26)
FY 2015-16	519	9.03%	43
FY 2016-17	524	0.96%	5

HB 09-1353 Adjustment		
FY 2013-14		-
FY 2014-15		-
FY 2015-16		41
FY 2016-17		61

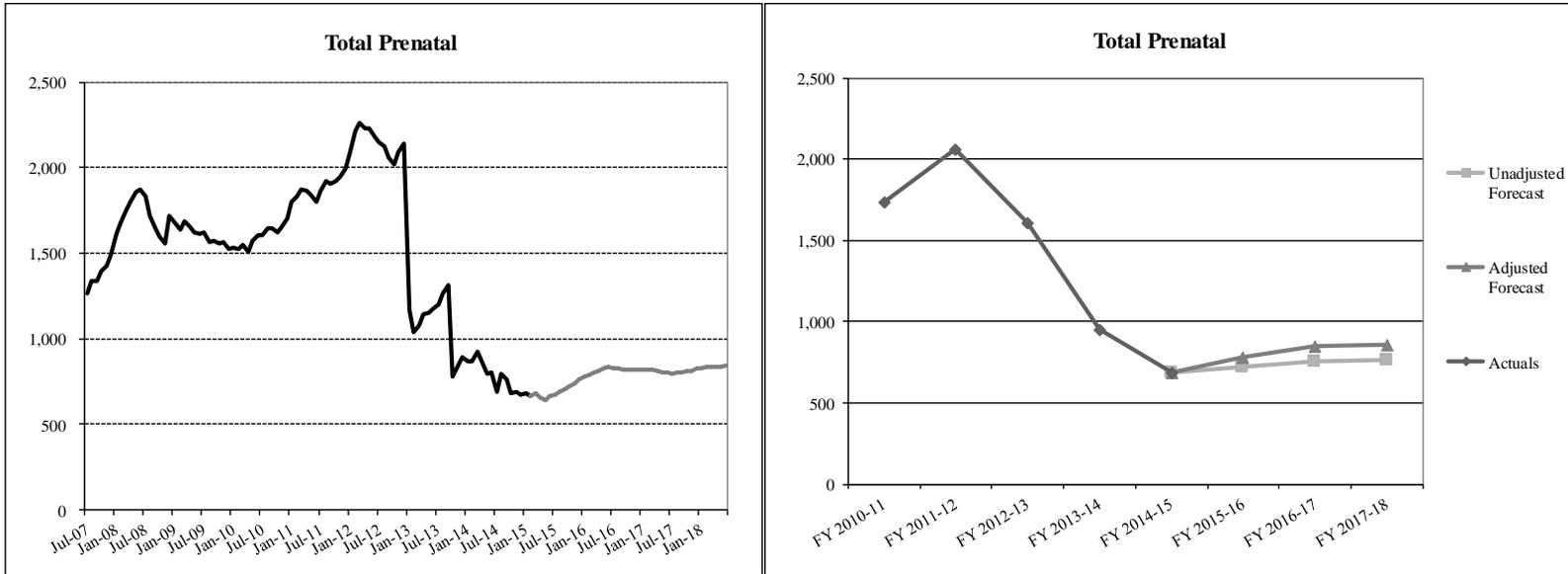
February 2015 Projection After Adjustments			
FY 2013-14	502	8.42%	39
FY 2014-15	476	-5.18%	(26)
FY 2015-16	560	17.65%	84
FY 2016-17	585	4.46%	25

Monthly Average Growth Comparisons		
February 2015 Forecast	(2)	-0.22%
FY 2014-15 Actuals	(9)	-1.59%
FY 2014-15 1st Half	(14)	-2.54%
FY 2014-15 2nd Half	(3)	-0.43%
FY 2015-16 Forecast	12	2.45%
February 2015 Forecast	2	0.29%
FY 2016-17 Forecast	(3)	-0.52%

February 2015 Forecast		
Forecasted June 2015 Level		505

Base trend from May 2015 level			
FY 2015-16	433	-6.21%	(29)

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- Average monthly caseload for FY 2014-15 (July 2014 through May 2015) for CHP+ prenatal was 693, which was 31 clients, or 4.29% under what was forecast in February 2015.
- As described above, there is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

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Total Prenatal: Historical Caseload and Projections			
	Actuals	Monthly Change	% Change
Jun-13	1,177	-	-
Jul-13	1,204	27	2.29%
Aug-13	1,262	58	4.82%
Sep-13	1,313	51	4.04%
Oct-13	779	(534)	-40.67%
Nov-13	847	68	8.73%
Dec-13	894	47	5.55%
Jan-14	871	(23)	-2.57%
Feb-14	866	(5)	-0.57%
Mar-14	926	60	6.93%
Apr-14	868	(58)	-6.26%
May-14	794	(74)	-8.53%
Jun-14	803	9	1.13%
Jul-14	689	(114)	-14.20%
Aug-14	792	103	14.95%
Sep-14	761	(31)	-3.91%
Oct-14	681	(80)	-10.51%
Nov-14	688	7	1.03%
Dec-14	678	(10)	-1.45%
Jan-15	683	5	0.74%
Feb-15	665	(18)	-2.64%
Mar-15	680	15	2.26%
Apr-15	658	(22)	-3.24%
May-15	645	(13)	-1.98%

	Caseload	% Change	Level Change
FY 2007-08	1,571		
FY 2008-09	1,665	5.98%	94
FY 2009-10	1,561	-6.25%	(104)
FY 2010-11	1,742	11.60%	181
FY 2011-12	2,064	18.48%	322
FY 2012-13	1,611	-21.95%	(453)
FY 2013-14	953	-40.84%	(658)
FY 2014-15	692	-27.39%	(261)
FY 2015-16	722	4.34%	30
FY 2016-17	757	4.85%	35
FY 2017-18	761	0.53%	4

HB 09-1353 Adjustment			
FY 2014-15			-
FY 2015-16			63
FY 2016-17			96
FY 2017-18			97

November 2015 Projections After Adjustments			
FY 2014-15	692	-27.39%	(261)
FY 2015-16	785	10.26%	93
FY 2016-17	853	7.21%	68
FY 2017-18	858	0.61%	5

Actuals		
	Monthly Change	% Change
6-month average	(7)	-1.05%
12-month average	(12)	-1.48%
18-month average	(11)	-1.29%
23-month average	(23)	-1.92%

February 2015 Forecast		
Forecasted June 2015 Level		778

Base trend from May 2015 level		
FY 2015-16	645	-6.35% (44)

February 2015 Projection Before Adjustments			
FY 2013-14	953	-40.84%	(658)
FY 2014-15	728	-23.61%	(225)
FY 2015-16	805	10.58%	77
FY 2016-17	821	1.99%	16

HB 09-1353 Adjustment		
FY 2013-14		-
FY 2014-15		-
FY 2015-16		63
FY 2016-17		96

February 2015 Projection After Adjustments			
FY 2013-14	953	-40.84%	(658)
FY 2014-15	728	-23.61%	(225)
FY 2015-16	868	19.23%	140
FY 2016-17	917	5.65%	49

Monthly Average Growth Comparisons		
February 2015 Forecast	(2)	-0.05%
FY 2014-15 Actuals	(14)	-1.72%
FY 2014-15 1st Half	(21)	-2.35%
FY 2014-15 2nd Half	(7)	-0.97%
FY 2015-16 Forecast	19	2.44%
February 2015 Forecast	12	1.41%
FY 2016-17 Forecast	(5)	-0.61%