COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2014-15, FY 2015-16, and FY 2016-17 Budget Request

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MEDICAL SERVICES PREMIUMS

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $121 million over the November request. The growth is primarily due to changes in expected caseload in three eligibility categories: MAGI Parents/Caretakers to 68% FPL, MAGI Adults, and Eligible Children. Current caseload estimates for the above mentioned categories increased over the November estimates, with adjustments made for the impact of new legislation, by approximately 8,000, 16,500, and 9,200 clients respectively. While per capita cost estimates for each of the Adult categories mentioned fell, the per capita estimate for Eligible Children has been increased since the November request. The increased caseload estimates for these groups contribute to a $106 million increase since the November. The increase in per capita estimates for Eligible Children results in a $36 million increase. These increases were tempered by lower per capita estimates for MAGI Adults and Disabled Buy-In; which decreased the estimate by nearly $20 million.
- Community-Based Long-Term Care – The current request is approximately $11.2 million over the November request. The increase is primarily due to client utilization of high per capita services growing at a faster pace than anticipated in the first half of FY 2014-15.
- Class I Nursing Facilities - The current request is approximately $7.1 million over the November request. The increase is primarily due to higher average rate paid to facilities in FY 2013-14 with complete run out, and a minor increase to the forecasted days in FY 2014-15.
- Program of All-Inclusive Care for the Elderly – The current request is approximately $5.9 million under the November request. Systems issues caused large fluctuations in enrollment in the MMIS on a paid basis, resulting in difficulty in accurately determining underlying trend in enrollment. The current request updated methodology to incorporate enrollment on a date of service basis to inform enrollment expectations, which resulted in lower expected enrollment than was in the November request.
- Prepaid Inpatient Health Plan Administration - The current request is approximately $17.6 million under the November request. This is primarily driven by Accountable Care Collaborative (ACC) policy changes that move a portion of administrative funding for the ACC into the next fiscal year.
- Hospital Provider Fee Supplemental Payments – The current request is approximately $172.3 million below the November request. The large decrease is due to changes in the hospital provider fee model due to changes in projections of revenue to be collected in the current fiscal year.

- The Department has determined that the 5% Federal Poverty Level (FPL) disregard used in the implementations of Affordable Care Act (ACA) was applied incorrectly. In Exhibit A, for clients where the 5% disregard was applied contrary to federal requirements, this financing adjustment moves their expenditure in two ways: for clients in the FPL range 63-68%, expenditures move from standard FMAP to 100% FMAP and for clients in the FPL range 55-60%, expenditures move from 0-59% FPL General Fund population to 60-68% Hospital Provider Fee funded population.
- When claiming the 100% FMAP for ACA Expansion, the Department chose the conservative route and excluded any clients that had any other type of medical insurance. Since the November request, the Department has received further clarification from CMS; only Medicaid/Medicare dually insured clients do not qualify for the 100% FMAP. The Department has adjusted the expenditure for clients that qualify for MAGI Adults and MAGI Parent/Caretakers 69-133% FPL, that also have another insurance type that is not Medicare, to 100% FMAP in Exhibit A.
- The Department implemented continuous eligibility for Medicaid in March 2014. Initially, the logic used to classify MAGI Eligible Children and SB 11-008 Eligible Children was not sophisticated enough to appropriately classify the clients that were enrolled due to continuous eligibility. The Department has since revised its caseload estimates for MAGI Eligible Children and SB 11-008 Eligible Children to appropriately classify clients that are enrolled in Medicaid due to continuous eligibility. This has resulted in an increased estimate of MAGI Eligible Children and a decreased estimate of SB 11-008 Eligible Children. Forecasts have changed accordingly. Cash-based actuals for FY 2013-14 have been restated to reflect the correct distribution of dollars between these two eligibility categories, which has resulted in historical per capita estimates for FY 2013-14 being restated as well.
- The Department has made an adjustment in Exhibit A to apply a resource proxy to the MAGI Non-Newly Eligible Disabled group within the MAGI Adult eligibility group. These clients are considered non-newly eligible for the ACA expansion because, due to their disability status, it is unknown if they would have been eligible for Medicaid in 2009 or not, which is the starting point for inclusion in the 100% federally financed population. The resource proxy is a mechanism that allows the Department to collect a higher FMAP for this population; 75% of the expenditure would draw a 100% FMAP, while 25% would draw the standard FMAP. Properly accounting for FMAP changes, the Non-Newly Eligible FMAP for FY 2014-15, 2015-16, and 2016-17 are 87.69%, 87.70%, and 85.81%, respectively. This allocation methodology is currently awaiting approval from CMS but the Department anticipates approval in the near future.

I. BACKGROUND

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

Further discussion depends on several key points that complicate the projection of this line item. They are summarized as follows:

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

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

   - Additional pages showing the effect of the delay are included in Exhibit C, Exhibit M, and Exhibit N.
   - In all cases, the Department's forecasts are based on the delay-adjusted cash-based actuals. As a result, the Department consistently forecasts a 52-week period in Exhibits F, G, H, and I.

2. The Department's request includes a number of references to various budget items and early supplemental budget reductions. July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced-budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding. Since experiencing economic recovery, the Department has continued to implement efficiencies, but has been able to restore provider rate increases. In FY 2013-14, rates were increased by 2% for Acute Care services and 8.26% for HCBS services, and in and FY 2014-15, rates were increased 2% across the board. Some services received varying targeted rate increases in FY 2014-15 as well.

3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom-line impacts. Bottom-line impacts can be found by service category (e.g., Acute Care, Community-Based Long-Term Care, Long-Term Care, Insurance, etc.) in the respective sections of this request. Those bottom-line impacts include the identification number of the originally submitted request, so that the bottom-line impact in the current year may be traced to the originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom-line impacts. Revisions to bottom-line impacts between requests are primarily limited to changes in implementation timeline. The Department generally does not adjust fiscal impact assumptions unless a deviation from assumptions in the original budget action is clear and significant.

4. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J.

5. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations, which gain eligibility as a result of HB 09-1293 and SB 13-200. This includes the expansion of eligibility to MAGI Adults and parents with Medicaid-eligible children up to 133% of the federal poverty level in FY 2013-14. These expansions increase Medicaid caseload and are discussed further in Sections II and III of this narrative.

6. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for administration and case management are included in Exhibit I. The Department's revised estimates are described in section V of this narrative.

7. The Department's request includes a forecast for FY 2014-15, FY 2015-16, and FY 2016-17. Some previous requests included only forecasts for the current and request years, therefore additional exhibits and changes in formatting to accommodate the additional year are present throughout.

8. The Department has added a new calculation for its Money Follows the Person grant program, known as Colorado Choice Transitions, to Exhibit G. Please see the narrative for Exhibit G and section V for additional information.

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

10. The Department's request includes SB 13-242, which created an adult dental benefit as well as the Adult Dental Benefit Fund to finance the design and implementation of the adult dental benefit program, effective April 1, 2014. The Department added a new calculation to estimate the impact of the adult dental benefit program, to Exhibit F. Please see the narrative for Exhibit F and section V for additional information.

11. The presence of varying funding mechanisms makes the Department's request more complex. Different Medicaid services have different federal match rates and are pertinent to different populations under Medicaid. Certain categories of service have historically been federally matched at different percentages than others. Indian Health Services, described further in this narrative, have historically received a 100% FMAP while Family Planning Services receive a 90% FMAP. BCCP services are matched at 65% FMAP. Medicaid expansion populations receive a different match rate than existing populations. Expansion Adults to 133% and the MAGI Adults populations, for instance, receive a 100% FMAP in FY 2014-15 and FY 2015-16, and a 97.5% FMAP in FY 2016-17 as the federal match for these populations falls to 95% in January 2017. The former CHP+ population that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of 65%. FMAP adjustments result in 65.53% FMAP for these populations in FY 2014-15. This enhanced FMAP only applies to the SB 11-250 Eligible Pregnant Adults population through July 31, 2015, after which time the FMAP associated with this population falls to the standard FMAP. The enhanced FMAP continues for the SB 11-008 Eligible Children population until October 2015, when this population will receive an additional 23 percentage point FMAP increase; the enhanced FMAP is expected to be 82.80% in FY 2015-16 and 88.50% in FY 2016-17.

12. Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing. The recommended services are those that have been given an A or B rating by the United States Preventive Services Task Force. The preventive services that are currently not included in the Colorado Medicaid benefit package are depression screening for adults, aspirin for the prevention of cardiovascular disease, counseling about screening for breast cancer susceptibility (BRCA), BRCA testing, shingles vaccines, and counseling interventions about tobacco use for non-pregnant adults. There is a bottom line adjustment in Exhibit F, Acute Care, for the estimated impact of providing these services. A further explanation of how these amounts were calculated is contained in this narrative under Acute Care.

13. Eligibility categories have changed to incorporate the Affordable Care Act's expansion population as well as other minor changes. Historical information has been updated to reflect the new eligibility categories. Please refer to the caseload narrative for more information.

14. The Centers for Medicare and Medicaid Services (CMS) has notified the Department that the State's FMAP for Medicaid services will decrease from 51.01% to 50.72% beginning October 1, 2015. The Department assumes that the decrease would remain in effect for the out year of the request and beyond, as well. Due to the FMAP increase to 51.01% effective October 1, 2014, FMAP for FY 2014-15 is 50.00% for the first quarter and 51.01% for the latter three quarters, resulting in an effective FMAP of 50.76% for the fiscal year. With the new FMAP of 50.72% beginning October 2015, FMAP for FY 2015-16 would be 51.01% for the first quarter and 50.72% for the latter three quarters, resulting in an effective FMAP of 50.79% for the fiscal year. FMAP for FY 2016-17 would be held constant at 50.72%. This FMAP change applies to Medicaid services only; Medicaid administrative costs would continue to receive a 50.00% FMAP. Although, the Department assumes the new FMAP rate would remain constant into FY 2015-16, there is the possibility that it would change again. If the FMAP does change, the Department would submit a supplemental funding request to account for the change in federal funds.

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

II. MEDICAID CASELOAD

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

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

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

A significant difference between this Budget Request and previous requests is the grouping and/or naming of the eligibility categories. Many categories remain unchanged, but the following changes have gone into effect:

- Categorically Eligible Low-Income Adults (AFDC-A) and Expansion Adults to 60% FPL have been combined into a single category, MAGI Parents/Caretakers to 68% FPL; historical information has been updated to reflect the merger of these eligibility categories in this Budget Request,
- Expansion Adults to 133% FPL has been renamed to MAGI Parents/Caretakers 69%-133% FPL,
- Adults without Dependent Children (AwDC) has been renamed to MAGI Adults,
- Baby Care Program – Adults has been renamed to MAGI Pregnant Adults,
- And two new eligibility categories have been added for the clients transitioning from CHP+ to Medicaid, SB 11-008 Eligible Children and SB 11-250 Eligible Pregnant Adults; these populations have been carved out of the Eligible Children and MAGI Pregnant Adults categories respectively, including historical information.

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

Rationale for Grouping Services for Projection Purposes

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

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

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services

- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long-Term Care:

- Home-and Community-Based Services: Elderly, Blind and Disabled
- Home-and Community-Based Services: Community Mental Health Supports
- Home-and Community-Based Services: Disabled Children
- Home-and Community-Based Services: Persons Living with AIDS
- Home-and Community-Based Services: Consumer Directed Attendant Support
- Home-and Community-Based Services: Brain Injury
- Home-and Community-Based Services: Children with Autism
- Home-and Community-Based Services: Children with Life Limiting Illness
- Home-and Community-Based Services: Spinal Cord Injury Adult
- Private Duty Nursing
- Hospice

Long-Term Care:

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

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration

Financing:

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

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

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from page EA-2. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

For the request year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the out year. The total Base Amount is compared to the total projected estimated out year expenditure from page EA-4. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the out year.

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

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service (FFIS) each year and is based on a statewide per capita earnings formula that is set in federal law. In October 2014, the FMAP for Medicaid services increased to 51.01%. The Centers for Medicare and Medicaid Services (CMS) has notified the Department that the State's FMAP for Medicaid services would decrease from 51.01% to 50.72% beginning October 1, 2015. The Department assumes that the FMAP for Medicaid services would continue at 50.72%. Although the Department assumes that the new FMAP rate would remain constant into FY 2016-17, there is a possibility that the FMAP rate could change in late Fall 2014. If the FMAP rate changes the Department would follow the Budget Process and submit a supplemental to account for the change in federal funds.

Certain populations and services receive different FMAPs than the new standard 51.01%. This is summarized below. Clients transitioning from CHP+ to Medicaid receive the CHP+ FMAP, which is usually 65% but has been recalculated at 65.71% effective October 2014 and 65.50% effective October 2015. Section 2105(b) of the Social Security Act further modifies the enhanced FMAP for CHP+ clients, and thus clients transitioning from CHP+ to Medicaid who are funded under Title XXI, by an additional 23 percentage points, effective October 1, 2015 through September 30, 2019. Therefore, FMAP for clients transitioning from CHP+ to Medicaid receive 82.80% FMAP in FY 2015-16 and 88.50% FMAP in FY 2016-17. Clients in the BCCP program also receive a 65% match, or 65.71% effective October 2014 and 65.50% effective October 2015. The FMAP increase to 51.01% occurred at the start of the second quarter of FY 2014-15, the FMAP is 50% for quarter one and 51.01% for the remainder of the year, resulting in a final FMAP of 50.76% for FY 2014-15. The same logic is applied to the populations receiving 65% for quarter one and 65.71% the remainder of the fiscal year, resulting in a final FMAP of 65.53% for FY 2014-15. Since the FMAP decrease to 50.72% occurs at the start of the second quarter of FY 2015-16, the FMAP would be 51.01% for quarter one and 50.76% for the remainder of the year, resulting in a final FMAP of 50.79% for FY 2015-16. This logic is applied to the populations receiving 65.71% for quarter one and 65.50% the remainder of the fiscal year, resulting in a final FMAP of 65.55% for FY 2015-16. The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 100% beginning January 1, 2014, though this falls to 95% beginning January 1, 2017, resulting in a final FMAP of 97.50% for these population for FY 2016-17. A sub-group of MAGI Adults, non-newly eligible disabled individuals, receive the ACA expansion FMAP for 75% of their expenditure and the standard FMAP for the remaining 25% resulting in an effective FMAP of 87.69%, 87.70%, and 85.81% for FY 2014-15, 2015-16, and 2016-17 respectively. The Disabled Buy-In population receives the standard match for expenditures net of patient premiums.

Calculation of expenditure by financing type can be found in Exhibit A.

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
FY 2014-15	65.53%	Qualifying clients transitioned from CHP+ to Medicaid, Clients in the BCCP program	Please see Exhibit F
	100%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	87.69%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.76%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.76%, Medicaid Buy-In Fund 0%
FY 2015-16	82.80%	Qualifying children transitioned from CHP+ to Medicaid	Please see Exhibit F
	52.02%	Qualifying prenatal clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.55%	Clients in the BCCP Program	Please see Exhibit F
	100%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	87.70%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.79%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.79%, Medicaid Buy-In Fund 0%
FY 2016-17	88.50%	Qualifying children transitioned from CHP+ to Medicaid	Please see Exhibit F
	50.72%	Qualifying prenatal clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.50%	Clients in the BCCP Program	Please see Exhibit F
	97.50%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	85.81%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.72%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.72%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2014-15	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.76%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Physicians to 100% of Medicare: ACA Section 1202	Please see bottom line adjustment in Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2015-16	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.79%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2016-17	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.72%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F

Calculation of Fund Splits

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

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g., Acute Care) by programs funded with either a different state source or a different FMAP rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds, though this changed to 48.99% General Fund and 51.01% federal funds in October 2014. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate, increased to 65.71% effective October 2014, and then decreased to 65.50% effective October 2015. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the state's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund.

- Family Planning: The Department receives a 90% FMAP available for all documented family planning expenditures. This includes those services rendered through health maintenance organizations. Please see Exhibit F for calculations.

- Indian Health Services: The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the State. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure.

- Affordable Care Act Preventive Services: Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing.

- SB 11-008 "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children from ages 6 to 19. Effective January 1, 2013, children under the age of 19 are eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for these clients will remain at the same level as if the clients had enrolled in the Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%, though the enhanced FMAP increased to 65.71% effective October 2014 and then decreased to 65.50% effective October 2015. Section 1205(b) of the Social Security Act increases the enhanced FMAP by an additional 23 percentage points, effective October 2015 through September 2019. Therefore, FMAP for this population for FY 2014-15, FY 2015-16, and FY 2016-17 is expected to be 65.53%, 82.80%, and 88.50% respectively.

- SB 11-250 "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As

with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients, though the enhanced FMAP is increased to 65.71% effective October 2014. The State has authority to claim the enhanced FMAP on this population through July 31, 2015; after this date, the FMAP is reduced to the standard Medicaid match rate of 51.01%. Effective October 1, 2015, the Department has received guidance from the Centers for Medicare and Medicaid Services (CMS) that the standard FMAP for Colorado will be reduced to 50.72%. The Department assumes 50.72% FMAP going forward.

- MAGI Parents/Caretakers 69% to 133% FPL: HB 09-1293, the Colorado Health Care Affordability Act of 2009, authorizes the Department to collect provider fees from hospitals for the purpose of obtaining federal financial participation for the State's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program, 2) increase the number of persons covered by public medical assistance to 100% of the federal poverty line, and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate the hospital provider fee to each applicable service category. Additionally, SB 13-200 amended Medicaid eligibility for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line in keeping with Medicaid expansion under the Affordable Care Act, which also ensures that MAGI Parents/Caretakers 69% to 133% of the federal poverty line receive a 100% federal match rate through the end of CY 2016, effective January 1, 2014. In CY 2017, the federal match rate for this population is reduced to 95%. See Exhibit J for additional information and detailed calculations.

- MAGI Adults: This population began participation in Medicaid in FY 2011-12 and was previously labeled Adults without Dependent Children (AwDC). The population was originally funded with a combination of federal funds and Hospital Provider Fee; however, SB 13-200 amended the Medicaid eligibility criteria for MAGI Adults to 133% of the federal poverty line in accordance with Medicaid expansion under the Affordable Care Act. Effective January 1, 2014, the Affordable Care Act provides this population a 100% federal match rate from CY 2014 through CY 2016 and a 95% federal match rate in CY 2017. This results in a 100% federal match rate for this population from FY 2014-15 through FY 2015-16 and approximately a 97.50% federal match rate in FY 2016-17. Calculations and information regarding this population can be found in Exhibit J.

- Disabled Buy-In: Funds for this population come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.

- Non-Newly Eligibles: Historically, MAGI Parents/Caretakers 69% to 133% FPL and MAGI Adults were funded with a combination of federal funds and Hospital Provider Fee. As explained above under those categories, the Affordable Care Act provides both populations with a 100% federal match rate, effective January 1, 2014. A caveat of this enhanced federal match rate is that the population receiving 100% FMAP cannot have been eligible for Medicaid services prior to 2009 (or else those clients are not

considered part of the Medicaid expansion population). A subset of the population may have been eligible for Medicaid services prior to 2009 under disability criteria, had the clients chosen to provide asset information when they applied for Medicaid services. For this population, the Department is unable to prove that these clients would not have been eligible for Medicaid services prior to 2009 if they had provided asset information, and therefore cannot claim 100% FMAP on their expenditure. These clients are now eligible for Medicaid under the expansion, and receive standard FMAP with the State portion funded through the Hospital Provider Fee, as is required by statute. The Department is pursuing a resource proxy, which is a mechanism that would allow the State to collect a higher FMAP for this specific population. The Department is currently awaiting approval from CMS but anticipates approval in the near future. When approved, the Department would be able to claim 75% of the expenditures for Non-Newly Eligible clients at 100% FMAP and the remaining 25% at standard FMAP. Please refer to Exhibit J for calculations and additional details.

- MAGI Parents/Caretakers 60% to 68% FPL: Historically, Parents/Caretakers over 60% FPL were funded with a combination of federal funds and Hospital Provider Fee. As explained above, the Affordable Care Act provides MAGI Parents/Caretakers 69% to 133% FPL with a 100% federal match rate, effective January 1, 2014. Due to new MAGI conversion rules (please refer to the Caseload Narrative for additional details), the non-expansion eligibility category MAGI Parents/Caretakers to 68% FPL now includes FPL levels over 60%. The MAGI Parents/Caretakers to 68% FPL clients who have FPL levels over 60% are funded with Hospital Provider Fee for the State's contribution, rather than General Fund, as is required by statute. Please refer to Exhibit J for calculations and additional details.

- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per-diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.

- Adult Dental Benefit Financing: SB 13-242 creates a limited dental benefit for adults in the Medicaid program, to be implemented by April 1, 2014. To fund the design and implementation of the adult dental benefit, SB 13-242 created the Adult Dental Fund effective July 1, 2013, financed by the Unclaimed Property Trust Fund. The majority of the design and implementation of the dental benefit is funded by a federal funds appropriation of $27,339,114, and the Adult Dental Fund cash fund appropriation is increased by $26,474,024. Beginning in FY 2014-15, the financing for populations not funded through the Adult Dental Fund are reported in their respective lines and savings are attributed to the Base Acute line.

- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare

reimbursement. The difference in rates between July 1, 2009 and January 1, 2013 were paid for by the federal government through an enhanced FMAP of 100%, through calendar year 2014. Additional details are provided in sections IV and V.

- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to 75 children living with autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to approximately $1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Clients are limited to a cap of $25,000 in waiver services. The Department estimates the funding needed from the Colorado Autism Treatment Fund based on the program estimate in Exhibit G, which includes $163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive federal financial participation. In aggregate, the Department estimates that approximately 84.5% of the total will receive federal financial participation in FY 2014-15, 84.5% in FY 2015-16, and 81.0% in FY 2016-17. The Department anticipates a decline in the portion of premiums matched with federal funds as a result of increased Disabled Buy-In enrollment over time.

- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The State share of funding is through certification of public expenditure.

- Upper Payment Limit Financing: Offsets General Fund as a bottom-line adjustment to total expenditures. This is further described in Exhibit K.

- Department Recoveries Adjustment: Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in Exhibit L.

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health Federally Qualified Health Centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2014-15, FY 2015-16, and FY 2016-17 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund was insolvent and no longer covered the cost of the programs. The balance in the Health Care

Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

- Service Fee Fund: SB 13-167 moved collection authority for provider fees collected from intermediate care facilities from the Department of Human Services (DHS) to the Department as of July 1, 2013. This eliminates the need to transfer funds between DHS and the Department in order to obtain the federal match to reimburse covered expenses incurred at intermediate care facilities. This changes the source of the provider fees from a reappropriated fund from DHS to a cash fund for the Department.

- Hospital Provider Fee for Continuous Eligibility: Continuous eligibility for children provides children with twelve months of continuous coverage through Medicaid, even if the family experiences an income change during any given year. The Department has the authority to use the Hospital Provider Fee Cash Fund to fund the State share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives the standard federal financial participation rate.

- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers.

The table below shows the impact by cash fund for FY 2014-15, FY 2015-16, and FY 2016-17.

Cash Funds	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Tobacco Tax Cash Fund (SB 11-210)	$2,230,500	$2,230,500	$2,230,500
Hospital Provider Fee Cash Fund (SB 13-200) - Continuous Eligibility	$6,431,818	$7,662,224	$8,434,576
Hospital Provider Fee Cash Fund (SB 13-230) - Upper Payment Limit Backfill	$15,700,000	$15,700,000	$15,700,000
Old Age Pension Health and Medical Care Fund (SB 13-200)	$5,495,027	$5,369,479	$5,240,893
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$30,057,805**	**$31,162,663**	**$31,806,429**

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2016-17. Adjustments for caseload effects which are not captured in trends are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3.

Pages EB-4 through EB-6 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through the first half of FY 2014-15.

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

Changes to the Eligibility Categories

The Department has chosen to alter the eligibility categories to reflect the different Federal Medical Assistance Percentage (FMAP) that is applied to different categories. Several steps in Medicaid expansion (described below) introduced new categories with an enhanced FMAP. Forecasting caseload by eligibility and FMAP categories allows for a more accurate expenditure estimate for each funding source. Beginning with the August 2014 JBC Monthly Report, caseload is restated to align with the eligibility categories described below.

- "Categorically Eligible Low-Income Adults" and "Expansion Adults to 60%" were combined into one category called "MAGI Parents/Caretakers to 68% FPL."
- "Expansion Adults to 133% FPL" is now titled "MAGI Parents/Caretakers 69%-133% FPL"
- On January 1, 2013, Colorado implemented SB 11-008 and SB 11-250 which expanded Medicaid Eligible Children to 133% FPL for all ages and expanded Baby-Care Adults to 185%. The incremental increase in eligibility receives an enhanced match equal to the CHP+ FMAP of 65%. Eligible Children and Baby-Care Adults are now separated into two categories each; Eligible Children and SB 11-008 Eligible Children, and MAGI Eligible Pregnant Adults and SB 11-250 Eligible Pregnant Adults.

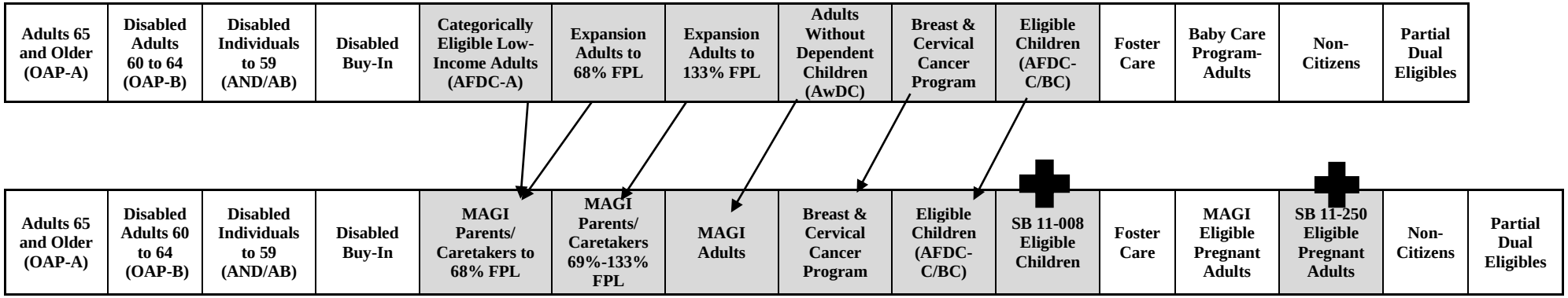


EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

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

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. The Prenatal State-Only program allows legal immigrants that entered the United States after August 22, 1996 to have State funded prenatal care and Emergency only Medicaid benefits for labor and delivery. These expenditures are included in the MAGI Pregnant Adults aid category for beginning in FY 2009-10. HB 09-1353 was passed in FY 2009-10, which allowed legal immigrants that have lived in the United States less than 5 years to qualify for Medicaid as pregnant adults, Medicaid children, or CHP+ clients, provided available funding. Funding for Medicaid pregnant adults was available July 2010. The population that was Prenatal State-Only now represents pregnant adults that are eligible under HB 09-1353. These expenditures are still included in the MAGI Pregnant Adults aid category.

Historical information for FY 2013-14 has been restated with the correction for continuous eligibility for the SB 11-008 Eligible Children and Eligible Children (AFDC-C/BC) categories, which updated the distribution of dollars between these two categories to more accurately reflect actual expenditure for each. The previous logic resulted in clients who should have been reflected in the Eligible Children (AFDC-C/BC) category who were on continuous eligibility being accounted for under SB 11-008 Eligible Children instead. Similarly, an error was found and corrected for cash-based actuals expenditure for Health Maintenance Organization and Pharmacy

service categories that resulted in expenditure being attributed to the Eligible Children (AFDC-C/BC) category that should have been attributed to the SB 11-008 Eligible Children category.

EXHIBIT D - CASH FUNDS REPORT

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

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

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

Comparison of Request to Long Bill Appropriation and Special Bills

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

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical per capita costs and the annual percent changes are also provided. The first step of the calculation is

to select a historical per capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom-line adjustments are made for legislation and other impacts not included in historical trends. Total expenditure after bottom-line adjustments is divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita, including a per capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2006-07 through FY 2013-14. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the bottom of page EF-1, the Department has provided a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per capita costs is used to modify the request-year per capita costs, although the Department makes adjustments to the selected trend where necessary.

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

The table below describes the trend selections for FY 2014-15, FY 2015-16, and FY 2016-17. In some cases, though not all, the Department has held the trend constant among the three years. In Exhibit F, the selected trend factors have been bolded for clarification. As described in the Department's caseload narrative, populations sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth has led to per capita declines due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new clients from economically sensitive populations may have had health insurance previously and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2014-15, FY 2015-16, and FY 2016-17, with the rationale for selection, are as follows:

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.78%	0.78%	0.78%	While FY 2013-14 per capita expenditures saw growth, the Department has identified that the vast majority of the growth can be attributed to rate increases for home health services. Because underlying utilization is both small and stable, the Department has selected trends accordingly of less than 1% annual growth. Rate increases are added via bottom line impact and need not be included in the base per capita trend.
Disabled Adults 60 to 64 (OAP-B)	0.35%	0.58%	0.58%	The Department has identified that increases in per capita expenditure in FY 2013-14 are largely attributable to rate increases for home health services. Because utilization of these services is stable, the Department has selected trends of less than 1% annual growth. Rate increases are added via bottom line impacts and need not be included in the base per capita trend.
Disabled Individuals to 59 (AND/AB)	0.80%	0.80%	0.80%	The Department has identified that increases in per capita expenditure in FY 2013-14 are largely attributable to rate increases for home health services. Because utilization of these services rose slightly in FY 2013-14, the Department has selected trends close to 1% annual growth. Rate increases are added via bottom line impacts and need not be included in the base per capita trend.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Disabled Buy-in	-15.00%	5.00%	5.00%	Analysis of expenditure through the first half of FY 2014-15 indicate that per capita costs for this population are stabilizing. The Department believes that per capita costs in FY 2012-13 and FY 2013-14 were high due to pent up demand for services from the most medically needy clients that applied for Medicaid services through the buy-in program. The Department has chosen an aggressive downward trend to account for this stabilization.
MAGI Parents/ Caretakers to 68% FPL	-7.50%	-2.78%	-2.78%	The Department has selected an aggressive downward trend as significant per capita decreases seen in FY 2013-14 are expected to continue due to strong caseload growth in this category and lower utilization of services from new clients that have been eligible for services but have failed to seek care for some time.
MAGI Parents/ Caretakers 69% to 133% FPL	-9.34%	-2.78%	-3.09%	Per capita for this population was roughly 80% that of the MAGI Parents/Caretakers to 68% FPL in FY 2013-14, the Department believes that per capita costs for this population will remain below those of the MAGI to 68% FPL group. Additionally, caseload growth continues to be strong for this population which is expected to put downward pressure on per capita costs.
MAGI Adults	7.50%	5.00%	2.50%	The Department anticipates strong pent-up demand for services from this population, thus an aggressive trend has been selected to modify per capita expenditure. The Trend has been reduced in FY 2015-16 and FY 2016-17 as the effects of pent-up demand subside.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Breast & Cervical Cancer Program (Page EF-6)	0.00%	0.00%	0.00%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	0.00%	0.00%	0.00%	Analysis of expenditure for this population indicates that the previous trend selected in the November R-1 may have been too aggressive. Per capita costs remain largely unchanged from previous fiscal years despite aggressive caseload growth. Additionally, reports of a strong flu season have led the Department to increase the trend to 0.00% to reflect expenditure in the first half of FY 2014-15.
SB 11-008 Eligible Children	-6.00%	0.00%	0.00%	The Department assumes a near doubling of caseload expected in 2014-15 will put strong downward pressure on per capita costs. Per capita is expected to stabilize in the request year and the out year so a trend of 0.00% was selected to modify per capita.
Foster Care	-4.00%	-2.00%	0.00%	Strong caseload growth and a number of prescription drug patent expirations contribute to the downward trend selected. The Department believes that drug patent expiration will continue to put downward pressure beyond FY 2014-15 but expects costs to stabilize in the out year.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
MAGI Pregnant Adults	0.00%	0.00%	0.00%	The Department does not expect the per capita growth within this category to continue. Analysis of expenditure through the first half of FY 2014-15 has not changed this assumption.
SB 11-250 Eligible Pregnant Adults	0.00%	0.00%	0.00%	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
Non-Citizens	2.95%	2.95%	2.95%	The Department has lowered the per capita growth trend for this population given actual per capita decreases in FY 2013-14.
Partial Dual Eligibles	1.34%	1.34%	1.34%	The Department has lowered the per capita growth trend for this population given lower than expected expenditure in the first half of FY 2014-15.

Legislative Impacts and Bottom-line Adjustments

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

- SB 10-117, OTC MEDS allows for pharmacists to prescribe certain over-the-counter drugs to Medicaid Clients. The program reduces expenditure by reducing more costly visits to the emergency room or physicians for over-the-counter prescriptions.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This was effective January 1, 2013 through the end of calendar year 2014.
- Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Additional detail can be found both in section V and in Exhibit I.

- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year, regardless of prior authorization.
- Estimated Impact of Increasing PACE Enrollment accounts for the Department's initiative to increase enrollment of new PACE clients. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community-Based Long-Term Care service groups to the PACE service category.
- SB 10-167, Colorado False Claims Act increases enrollment in the Health Insurance Buy-In (HIBI) program. As of December 2014, there were 470 enrollees in the program. The Department expects to increase enrollment by approximately 2% per month through FY 2016-17.which is more expensive than CDASS, resulting in savings allocated to acute care.
- Colorado Choice Transitions adjusts for increased home health service expenditure associated with clients transitioning to alternative care settings. Additional detail can be found in Exhibit G.
- R-6 (FY 2012-13), Dental Efficiency, reflects a refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated.
- R-6 (FY 2012-13), Augmentative Communication Devices, accounts for the availability of new, cheaper, communication assistance technology for clients with disabilities impairing their ability to communicate.
- Fifty-Three Pay Periods in FY 2013-14 accounts for the Department's claims processing cycle including a 53rd payment period every seven years. This adjustment accounts for the additional payment period in FY 2013-14, which results in a reduction in expenditure in FY 2014-15.
- R-7 (FY 2013-14), Substance Use Disorder Benefit, accounts for savings associated with enhancing the existing substance abuse disorder benefit by adding appropriate services to make a more robust program.
- R-9 (FY 2013-14), Dental ASO, accounts for savings associated with implementing a dental administrative service organization (ASO) for the Medicaid children's dental benefit.
- R-13 (FY 2013-14), 2% Provider Rate Increase, accounts for added expenditures associated with increasing provider rates by 2% for services impacted by rate reductions in recent years.
- SB 13-242, Adult Dental Benefit accounts for added expenditures associated with providing a dental benefit for adults in the Medicaid program.
- SB 13-200 Medicaid Expansion adjustment is an adjustment made to account for lower average per capita expenditure expectations for clients newly entering the Medicaid program. The Department has revised the adjustment in FY 2014-15 based on actual expenditure in FY 2013-14.
- Preventive Services accounts for the differences in the benefits packages between the expansion requirements and the current Colorado Medicaid benefits package. Colorado Medicaid offers preventive services not required under the expansion but still available to clients. An adjustment is made to account for this difference.
- Fluoride Benefit Expansion for Children accounts for additional costs associated with the expansion of fluoride varnish services to certain providers as required in a 2013 Long Bill footnote.

- CDASS Service Expansion into the Brain Injury (BI) Waiver – clients on the CBLTC BI waiver would utilize the CDASS as a service delivery option for health maintenance activities rather than long-term home health, which is more expensive than CDASS, resulting in savings allocated to acute care.
- R-7 (FY 2014-15), Adult Supported Living Service Waiting List Reduction, accounts for savings resulting from clients utilizing SLS waiver services in place of state plan services.
- R-8 (FY 2014-15) and HB 14-1252 Client Movement to the DD Waiver: FY 2014-15 R-8: "Developmental Disabilities New Full Program Equivalents" and HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity" are combined into one bottom-line adjustment – FY 2014-15 R-8 allows for emergency enrollments onto the Division for Intellectual and Developmental Disabilities (DIDD) Developmental Disabilities (DD) waiver and HB 14-1252 is the bill that incorporates the Department's BA-5/S-5 request "Community Living Caseload and Per Capita Changes," which reduced the waitlist for the DD waiver. The impact to Acute Care is due to the increased caseload and per capita costs for the DIDD Medicaid waivers attributable to those formerly utilizing state plan services in Acute Care. This results in decreased costs in Acute Care.
- R-9 (FY 2014-15), Medicaid Community Living Initiative, accounts for added expenditure for counseling nursing home residents regarding community-based living options.
- R-10 (FY 2014-15), Primary Care Specialty Collaboration, accounts for added expenditure for primary care providers and specialists to acquire and utilize technology that allows remote specialty consultation.
- R-11 (FY 2014-15), Community Provider Rate Increases, accounts for added expenditure from a 2% across the board increase for eligible providers.
- R-11 (FY 2014-15), Targeted Community Provider Rate Increase, accounts for added expenditure from targeted rate increase for the purpose of addressing issues with clients access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F1.
- BA-10 (FY 2014-15), Continuation of 1202 Provider Rate Increases, accounts for added expenditure to pay for primary care services at 100% of Medicare Rates.
- BA-12 (FY 2014-15), State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees, accounts for added expenditure to enroll clients dually eligible for Medicaid and Medicaid in the Accountable Care Collaborative (ACC) so that they will receive care coordination.
- FY 2014-15 JBC Action, Matching Incentives to Ambulatory Surgery Center Facilities, accounts for added expenditure for matching funds paid to Surgeons accounted for within the R-11 Targeted Community Provider Rate Increase.
- FY 2014-15 JBC Action, Family Planning Rate Increase, accounts for added expenditure to standardize oral contraceptive rates and increase Family Planning rates by 15%.
- FY 2014-15 JBC Action, Raising FQHC Rate Increase to APM, accounts for added expenditure to bring rates for Federally Qualified Health Centers up to the rate called for in Colorado's Alternative Payment Method.

- FY 2014-15 JBC Action, Full Denture Benefit, accounts for added expenditure to provide clients with full dentures with prior authorization as part of the Adult Dental Benefit.
- EPSDT Personal Care adjustment accounts for added expenditure from personal care services deemed medically necessary for EPSDT eligible children. In late FY 2013-14 the Department received notice from CMS that personal care is a covered benefit under EPSDT if deemed medically necessary. The Department anticipates that clients utilizing personal care under EPSDT will fall into three categories: clients substituting long-term home services with less costly personal care services; resulting in savings in acute care, clients directly substituting units under the state plan from waivers, resulting in an increase in acute care expenditure and decrease to HCBS wavier expenditure, and clients who have never had access to personal care that have a medical necessity, resulting in an increase in acute care expenditure.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits

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

HB 14-1045 extended the repeal date of the program through July 1, 2019. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the State's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund. All Breast and Cervical Cancer Program expenditures receive a 65.53% federal match rate.

Per Capita Cost

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

on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as 32.73%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per capita expenditures. The Department assumes the decline in the per capita expenditures is a temporary product of increasing caseload and, as the new clients incur costs, the per capita rate will begin to slow down in its decline. For the current year trend, the Department assumes that per capita costs will remain unchanged from FY 2013-14.

Fund Splits

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

Adult Dental Benefit Per Capita Detail

In 2013, the General Assembly passed SB 13-242, which established the Adult Dental Benefit program along with the Adult Dental Cash Fund which is funded through the Unclaimed Property Tax Fund. The Adult Dental Cash Fund provides the funding for the State share of the Dental Benefit program. In 2014, the General Assembly passed HB 14-1336 which provided funding for the addition of full dentures as part of the Adult Dental Benefit. The Department previously covered dental services for adults only in emergencies or in the case of co-occurring conditions that required dental services. The Department does not have a way to systematically distinguish between dental services received in the case of emergency or co-occurring conditions and those covered under the Adult Dental Benefit. The Adult Dental Exhibit on pages EF-6 through EF-8 reports total Dental expenditure and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate expenditure that requires financing from the Adults Dental Cash Fund.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group within the Pharmaceutical Drug service category. Exhibit F, pages EF-9 through EF-10, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational-only line item in Long Bill group (3), effective with HB 08-1375.

The Department experienced a large decrease in gross aggregate and per-capita acute antipsychotic pharmaceutical expenditure in FY 2012-13 due to several antipsychotic drugs going generic and per-unit costs decreasing significantly.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on data through quarter four of FY 2013-14. Historical actuals have been restated as the Department has transitioned from accrual-based accounting to cash-based accounting.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. Some family planning services are provided through fee-for-service, and, beginning in late FY 2001-02, the Department was also able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on about 95% of the family planning services provided to Medicaid clients. Totals listed on page EF-12 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, the Department no longer has contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

The Department believes the 40.31% increase in reported total expenditure between FY 2007-08 and FY 2008-09 represents a level shift in expenditure that is the result of a concerted effort to educate providers as to which services are billable as family planning

services. This effort was motivated by research indicating that, at the time of the study, only a fraction of allowable services were being appropriately billed.

In light of the Department's view of the increase between FY 2007-08 and FY 2008-09 as a one-time level shift, the FY 2014-15 estimate for total reported expenditure is the average of annual total reported expenditure increases since the program's inception, attributing 8.0% growth, in addition to the JBC action which raised reimbursement rates on oral contraceptives for family planning purposes, which attributes 16.68% additional growth over FY 2013-14. This methodology is motivated by the Department's expectation of an upward expenditure trend, despite the sporadic behavior of total annual expenditures observed over the previous fiscal years. As the Department anticipates family planning expenditures to resolve into a more stable growth pattern, estimates for FY 2015-16 and FY 2016-17 total expenditures are the result of the application of the average of annual growth rates for FY 2010-11 and FY 2012-13 to the previous year's estimated expenditure. The Department selected this time period as a model for future expenditure growth because it represents the most recent occasion for which moderate growth was observed in consecutive fiscal years.

As drug rebates become an increasingly larger component of total reported expenditure, the Department has begun to explicitly show the impact of rebates on the total expenditure with this request. After analyzing recent data on family planning expenditure, it has been determined that the Department is ineligible to claim the 90% federal match on about five percent of total expenditure. Expenditure not eligible for the enhanced match is claimed at the standard Medicaid match. Fund split calculations for the current year and the request year are shown in EF-4.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" is expected to contribute $29,160 in local funds for FY 2014-15, $30,026 in local funds for FY 2015-16, and $5,153 in local funds for FY 2016-17. The Department continues to explore opportunities to expand this program.

Indian Health Service

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

The Department uses historical expenditure to estimate total expenditure for services to these clients. In FY 2008-09, Indian Health Service expenditure grew by 44.48%; in FY 2011-12, expenditure decreased by 14.21%. In an effort to forecast FY 2014-15 expenditure

growth in a fashion representative of more regular patterns observed in other fiscal years, half the average annual growth for FY 2007-08 through FY 2013-14 was applied to FY 2013-14 expenditure in the previous request. The current request increases the forecast significantly due to an increase in expenditure experienced in the first have of FY 2014-15. In FY 2014-15 Q1&Q2, year-to-date expenditure was 80% of FY 2013-14 total expenditure. The Department used the most recent cost per client and enrollment data to project the final expenditure in FY 2014-15, resulting in an increase over FY 2013-14 of nearly 40%. With the uncertainty of expenditure for this population, as seen by extreme fluctuations in expenditure historically, the growth rate chosen for FY 2015-16 and 2016-17 is the average of FY 2007-08 through FY 2013-14.

Prior-Year Expenditure

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

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home- and Community-Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2013-14, the Department paid HCBS claims for an average of 25,937 clients per month.

Clients receiving CBLTC services have access to 12 HCBS waivers, each targeted to specific populations. Of the 12 waivers, 11 are administered by the Department, and the remaining waiver is managed by the Department of Human Services. Of the 11 waivers administered by the Department, 8 are included in the Medical Services Premiums line item and the remaining 3 fall under the Office of Community Living Division of Intellectual and Developmental Disabilities. The Persons Living with AIDS adult waiver is no longer active and clients were phased into the Elderly, Blind and Disabled waiver by the end of FY 2013-14. The waivers included in the Medical Services Premiums line item are:

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[1]
- Disabled Children's Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver[2]
- Spinal Cord Injury Adult Waiver[3]

Calculation of Community-Based Long-Term Care Expenditure

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

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

The selected enrollment trend factors for FY 2014-15, FY 2015-16, and FY 2016-17, with the rationale for selection, are below. In most cases, the Department kept the trend for the out year the same as the request year. In situations where the out years do not carry the same trend, the variation is noted.

[1] Previously known as "Persons with Mental Illness"
[2] Previously known as "Pediatric Hospice Waiver"
[3] Previously known as "Alternative Therapies Waiver"

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2014-15 through FY 2016-17: Linear: 3.01%, 4.17%, and 4.36% respectively	FY 2014-15: 4.53% - Adjusted linear. FY 2015-16 through FY 2016-17: 1.37%, 1.37%, average growth from FY 2010-11 to FY 2012-13	Enrollment history is very steady, growing at approximately 5% per year. The enrollment trend selected continues historical growth both in the request year and the out year. Due to a systems issue, enrollment in the first half of FY 2013-14 came in lower than expected, though the issue was resolved and enrollment resumed normal levels thereafter. However, actual enrollment did not fall, and so per enrollee cost is inflated in FY 2013-14. Enrollment in the first half of FY 2014-15 came in lower than expected, and the trend was adjusted to account for this. Per enrollee costs increased in the first half of FY 2014-15, primarily driven by growth in client utilization of CDASS. Growth in per enrollee costs is expected to continue, but at a slower rate, in FY 2015-16 and FY 2016-17.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Community Mental Health Supports Waiver (CMHS)	FY 2014-15 through FY 2016-17: Constant: 8.70%	FY 2014-15: -4.21%, Adjusted linear. FY 2015-16 and FY 2016-17: Constant: 0.00%	This waiver has seen historically high growth in enrollment, with higher growth recently. To account for the recent growth, a trend of 8.70% (linear trend for FY 2014-15) is held constant through the out year, as the Department expects growth to continue. Per enrollee cost has decreased in recent fiscal years, with the increase in FY 2013-14 overstated due to systems issues that make enrollment appear to be lower than it actually was. The true per enrollee cost trend for FY 2013-14 was negative, resulting from the low percent change in unique clients using services for this waiver coupled with high enrollment growth. The negative trend is continued in FY 2014-15, but then held constant at 0.00% for the request year and the out year.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2014-15 through FY 2016-17: Trends reflect program expectations: 0.19%, 6.50%, and 2.55% respectively	FY 2014-15 through FY 2016-17: constant, 41.90%	Historically, enrollment growth was negative; however, the Department has made significant efforts to eliminate the waitlist for this waiver by enrolling clients. Therefore, the Department expects positive growth in the request year forward as the waitlist is enrolled and as stakeholders become aware of the elimination of the waitlist. For this reason, the Department chose a positive trend for the November Budget submission that reflects current expectations for enrollment in the waiver. The February Budget submission incorporates the same trend as that used for November, but is adjusted to include six-month actuals. Only two services are offered on the waiver: In-home Supportive Services (IHSS) - Health Maintenance Activities and case management. While IHSS is expensive, it is less costly than Long-Term Home Health services. Very large growth in per-utilizer costs were driven by IHSS - Health Maintenance Activities client utilization. The number of clients utilizing this service has increased dramatically in the past few fiscal years, and the penetration rate of clients utilizing IHSS compared to those enrolled in this waiver reached 14.38% in FY 2013-14. This has driven the increase in per enrollee cost for this waiver. Client utilization of IHSS is expected to continue to grow, and so the Department held the average yearly growth rate from FY 2008-09 to FY 2013-14 (41.90%) constant for each of the years in this Budget Request.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Persons Living with AIDS Waiver	N/A	N/A	The clients on this waiver were fully phased into the Elderly, Blind, and Disabled Adult Waiver. There was no enrollment on this waiver at the end of FY 2013-14.
Consumer Directed Attendant Support-State Plan	FY 2014-15 through FY 2016-17: Linear Growth: -19.35%, -16.00%, and -14.29% respectively	FY 2014-15 through FY 2016-17: Constant, 0.00%	Additional enrollment in this program is currently prohibited; the chosen negative growth rates reflect clients leaving the program. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit; interestingly, the average cost per enrollee reached its peak in FY 2011-12 and then decreased in FY 2012-13 and FY 2013-14, suggesting that client allocations have reached stability. Therefore, the Department chose to keep the growth of the per-enrollee cost flat, at the same level selected in the February Request.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Brain Injury Waiver	FY 2014-15 through FY 2016-17: Linear Growth: 14.53%, 6.78%, and 7.18% respectively	FY 2014-15: -3.40% FY 2015-16 through FY 2016-17: Constant: -1.70%	Historically there has been slow and steady growth in BI enrollment. The Department saw this growth increase rapidly in FY 2012-13, which continued in FY 2013-14. The Department expects waiver enrollment to grow in FY 2014-15 and beyond at a linear growth rate, due to the Department's work to dispel myths regarding who is eligible and what services can be accessed under this waiver, as well as proactive stakeholder education for this waiver. Six-month actual enrollment in FY 2014-15 was higher than anticipated and the trend has been adjusted upward accordingly. There has been negative per enrollee cost growth over the last few years. Due to the large waiver growth and clients slowly entering the HCBS system, the cost per-enrollee trend decreased in FY 2012-13 and FY 2013-14. The Department expects negative growth to continue, and based on six-month actuals, has adjusted the per enrollee trend for FY 2014-15 downward. For the out years, the Department has used the average growth rate from FY 2008-09 to FY 2013-14 to select the per enrollee cost trend for this Budget Request.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Autism Waiver	FY 2014-15 through FY 2016-17: Adjusted for six-month actuals: 1.82%, 8.93%, and 4.92% respectively	FY 2014-15 through FY 2016-17: Constant: 0.00%	This waiver is capped at 75 clients. This cap has already been met, and the waiver currently has a waiting list. Average monthly enrollment is below 75 clients because of client churn; however, there are no available spots on the waiver. The waiver has seen above average growth in FY 2012-13. The apparent decrease in enrollment in FY 2013-14 is primarily due to systems issue that made it appear as though enrollment fell, when in actuality it did not. The growth is linear, but because of recent waitlist prioritization changes, slight growth is expected to continue. The current trend selection does not cause enrollment to exceed the cap, and only differs from the previous selection to account for six-month actuals. Expectations remain unchanged. It is likely that costs per enrollee have been dropping because clients are not on the waiver very long before they age out. As a result, the clients do not receive many services while on the waiver. Client access issues have been addressed and service utilization should increase. However, per enrollee cost has continued to decrease, though at a decreasing rate. The Department has selected a 0.00% growth rate to account for this.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Life Limiting Illness Waiver	FY 2014-15 through FY 2016-17: Constant: -10.65%, 6.62%, and 1.86% respectively	FY 2014-15 through FY 2016-17: Linear Growth: 9.19%, 8.42%, and 7.77% respectively	Waiver programmatic changes have improved the program resulting in large positive growth, though recent growth has been negative. The waiver is capped at 200 clients and average enrollment in FY 2013-14 was 169 clients. While enrollment was lower than anticipated for the first half of FY 2014-15, enrollment is expected to increase as more providers become available as they become aware of recent rate increases and programmatic changes. Therefore, the Department anticipates a positive growth rate, though reduced from that assumed in the previous request, as enrollment is expected to approach the waiver's cap of 200 clients at a slower rate. Client utilization of expressive therapy and counseling increased significantly between FY 2012-13 and FY 2013-14 (by 57.63% and 22.73% respectively), resulting in a very large increase in per enrollee cost. The Department anticipates this to continue but at a lesser rate and used a linear trend to forecast per enrollee cost.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Spinal Cord Injury Adult Waiver	FY 2014-15: growth to the cap, 29.41%	FY 2014-15: No change, 0.00%	Enrollment in the waiver grew slower than anticipated in FY 2013-14, but the Department anticipates the waiver enrollment to be around the cap of 67 clients by the end of FY 2014-15. There will be little turnover as clients are likely to remain on the waiver for an extended period of time as they receive services. However, HB 09-1047 "Alternative Therapies for Medicaid", which authorized this waiver and the alternative therapies provided on it, will sunset July 1, 2015. Therefore, the Department anticipates clients moving to the Elderly, Blind and Disabled waiver at that time, and no expenditure is anticipated on this waiver for FY 2015-16 and FY 2016-17. An enrollment bottom line impact is used to account for this transition. For per-enrollee growth, the Department chose to keep the trend flat, as clients cost more in the first year of receiving services than in later years. A bottom line impact is used to account for the incremental difference in cost of these clients transferring to the Elderly, Blind and Disabled waiver.

Legislative Impacts and Bottom-Line Adjustments

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

Expenditure

- HB 14-1357: "In-Home Support Services in Medicaid Program" – HB 14-1357 expands In-Home Support Services (IHSS) into the Spinal Cord Injury Waiver, allows for the delivery of IHSS in the community, permits the person receiving services, or his or her representative, in conjunction with the in-home support services agency to determine the amount of nurse oversight needed in connection with the person's in-home support services, and permits family members to be reimbursed for in-home support services provided to eligible persons and requiring the medical services board to promulgate rules, as necessary, regarding reimbursement for services.
- Annualization of Adjustment for 53 pay periods – there are normally 52 periods; in FY 2013-14 there is an extra pay period. This impact annualizes out the effect of FY 2013-14's extra pay period for FY 2014-15.
- Children with Life Limiting Illness Waiver Audit Recommendations – Audit recommendations found services in the CLLI waiver to be non-sufficient for the clients the waiver supports. Recommendations include simplifying services that providers found confusing and expanding service components to better meet client needs.
- Colorado Choice Transitions – The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community-based services. The program began enrolling clients in May 2013.
- Annualization of the 8.26% Rate Adjustment – In FY 2012-13, the Joint Budget Committee approved an 8.26% rate increase for HCBS services effective July 1, 2013. This adjustment annualizes the impact to account for run out in FY 2014-15.
- Annualization of Expansion of the Consumer Directed Attendant Support Services (CDASS) option into the Brain Injury wavier – Participant direction of personal care, homemaker, and health maintenance activities were added to the Brain Injury Waiver, resulting in movement of clients from the Consumer Directed Attendant Support—State Plan to the Brain Injury Waiver.
- Annualization of Alternative Therapies Waiver Chiropractic Rate Increase – The rate was too low compared to the private sector and the Department was having trouble recruiting providers for this short-term pilot program. Increasing the rate was expected to bring new providers on in time before the pilot waiver expires. This accounts for the annualization of this impact in FY 2014-15.
- Raising the Cap on Home Modifications – A Joint Budget Committee action raised the cap on home modifications in FY 2014-15, resulting in an impact to waivers that include home modifications.
- FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" – This impact shows as savings to HCBS waivers (the Elderly, Blind, and Disabled Adult Waiver) due to the waitlist reduction of the DIDD Adult Supported Living Services waiver for the clients formerly on the EBD waiver who transitioned over.
- FY 2014-15 R#8 and HB 14-1252 Client Movement to the DD Waiver: FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents" and HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity" are combined into one bottom-line adjustment – FY 2014-15 R#8 allows for emergency enrollments onto the Division for Intellectual and Developmental Disabilities (DIDD) Developmental Disabilities (DD) waiver and HB 14-1252 is the bill that incorporates the Department's BA-5/S-5 request "Community Living Caseload and Per Capita Changes," which reduced the waitlist for the DD

waiver. The impact to HCBS waivers is due to the increased caseload and per capita costs for the DIDD Medicaid waivers attributable to those formerly on Medicaid HCBS waivers (in this case, the Elderly, Blind, and Disabled Adult Waiver). This shows as savings to HCBS waivers.

- FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20% – The Joint Budget Committee approved a 20% rate increase to Pediatric Hospice Services, effective July 1, 2014, which affects the Children with Life Limiting Illness Waiver.
- FY 2014-15 R#11: "Community Provider Rate Increase" 2% Across the Board – The Joint Budget Committee approved a 2% across-the-board rate increase, effective July 1, 2014, which affects services provided by HCBS waivers.
- FY 2014-15 R#12: "Administrative Contract Reprocurement" – The Department requested funding to help transition contracts for Financial Management Services (FMS) for the CDASS program between vendors. The current contract expires 12/31/2014.
- EPSDT Personal Care – accounts for a decrease in expenditure from personal care services in the waivers deemed medically necessary for EPSDT eligible children, which accompanied by an increase in state plan expenditure. In late FY 2013-14 the Department received notice from CMS that personal care is a covered benefit under EPSDT if deemed medically necessary. The Department anticipates that clients utilizing personal care under EPSDT will fall into three categories: clients substituting long-term home services with less costly personal care services; resulting in savings in acute care, clients directly substituting units under the state plan from waivers, resulting in an increase in acute care expenditure and decrease to HCBS wavier expenditure, and clients who have never had access to personal care that have a medical necessity, resulting in an increase in acute care expenditure.
- CDASS Administrative FMS & Training Contract Competitive Reprocurement – Because of the competitive reprocurement of the FMS contract, client per member per month (PMPM) administrative expenditures are expected to come in less than the current PMPM expenditure resulting in savings to the EBD, CMHS, BI, and SCI waivers.
- Sunset of HB 09-1047 "Alternative Therapies for Medicaid" – This bill authorized the Spinal Cord Injury (SCI) waiver, and sunsets July 1, 2015. Two bottom-line adjustments account for this in FY 2015-16. The first is a caseload adjustment that moves enrollment from the SCI waiver to the Elderly, Blind and Disabled (EBD) waiver. The second is an expenditure adjustment that accounts for the incremental average cost difference between clients on the SCI waiver and clients on the EBD waiver, accounting for therapies that are currently available on the SCI waiver but not on the EBD waiver.

Colorado Choice Transitions

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

the long-term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the two types of services the Department will offer through the program, demonstration (new services offered through the program), and qualified services (existing waiver services and home health). These costs are reflected in Exhibits F and G, Community-Based Long-Term Care as a bottom line impact. The exhibit then reports the savings anticipated from transitioning clients from nursing facilities which is reflected in Exhibit H, Class I Nursing Facilities as a bottom-line impact. Following the net impact of the program, the Department reports on the rebalancing funds the Department anticipates earning. Rebalancing funds are calculated as 25% of total expenditure and are 100% federal funds.

The Department delayed implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented on March 1, 2013, with the first client transitioning in May 2013. The Department currently anticipates approximately 100 clients will transition per 365 days beginning in May 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of $2,743,310 total funds in FY 2014-15 and a reduction of $7,635,116 in FY 2015-16. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2013-14 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2014-15, FY 2015-16, and FY 2016-17 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – are expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. These expenditures represented approximately 75% of total hospice expenditure in FY 2013-14. The remaining portion of hospice expenditure is represented under the Hospice Services category and includes Hospice General Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

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

To create the patient days forecast, the Department used claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day counts; then, the Department used an autoregressive model with seasonality to estimate patient days for the years covered in this request. As hospice client nursing facility per diems are linked to the per diem for Class I Nursing Facility clients, they are assumed to grow at the same 3% per-year rate. Rate reductions are accounted for in the same fashion as they are for nursing facilities: their impact is included in calculations as a bottom-line impact. Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted patient per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year.

Please refer to the portion of the narrative devoted to Class I Nursing Facilities for a more detailed description of IBNR analysis, the 3% general fund growth cap for nursing facility rates, and nursing facility rate reductions. Additional information is available in footnotes (1) through (7) in the footnotes section of the hospice forecast.

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

The largest component of this expenditure category is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two to three times per week, generally by nurses. In FY 2013-14, Hospice Routine Home Care expenditure was approximately $9.2 million and thus represented 84% of Hospice Services expenditure and 21% of total hospice expenditure. Hospice Routine Home Care expenditure is computed as a product of patient days and the daily rate. The Department arrives at estimates for days for FY 2014-15, FY 2015-16, and FY 2016-17 by using an autoregressive model with seasonality and linear time trend. The Hospice Routine Home Care per diem is forecasted by applying a linear time trend to observed daily rates between FY 2007-08 and the first half of FY 2014-15.

The next-largest component of hospice services expenditures is Hospice General Inpatient Care. These expenditures are incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2013-14, the Department paid approximately $1.6 million for Hospice General Inpatient Care. The Department selected a linear time trend applied to historical claims data with seasonal dummy variables added depending on whether the expenditure took place in the first or second half of the year to develop expenditure forecasts for FY 2014-15, FY 2015-16, and FY 2016-17.

The remaining components of hospice services expenditures in total represent approximately $75,000 of expenditure for FY 2013-14; in every prior year except FY 2012-13, they accounted for less than $50,000 of combined expenditure. The Department annualized expenditure in the first half of FY 2014-15 to develop an estimate for total FY 2014-15 expenditure. FY 2015-16 and FY 2016-17 expenditure estimates are results of the application of the average growth rate for the past three years, 4.62%, to the previous fiscal year's estimate.

Private Duty Nursing

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

As PDN expenditure is the product of the hourly rate and the number of hours, and the Department expects rates to remain constant, expenditure forecasts for FY 2014-15, FY 2015-16, and FY 2016-17 are primarily based on hours forecasts for those fiscal years. The hours forecast is separated into three pieces that are consistent with the three rate groups: RN hours; RN-group, LPN, and blended hours; and LPN-group hours.

In FY 2013-14, the Department paid claims for 1,493,899 total hours for PDN services; 898,452 were billed as RN hours. Linearly regressing RN hours between FY 2008-09 and FY 2011-12 explains 98.8% of the variation in hours. As such, the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2014-15, FY 2015-16, and FY 2016-17. This model predicts growth at 15.10% per fiscal year.

RN hours were stable prior to FY 2008-09 but began increasing significantly in FY 2009-10. The Department examined RN hours per distinct client per month between FY 2005-06 and FY 2011-12 in an effort to investigate potential causes for the increase in hours. While there was a slight upward trend in RN hours per distinct client per month over the course of this period, this alone is far from sufficient to explain the growth in aggregate hours. This analysis was extended to the other two groups of PDN service. No discernible trend exists in changes of hours per distinct client per month. For all three categories of PDN service, changes in usage appear to be driven entirely or almost entirely by the addition of new clients. To ensure proper delivery of services, The Department is working with its utilization review contractor to make sure that the clients receiving PDN services are doing so out of medical necessity. The Department has seen some positive outcomes from its work with the utilization review contractor and focus on proper utilization of PDN. In the first six months of FY 2014-15, for all services, growth in hours are below that from the first six months of FY 2013-14, and the results are reflected in the decreased growth rate for forecasts of PDN services.

As is consistent with RN services, paid hours for the intermediate-rate group of PDN services – RN-group, LPN, and blended – were largely stable between FY 2005-06 and FY 2008-09 before reporting rapid growth in FY 2009-10 and FY 2010-11. Unlike RN services,

however, growth for these services was very small between FY 2010-11 and FY 2011-12, but then jumped up again from FY 2011-12 to FY 2012-13, growth above historical growth continued in FY 2013-14. In FY 2013-14, the Department paid claims for 567,865 total hours for the intermediate-rate group services or 38.01% of total PDN hours. To this end, the Department elected to estimate hours for the next three fiscal years for these services by applying a linear trend of 13.05%.

LPN-group services have both the smallest rate and represent by far the smallest portion of PDN claims. In FY 2013-14, these services accounted for only 27,582 hours of claims, or 1.84% of total hours. Due to erratic growth rates in recent years the Department chose to forecast FY 2014-15, FY 2015-16, and FY 2016-17 linearly at 5.47%.

Final expenditure estimates for FY 2014-15, FY 2015-16, and FY 2016-17 are produced by multiplying projected hours by the projected rate for each of the three service categories and then summing these figures. The Department is forecasting large growth in FY 2014-15, 16.42%, which includes a 2% rate increase and significant increases in utilization for all services but the LPN-group service. The trend is decreased in the request and out-years to 16.05% and 14.36% respectively, which is on par with historical growth.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

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

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

Summary of Long Term Care and Insurance Request

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

Class I Nursing Facilities

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

Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% between FY 1999-00 and FY 2009-10. This is due to efforts by the Department to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program of All-Inclusive Care for the Elderly (PACE). Recent history makes it difficult for the Department to anticipate the behavior of patient days; patient days had been trending upward, but fell unexpectedly in FY 2012-13, but then grew slightly in FY 2013-14.

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

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

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

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

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non-Medicare day. These changes, however, had no impact on the General Fund portion of nursing facility rates. SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

HB 12-1340 extended the 1.5% rate reduction of SB 11-125 into FY 2012-13. The reduction expired June 30, 2013.

HB 13-1152 extended the 1.5% rate reduction of HB 12-1340 permanently, effective July 1, 2013. As all other rate reductions expired before the start of FY 2013-14, this reduction represents the total value of the rate reduction for FY 2013-14. For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[4]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2014-15.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment for claims that will be incurred in FY 2014-15. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2014-15 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2014-15.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2014-15.
- Of the estimated total reimbursement for claims incurred in FY 2014-15, only a portion of those claims will be paid in FY 2014-15. The remainder is assumed to be paid in FY 2015-16. The Department estimates that 92.86% of claims incurred in FY 2014-15 will also be paid during FY 2014-15. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2014-15.
- During FY 2014-15, the Department will also pay for some claims incurred during FY 2013-14 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2013-14 to calculate an estimate of outstanding claims to be paid in FY 2014-15.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2014-15 prior to adjustments.

[4] For clarity, FY 2014-15 is used as an example. The estimates for FY 2015-16 and FY 2016-17 are based on the estimate for FY 2014-15, and follow the same methodology.

- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2014-15, this includes HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013. SB 14-130, which increases the personal care allowance for nursing facilities from $50.00 to $75.00 monthly is also included.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2014-15 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2014-15, FY 2015-16, and FY 2016-17 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2014-15 through FY 2016-17. Please refer to Footnote 6 on page EH-8 for more detail. The estimate for FY 2014-15 is calculated by averaging the percent growth from FY 2008-09 through FY 2013-14 and trending the FY 2013-14 actual expenditures forward by that amount. In FY 2013-14 the Department experienced an abnormal growth in expenditure, over 54%. The Department chooses to place a conservative growth factor to FY 2014-15 because of the uncertainty of how real that growth actually was, or if it was a result of re-enrolling clients.
- Prior to FY 2010-11, the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2014-15, FY 2015-16, and FY 2016-17. FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform," increased the number of Department auditors resulting in additional audits of nursing facilities. As such, there was a large increase in recoveries observed in FY 2011-12 related to the prior fiscal year and the following fiscal years. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-8 contains additional detail about these recoveries.
- HB 12-1340 implemented a 1.5% rate reduction for Class I Nursing Facilities per diems effective July 1, 2012, through June 30, 2013. As a result of claims run-out, the fiscal impact of this bill extends into FY 2013-14. Footnote 8 on page EH-9 contains additional detail regarding the fiscal impact of this bill.

- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non-Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments but will be unable to fully fund growth beyond the General Fund cap. The Department estimates approximately 57% of growth beyond the General Fund cap will be supported by the provider fee.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.
- The Colorado Choice Transitions adjustment accounts for the reduction in Class I Nursing Facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in Exhibit G.
- Estimated savings due to client movement from Class I Nursing Facilities to HCBS through the Colorado Choice Transitions (CCT) program are added as a bottom line adjustment for each fiscal year of the request.
- SB 14-130 raises the basic minimum amount payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to $75.00, monthly.
- In FY 2014-15, the Department is required to make a General Fund only payment relating to an OIG audit finding concerning Nursing Facility Supplemental Payments. The OIG audit found that the Department made payments that exceeded applicable upper payment limits (UPLs). These payments took place between FY 2009-10 and FY 2010-11 and as a result of the overpayment, the Department incorrectly claimed federal reimbursement amounting to $2,470,450. The payment will be used to refund the federal government for the matching funds incorrectly claimed. This payment is in FY 2014-15 only, and will not be required in future years. The Department has developed internal processes to ensure that payments are made according to the approved Medicaid State Plan and within the upper payment limits so this does not occur in the future.

Incurred-But-Not-Reported Adjustments

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

The Department uses an extensive model that examines past claims by month of service and month of payment to estimate the claims that will be paid in the future. This is known as an “Incurred But Not Reported” (IBNR) adjustment. IBNR adjustments analyze the

prior pattern of expenditure (the lag between when past claims were incurred and when they were paid) and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly Footnotes 4 and 5 of Exhibit H, page EH-7. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2013-14 that will be paid in FY 2014-15 and the percentage of claims incurred in FY 2014-15 that will be paid in FY 2014-15 and subsequent years. The Department applies the same factor to the FY 2015-16 and FY 2016-17 estimates.

The Department uses the IBNR adjustment calculation for the November 2014 Request using paid claims data through June 2014. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting the time between the date of service and the payment date of a typical claim may be decreasing.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009	92.27%
November 2009	92.27%
February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%
November 2012	92.43%
February 2013	92.75%
November 2013	92.95%
February 2014	93.35%
November 2014	92.86%
February 2015	92.64%

Patient Days Forecast Model

To forecast patient days, the Department selected an auto-regressive model without a linear time trend and a dummy variable for FY 2010-11 to account for the fall in days expected from that time period forward.

The Department presents statistical results supporting the selection of this forecasting model: the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. The Adjusted R Squared of the model is 0.9766, indicating that 97.6% of the variance in the data is explained by this model.

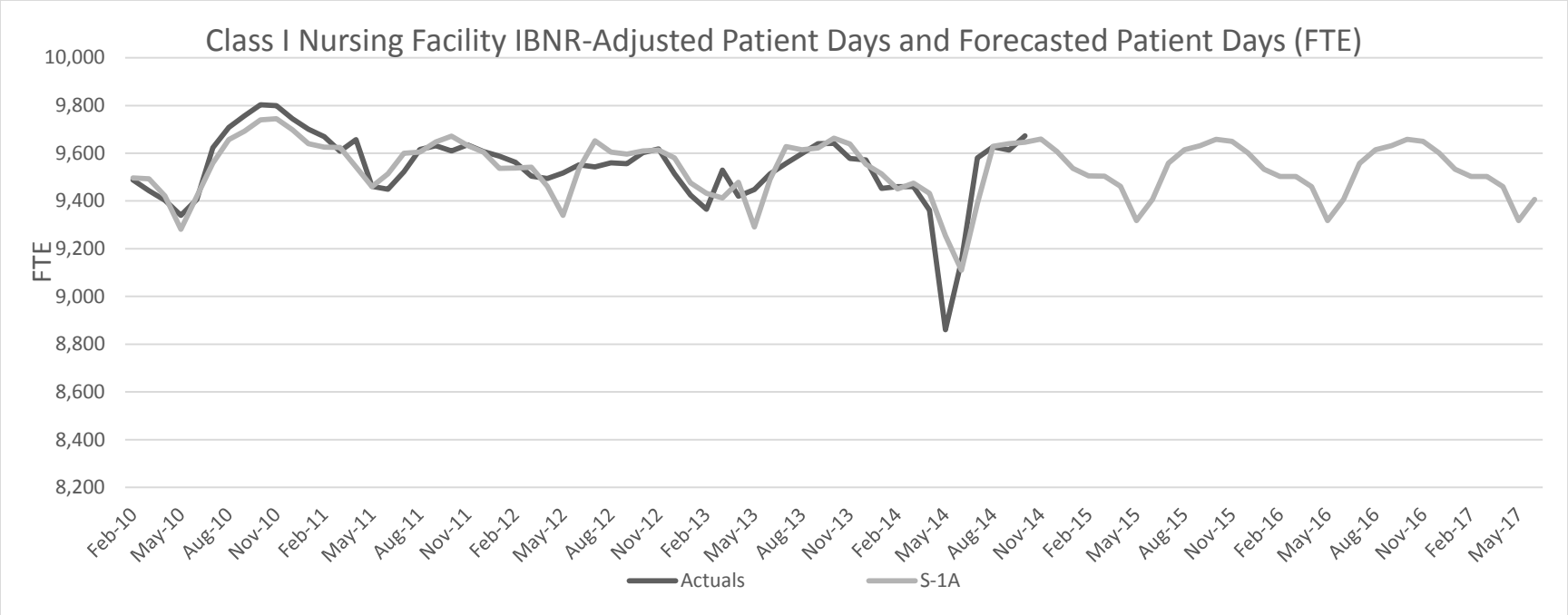
Testing the Overall Predictive Ability of the Model

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

Forecasting Patient Days

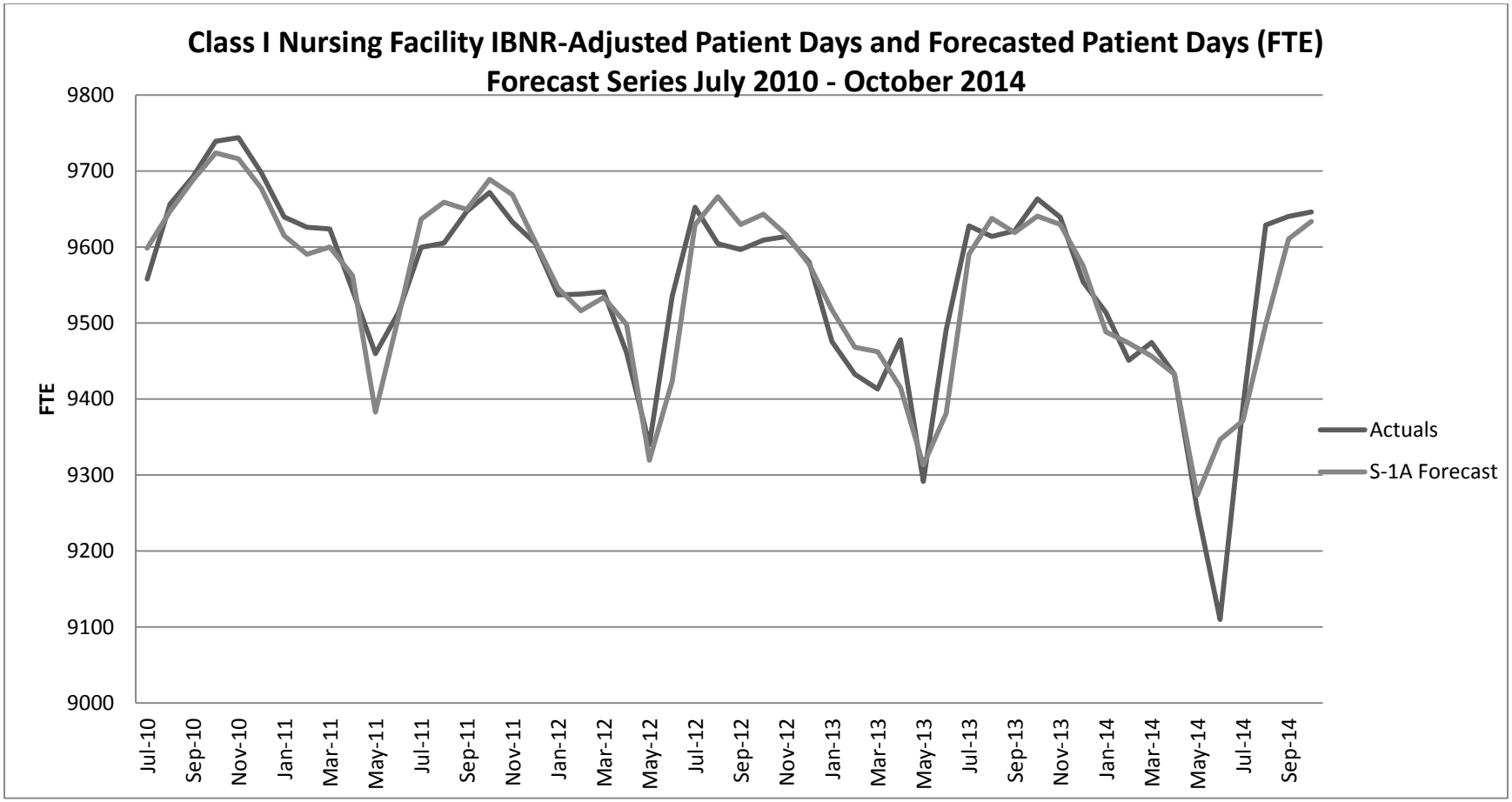
Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of patient days in each month is divided by the number of days in the month to create the number of FTE (full time equivalent)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

Historically, the Department's efforts toward increasing utilization of Home- and Community-Based Services have resulted in downward pressure on the Class I Nursing Facility days trend. However, in the face of an aging population and ever-increasing demand for long-term care services, recent years have displayed a return to marginal annual growth in patient days. However, data from FY 2012-13 and FY 2013-14 had shown a drop in patient days of 0.91% and 0.68%, respectively. In the November R-1 request, FY 2013-14 showed a minor uptick in days, but when accounting for complete run out, FY 2013-14 decreased as noted above. Because of the uncertainty of future behavior of patient days, the Department assumes days will increase slightly in FY 2014-15 and FY 2015-16 and decrease slightly in FY 2016-17 to remain fiscally conservative.


Class I Nursing Facility IBNR-Adjusted Patient Days and Forecasted Patient Days (FTE)
FTE
10,000
9,800
9,600
9,400
9,200
9,000
8,800
8,600
8,400
8,200
Feb-10
May-10
Aug-10
Nov-10
Feb-11
May-11
Aug-11
Nov-11
Feb-12
May-12
Aug-12
Nov-12
Feb-13
May-13
Aug-13
Nov-13
Feb-14
May-14
Aug-14
Nov-14
Feb-15
May-15
Aug-15
Nov-15
Feb-16
May-16
Aug-16
Nov-16
Feb-17
May-17
Actuals
S-1A

Ex Post/In-sample Forecasts

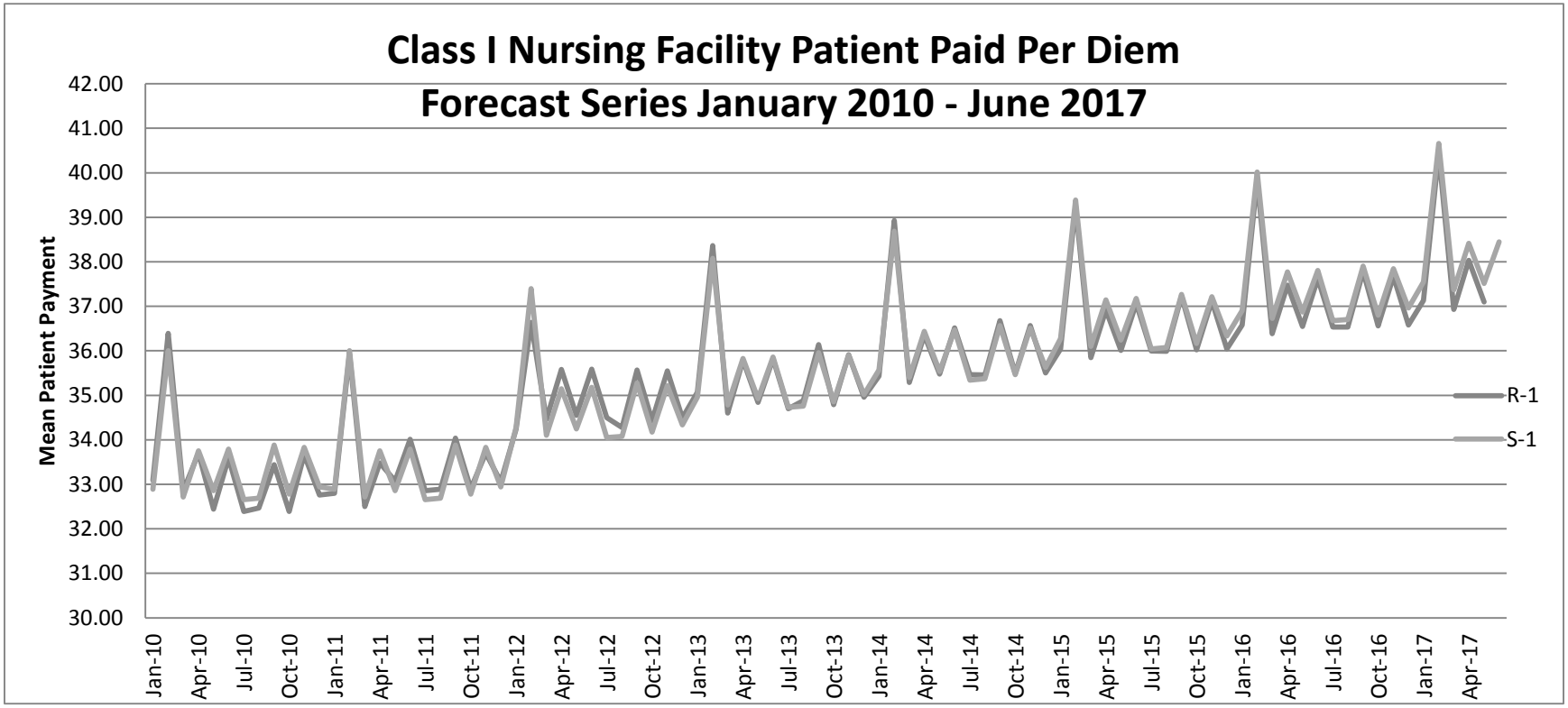
Because ex post/in-sample forecasts usually serve as an additional test of the reasonableness and robustness of forecasts, the Department calculated an in-sample forecast (using the data from July 2010 through October 2014) and compared the results to actual data reported for April 2014 through October 2014. Rather than serving as a test of reasonableness and robustness, the in-sample forecast highlights the abnormality of the most recent data points.



The ex post forecast model underestimates FTE in the forecast period for April 2014 through October 2014. Observed patient days in FY 2014-15 Q1&Q2 make a departure from previously observed seasonality. More information is necessary to determine whether the data will return to previous levels.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model with a dummy variable to account for cost of living adjustment (COLA) increases to forecast patient payment. Neither the current time period nor the previous time period are relevant to this forecast. The only indicators of patient payment are the number of days in the month and the COLA increase for a given year. For this reason, neither a linear nor an autoregressive model was used, as they did not add value to the forecast.



Testing the Overall Predictive Ability of the Model

Utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. The patient payment model has a p-value of 0.00017 and is statistically significant at the 99% confidence level. The Adjusted R-squared for the model is 0.9777, suggesting 97.77% of the variation in this series can be explained by the monthly seasonality and COLA increases.

Nursing Facility Rate Methodology Changes

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

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

	for administration and general services under certain circumstances; and made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.
FY 2010-11	HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.
FY 2011-12	SB 11-125 increased the level of the provider fee to $12.00 per non-Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
FY 2011-12	SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2012.
FY 2012-13	HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2013.
FY 2013-14	HB 13-1152 extended the 1.5% rate reduction from the prior year. The rate reduction is permanent.
FY 2014-15	SB 14-130 raises the basic minimum payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to $75.00, monthly.

Department Forecast Methodology Change

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

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

The Department updated its methodology for calculating the nursing facility per diem for the November 2012 request. The Department developed the weighted average per diem for FY 2012-13 by weighing FY 2012-13 per diems for each provider by the FY 2011-12 provider days distribution. Previously, the Department forecasted per diems in aggregate; this methodology would only be accurate if

the provider-days distribution were uniform. As this is not the case, the Department's new methodology addresses variance between the forecasted per diem and the observed per diem in two ways: first, the current year per diem is based on actual rates rather than a projection of rates, and, second, the Department used provider days from FY 2011-12 as a proxy for provider days for FY 2012-13 rather than assume the distribution to be uniform.

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

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

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

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. At the end of FY 2005-06, the provider increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility remained constant**.** Additionally, this facility received an annual cost-based rate adjustment, similar to Class I Nursing Facilities. As a result, this service category experienced expenditure growth that differs sharply from previous years. FY 2009-10 enrollment rates were slightly lower than in the previous years. However, for FY 2010-11 and FY 2011-12, enrollment returned to the 20 client enrollment level. There was a rate increase for FY 2012-13 based on audited cost reports from CY 2011, which more than doubled expenditure for FY 2012-13 compared to the previous year. The growth rate for FY 2013-14 was based on anticipated changes in per-diem reimbursement using information from unaudited cost reports for CY 2012, which showed a 30% drop in the rate from FY 2012-13 to FY 2013-14. This can be seen in the approximately -30% growth in expenditure. Because all clients are paid the same rate regardless of aid category, and anticipated changes in per-diem reimbursement using information from unaudited cost reports for CY 2013 show high growth in the rate from FY 2013-14 to FY 2014-15, the Department has selected a trend of approximately 20% for the per-diem rate for FY 2014-15, reducing the rate in the request and out years. The Department anticipates that expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

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

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

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

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

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

In recent years, the Department has added a number of new PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in the spring of 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. InnovAge (formerly Total Long Term Care), the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo, and another facility is scheduled to open in northern Colorado in spring of CY 2015. The Department anticipates this new facility will begin serving clients during late fall of 2014. The Department received enrollment estimates from the future administration of the new facility and anticipates that the initial enrollment pattern for this facility will follow these estimates, rather than those for more mature facilities in other parts of the state.

Expenditure estimates for PACE for FY 2014-15, FY 2015-16, and FY 2016-17 are the product of two pieces: projected enrollment and cost per enrollee. As is consistent with convincing historical enrollment data suggesting linear trends for PACE enrollment, linear regression models are used to estimate future enrollment on a by-provider by-eligibility-type basis. Enrollment caps are not anticipated

to limit growth for the forecast period as a result of the manner in which PACE services are provided: that is, clients are not full-time residents of PACE facilities. Systems issues have resulted in clients who are eligible for Medicaid and receiving PACE services showing up in the MMIS as not having an enrollment span in the program, causing a delay in monthly capitation payments for these clients. In the February 2014 Request, the Department assumed that this systems issue would be resolved by the end of FY 2013-14 with retroactive payments made by that time as well. As this did not occur, a bottom line impact was added to FY 2014-15 of the November Request, which accounts for an estimate of retroactive payments that would be made in FY 2014-15 for services accrued in FY 2013-14. The systems issues are now resolved and processes are in place to lessen the likelihood of this occurring going forward. To account for fluctuation due to these systems issues, the Department incorporated enrollment on a date of service basis to inform estimates. This resulted in lower current projections for enrollment than were previously estimated.

Per-enrollee costs for FY 2014-15 are determined by cross-walking the actual FY 2014-15 rates for PACE services with an eligibility-type distribution estimate derived from FY 2014-15 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2014-15 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

PACE rates have been declining since FY 2008-09. The Department believes rate cuts for other services that are components of the PACE rate calculations have contributed significantly to this trend. Additionally, there has been a shift in the methodology for the calculation of institutional-to-non-institutional client splits for PACE, which has resulted in a dramatically different view of the client population. Previously, the calculation – prepared externally – reflected a proportion of high-cost institutional clients as high as 85%. A revision to this process resulted in estimates of high-cost clients of only 50% to 55%. As the Department views this revision as representative of a level-shift in reported client distribution, this source of downward rate pressure is not expected to drive changes in PACE rates in the future. PACE rates for FY 2013-14 increased by an average of approximately 10% over the previous year's rates, considered to be due to the rate increase for Home- and Community-based Long-Term Care. Further, the Department anticipates other components of the PACE rate calculation will demonstrate upwardly-trending behavior, as demonstrated by the increase in PACE rates for FY 2014-15 of approximately 4% over FY 2013-14 rates. To this end, the Department is projecting moderate growth in cost-per-enrollee figures for FY 2015-16 and FY 2016-17. The rate trend is the average of FY 2007-08 through FY 2012-13 cost-per-enrollee growth (1.27%) and is applied to each eligibility type separately rather than in an aggregate fashion.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligible receive payment for Medicare Part B and, in some cases, Medicare Part

A. The Partial Dual Eligible aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[5] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as "Medicare Qualified Individual (1)." Legislation for the second group, referred to as "Medicare Qualified Individual (2)," comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[6]

[5] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.
[6] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%
2013	$441.00	-2.21%	$104.90	5.01%
2014	$426.00	-3.40%	$104.90	0.00%
2015	$407.00	-4.46%	$104.90	0.00%

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

To forecast FY 2014-15, the Department inflates the actual expenditure in the first half FY 2014-15 by half the estimated increase in caseload from FY 2013-14 to FY 2014-15. This generates the anticipated expenditure for the second half of FY 2014-15. As there were no increases to Medicare Part B premiums for CY 2015, the estimate for the second half of FY 2014-15 is complete. The total estimated expenditure for FY 2014-15 is the sum of the first half actual expenditure and the second half estimated expenditure.

To forecast FY 2015-16, the Department first inflates the estimated expenditure from the second half of FY 2014-15 by half the estimated caseload trend for FY 2015-16 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2015-16. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2015-16 and the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2015-16 is the sum of the first half and second half estimates. The forecast of FY 2016-17 expenditure utilizes the same methodology as the forecast of FY 2015-16.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost-effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2013). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost-effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB) for clients who do not qualify for the Medicare Part D benefit.

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

Beginning with the November 2014 Request, contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget and the February 2014 Request where the Department examined total expenditure trends to estimate expenditure, the Department instead estimated expenditure based directly on the contractor's program enrollment estimates, in order to calculate provider and premiums payments for clients enrolled in HIBI. The Department believes this methodology to be more accurate as HIBI enrollment does not bear a direct relationship to Medicaid caseload and enrollment is the primary driver in differences between cost estimates and actuals.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the per capita or trend factors, the Department previously added total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts were included in February 2014 Request calculations for the Health Insurance Buy-In Program, but, beginning with the November 2014 Request, are the sole source of the estimates in the current Budget Request:

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacts the HIBI program in FY 2014-15 forward by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for eligible clients to create cost savings for the State. The contractor estimates approximately 2% growth in enrollment per month for FY 2014-15. Savings as a

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

EXHIBIT I – SERVICE MANAGEMENT

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

Summary of Service Management

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

Single Entry Points

Single entry point agencies (SEPs) were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to section 25.5-6-105, C.R.S. (2013). A SEP is an agency in a local community through which persons 18 years or older can access needed long-term care services.

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

The major functions of SEPs include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. SEPs also serve as the utilization review coordinator for all community based long term care services.

The Department pays SEPs a case-management fee for each client admitted into a community-based service program. SEPs also receive payment for services provided in connection with the development and management of long-term home health prior authorization requests for work associated with client appeals and for utilization review services related to HCBS and nursing facilities.

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

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

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

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer-directed care to home- and community-based waiver services. These services must be approved by SEPs. The Department received approval from CMS to add consumer-directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007. The Department began to provide these services effective January 1, 2008. Consumer-directed care has since been expanded to the Spinal Cord Injury and Brain Injury waivers.

Effective with the November 1, 2007 Budget Request, the Department revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, SEPs are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by SEPs has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, SEPs would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to SEP contracts. The requested increase is based on the expected increase in HCBS enrollment, as determined by average monthly enrollment in the Department's HCBS programs. This figure is therefore consistent with the caseload growth of the HCBS waivers in Medical Services Premiums. The Department believes that growth in enrollment is a good proxy for growth in SEP caseload.

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

For FY 2014-15, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2014-15 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). In FY 2014-15, the Joint Budget Committee agreed to a 10% rate increase for SEPs, resulting in an increase, outside of enrollment increases, of $1,229,790 for FY 2014-15. The Department's projection uses the total waiver enrollment forecast and the number of clients utilizing services in FY 2013-14 to proportion trends for all eligibility categories.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2014-15 through FY 2016-17, beyond the FY 2014-15 10% rate increase previously mentioned and accounted for.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316, C.R.S. (2013)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

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

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

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

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), high risk obstetrics, and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117(2)(d)(IV.5), C.R.S. (2013), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

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

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were applied toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2013) (further described in Exhibit A). The Department's telemedicine program had two months of expenditures encumbered for FY 2009-10. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

FY 2014-15, FY 2015-16, and FY 2016-17 expenditures are affected only by caseload and bottom line impacts. In FY 2011-12, the Department requested a transfer of spending authority from DPHE for the purpose of attaining federal funds to establish the Smoking Cessation Quitline for Medicaid Clients. A bottom line impact of $773,859 reflects this change in FY 2014-15.

Accountable Care Collaborative and Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Until FY 2009-10, the Department contracted with only one prepaid inpatient health plan, Rocky Mountain Health Plans. The Department then contracted with three additional prepaid inpatient health plans in FY 2009-10. These included Colorado Access and Kaiser Foundation Health Plan, jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-9 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost-avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care and Community-Based Long-Term Care. In the current request, the Department forecasts enrollment and costs for each program separately.

Rocky Mountain Health Plans

Through HB 12-1281, the Department accepted proposals for innovative payment reform pilots. The Department solicited proposals from the seven RCCOs in the State and on July 1, 2013, announced that it selected a Medicaid payment reform proposal submitted by Rocky Mountain Health Plans. The two-year pilot program will begin on or before July 1, 2014 and will focus on clients in certain counties within the state. As part of Rocky Mountain Health Plan's proposal, the pilot will also disenroll clients in the prepaid inpatient health plan and enroll clients into this pilot. The transition to the pilot did not occur as quickly as anticipated in the February Request; therefore, administrative fees associated with Rocky Mountain Health Plans still apply in FY 2014-15, but have been removed for FY 2015-16 and FY 2016-17 to account for this adjustment. Currently, the enrollment shift is expected to take place by December 2014. Therefore, the Department will update future requests accordingly as information is available.

The administrative fees remain the same in FY 2014-15. As such, the Department uses actual enrollment to forecast expenditure for Rocky Mountain Health Plan for FY 2014-15, accounting for phase out by December of 2014. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group. For this request, enrollment is forecasted in aggregate based on actuals. The administrative fees paid are the same regardless of the eligibility category of the clients served.

To forecast enrollment in Rocky Mountain Health Plan for the current year, the Department assumes the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its health plan. Therefore, the Department estimates that the linear growth for FY 2014-15 of -52.25% will be appropriate. Rocky Mountain Health Plan transitioned all clients into the pilot program by the end of CY 2014, and therefore the Department assumes no enrollment in the prepaid inpatient health plan after FY 2014-15.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost-avoidance payments to Rocky Mountain Health Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was made. At that time, the Department anticipated it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09 with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department has completed all CMS requirements pertaining to Rocky Mountain Health Plan and made a cost-avoidance payment to Rocky Mountain Health Plan for services rendered in FY 2009-10 in the latter half of FY 2011-12. Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department also made a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the prior year.

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

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

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access

in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access was completed in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. This program was discontinued effective June 30, 2012.

Colorado Alliance & Health Independence (CAHI)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64 designed to provide a network of services that are high-quality and cost-effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. Effective January 1, 2013, clients currently enrolled in the CAHI program began transitioning into the Accountable Care Collaborative program. No expenditure is anticipated in FY 2013-14 or subsequent request years.

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6 "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5 "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." The Department has since expanded enrollment in the program and reached an enrollment total of approximately 745,000 by December 2014. The cost savings estimated for this program are included in Acute Care; please see Exhibit F and Section V for more information on its impact to Acute Care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2014-15 include $3,250,000 paid to the SDAC, a weighted average PMPM of $9.50 PMPM paid to the RCCOs, $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. An additional $3 PMPM was added to AwDC PMPMs to RCCOs in FY 2012-13.

Based on the experience from the first year of program operations, the Department assumes that approximately 25% of clients enrolled in the ACC program will not be attributed to a PCMP and that only the RCCO administrative fee will be paid for these clients. The fees in FY 2015-16 and FY 2016-17 are the same. In the current and request years, the Department assumes the full $2.00 incentive will be

paid out to the RCCOs and PCMPs for each of their members even though the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. Two policy changes took place in fall of 2014 that impact the expected administrative payments for FY 2014-15 and future years. The first, which began September 2014, is a $0.50 reduction in the base PMPM for RCCOs. These funds would be spent in the following fiscal year as incentive payments to PCMPs. The second, which began October 2014, is that RCCOs would only be paid 65% of their PMPM for clients who have been unattributed to a PCMP for at least six consecutive months. These funds would be spent in the following fiscal year as incentive payments to RCCOs that meet predetermined benchmarks. For this reason, administrative payments for the ACC are expected to be lower in FY 2014-15 than previously anticipated, as some portion of these payments are moved to the following fiscal year in an ongoing process.

Enrollment in the ACC grew at a high rate between FY 2012-13 and FY 2013-14, due to Medicaid expansion and the enrollment of clients who were eligible for Medicaid prior to expansion, but not enrolled previously. The Department has passively enrolled expansion clients and will continue to do so.

Accountable Care Collaborative: Medicare-Medicaid Program (ACC:MMP)

The Department negotiated with the Centers for Medicare and Medicaid Services (CMS) throughout FY 2013-14 regarding the implementation of a pilot program targeting clients fully eligible for both Medicare and Medicaid. Research has shown that coordinating care for this population has the potential to create significant cost savings. However, to achieve these savings, both payers must work collaboratively to ensure providers have the support and data needed to provide coordinated care, and that savings are distributed between the payers equitably. To provide this coordinated care environment, the Department proposed to leverage existing infrastructure and enroll dually eligible clients in the Accountable Care Collaborative with an enhanced PMPM to account for the greater resource intensity needed to provide care coordination for this complex population. The pilot was approved late FY 2013-14 and enrollment of full benefit Medicare-Medicaid eligible clients into the ACC began September 1, 2014. Extensive analysis by the Department and the Department's actuaries has shown that, even with an enhanced PMPM, there is significant savings opportunity. The impact of this pilot program is incorporated as a bottom-line impact for savings to Acute Care, and is also accounted for as a bottom-line impact to the prepaid inpatient health plan administration exhibit. The bottom-line impact in Exhibit I has been updated in this request to remove the impact of funding that is 100% federal grant funding from the budget.

Legislative Impacts and Bottom-Line Adjustments

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

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

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

Hospital Provider Fee Fund

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

MAGI Parents/Caretakers 69% to 133% FPL
While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level (FPL). This expansion population receives the standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund had funded this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match began and the population expanded to 133% FPL on January 1, 2014.

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

For caseload estimates and methodology, please see the Acute Care section of this narrative.

MAGI Adults
This expansion allows MAGI Adults to be eligible for Medicaid benefits. Eligibility for this population began in May 2012. The Department was granted a Section 1115 Demonstration Waiver in order to implement eligibility of the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012. With the advent of SB 13-200, effective July 1, 2013, MAGI

Adults are now covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund had funded this population in the interim before the population expanded and the enhanced federal match began on January 1, 2014.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed there were 143,191 uninsured MAGI Adults in Colorado in 2009, 49,511 of which were in the 0-10% FPL bracket. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion under HB 09-1293 at 10,000.

The Department assumes the per capita costs for this population will be a blend of the historical per capita for this population from 0-10% FPL with an increase in per capita estimates based on the assumed health needs of this population beyond the 10,000 enrollment cap that was in place prior to January 1, 2014, and estimated per capita for this population from 11-133% FPL, since no historic data exists for the expansion population. The Department assumes these clients will be the most high-need clients, with significant pent-up demand. To allow for potentially higher-than-anticipated costs with the rollout of a new population, the Department is remaining conservative in determining per capita estimates.

Non-Newly Eligibles

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the 100% federal medical assistance percentage (FMAP) that occurred January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information in order to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for 100% FMAP. Instead, these clients receive standard FMAP, and the State portion is funded through the Hospital Provider Fee Fund in compliance with statute. The state is anticipating approval of a resource proxy for the non-newly eligibles where 75% of expenditures would receive 100% FMAP, while the remaining 25% would receive the standard FMAP, funded from the Hospital Provider Fee Fund. The Department has incorporated the resource proxy in this request.

MAGI Parents/Caretakers 60% to 68% FPL

Historically, clients who fell under the Expansion Parents to 133% FPL eligibility category (any client over 60% FPL) were considered expansion clients and the State's share of funding was provided through the Hospital Provider Fee Fund. The MAGI conversion has resulted in some clients with over 60% FPL falling into the MAGI Parents/Caretakers 60% to 68% FPL category. The State share of funding for these clients comes from the Hospital Provider Fee Fund, in compliance with statute.

Medicaid Buy-in Fund

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

Buy-in for Individuals with Disabilities

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

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

The Department assumes most clients in the Buy-In program will have lower utilization of many Home- and Community-Based Services (HCBS) waivers and other Long-Term Care services than the current Medicaid Disabled Individuals to 59 (AND/AB). The Department assumes proportionally fewer individuals with the ability to work would meet the level of care for either a waiver or nursing facility than in the current Disabled Adults to 59 population. In addition, clients who are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. In addition, the Department also assumes 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services.

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients. Hospital provider fee supplemental payments have been updated to reflect the most current model which takes into account new information such as Medicaid Expansion. The large decrease since the November Request is due to changes in the hospital provider fee model based on lower than expected revenue to be collected in the current fiscal year.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

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

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

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

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

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

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

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

EXHIBIT L – DEPARTMENT RECOVERIES

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

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

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

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 11 years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12-month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Operations Resource Engine (CORE) are not allocated to eligibility categories. The basis for this allocation is data obtained from the Department's Medicaid Management Information System (MMIS).

This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community-Based Long-Term Care, Long-Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

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

Service Group	**Old Title**	**New Title**
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community-Based Long-Term Care	Home- and Community-Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community-Based Long-Term Care	Home- and Community-Based Services - Mentally Ill	HCBS - Mental Illness
Community-Based Long-Term Care	Home- and Community-Based Services- Children	HCBS - Disabled Children
Community-Based Long-Term Care	Home- and Community-Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community-Based Long-Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community-Based Long-Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

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

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

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

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

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

Effective with the November 1, 2012 Budget Request, the Department is reporting expenditure for MAGI Adults and Disabled Buy-in eligibility types.

Effective with the November 1, 2014 Budget Request, the Department made numerous changes to this exhibit; historical actuals have been adjusted accordingly:

- Categorically Eligible Low-Income Adults (AFDC-A) and Expansion Adults to 60% FPL have been combined into a single category, MAGI Parents/Caretakers to 68% FPL; historical information has been updated to reflect the merger of these eligibility categories in this Budget Request,
- Expansion Adults to 133% FPL has been renamed to MAGI Parents/Caretakers 69% to 133% FPL,
- Adults without Dependent Children (AwDC) has been renamed to MAGI Adults,
- Baby Care Program – Adults has been renamed to MAGI Pregnant Adults,
- And two new eligibility categories have been added for the clients transitioning from CHP+ to Medicaid, SB 11-008 Eligible Children and SB 11-250 Eligible Pregnant Adults; these populations have been carved out of the Eligible Children and MAGI Pregnant Adults categories respectively, including historical information.

Effective with the February 2015 Budget Request, the Department has restated historical actuals for FY 2013-14 to account for continuous eligibility for children. The Department also restated historical actuals for FY 2013-14 to correct for a technical error that

incorrectly split dollars spent for Pharmacy and Health Maintenance Organizations between the Eligible Children and SB 11-008 Eligible Children categories, and between the MAGI Pregnant Adults and SB 11-250 Eligible Pregnant Adults categories.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2013-14 final actual expenditures are included in this Budget Request for historical purpose and comparison.

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

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2013-14 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2013-14 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations for FY 2013-14, FY 2014-15 and FY 2015-16 in the chronological order of the requests/appropriations.

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends.

EXHIBIT Q – TITLE XIX AND TITLE XXI TOTAL COST OF CARE

Effective with the November 1, 2014 Budget Request, the Department included a new exhibit detailing the total cost of Medicaid services, including lines outside of Medical Services Premiums, such as service expenses for Medicaid Behavioral Health, the Office of Community Living, Medicaid-funded DHS services, and CHP+, separating Title XIX and Title XXI fund sources, to show the total

services cost of providing care to clients. This exhibit also includes a total cost of care per capita exhibit for these combined services, including both Title XIX expenditure and Title XXI expenditure, by eligibility category.

V. ADDITIONAL CALCULATION CONSIDERATIONS

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

New Legislation and Impacts from FY 2014-15 Budget Cycle Requests

This section describes the impact from legislation passed during the 2014 Legislative Session and includes impacts from the Department's FY 2014-15 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

HB 14-1336 – FY 2014-15 Long Bill

The FY 2014-15 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2014 Legislative Session that impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- CDASS Service Expansion into the Brain Injury Waiver – Consumer Directed Support Services (CDASS) was expanded to the Brain Injury Waiver, most of the clients transitioning from the 1915(i) option, but new clients would substitute long-term home health for the health maintenance component of CDASS increase HCBS expenditure and decreasing acute care expenditure by $112,237 in FY 2014-15.
- R-7 (FY 2014-15) Adult Supported Living Service Waiting List Reduction: The Department was approved funding to decrease the waitlist for the Supported Living Services waiver. Savings to Acute Care and Community-Based Long Term Care result from clients utilizing waiver services in place of State Plan services. This is expected to decrease expenditure by $2,241,491in FY 2014-15.
- R-8 (FY 2014-15) Development Disabilities New Full Program Equivalents: The Department was approved funding to allow for emergency enrollments, youth transitions, and de-institutionalizations onto the DD waiver. This has been combined with the adjustment for HB 14-1252 as both would increase enrollment on the DD waiver but the Department is unable to pull the two policies apart when new clients are enrolled. HB 14-1252 was an adjustment to existing appropriations between waiver services. The Department had experienced significant under-expenditure in the HCBS-DD and the HCBS-CES waiver programs that was

used to rebalance over-expenditure in the HCBS-SLS waiver program. The request included funding for additional FPE to allow more clients to be served on the waiver programs in place of State Plan services, resulting in a negative fiscal impact. Savings result from clients utilizing waiver services in place of State Plan services. This is expected to decrease expenditure by $705,217 in FY 2014-15.

- R-9 (FY 2014-15) Medicaid Community Living Initiative: The Department was approved funding for counseling nursing home residents regarding community-based living options. This is expected to increase expenditure by $364,073 in FY 2014-15.
- R-10 (FY 2014-15) Primary Care Specialty Collaboration: The Department was approved funding to establish and maintain a system for primary care doctors to communicate with specialty care providers. This is expected to decrease expenses related to additional appointment for specialty providers. This is expected to increase expenditures by $194,282 in FY 2014-15.
- R-11 (FY 2014-15) Community Provider Rate Increases: The Department was approved funding to increase provider rates 2.00% across the board. This is expected to increase expenditures by $64,321,150 in FY 2014-15.
- R-11 (FY 2014-15) Targeted Community Provider Rate Increase: The Department was approved funding for the purpose of addressing issues with clients access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F1. The total impact of the targeted rate increases is $13,880,911 in FY 2014-15.
- BA 10 (FY 2014-15) Continuation of 1202 Provider Rate Increases: The Department was approved funding to continue rate increases that were included in section 1202 of the Health Care and Education Reconciliation Act that required that states pay for primary care services at 100% of Medicare rates. The total impact of this program is $44,277,696 in FY 2014-15.
- BA 12 (FY 2014-15) State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees: The Department was granted funding to enroll clients dually eligible for Medicaid and Medicaid in the Accountable Care Collaborative (ACC) so that they will receive care coordination. The total impact is a decrease of $245,533 in FY 2014-15.
- FY 2014-15 JBC Action, Matching Incentives to Ambulatory Surgery Center Facilities: The 2014 Long Bill included $500,000 in funding to match payments made to Surgeons accounted for within the R-11 Targeted Community Provider Rate Increase. Current implementation is delayed until October, 2014 so the Department assumes an impact of $333,333 in FY 2014-15.
- FY 2014-15 JBC Action, Family Planning Rate Increase: The 2014 Long Bill included $1,817,275 in funding for the Department to standardize rates for oral contraceptives as well as a 15% rate increase for Family Planning Services.
- FY 2014-15 JBC Action, Raising FQHC Rate Increase to APM: The 2014 Long Bill included $7,261,751 in funding to increase rates to Federally Qualified Health Centers to Colorado's Alternative Payment Method.
- FY 2014-15 JBC Action, Full Denture Benefit: The 2014 Long Bill included funding for the Department to provide full dentures as a part of the Adult Dental Benefit established in SB 13-242. The Department estimates this will increase expenditure by $24,509,713 in FY 2014-15.

HB 14-1045 – Continuation of BCCP

HB 14-1045 extended the repeal date of the Breast and Cervical Cancer Program through July 1, 2019. This will ensure that these clients do not experience any lapse in coverage. Beginning in FY 2014-15 100% of the state share of the funding for this program will be from the Breast and Cervical Cancer Prevention and Treatment Fund. All Breast and Cervical Cancer Program expenditures receive a 65.53% federal match rate in FY 2014-15. This is expected to increase expenditure by $6,096,581 in FY 2014-15.

HB 14-1252 – Intellectual and Developmental Disabilities Services System Capacity

HB 14-1252 was an adjustment to existing appropriations between waiver services. The Department had experienced significant under-expenditure in the HCBS-DD and the HCBS-CES waiver programs that was used to rebalance over-expenditure in the HCBS-SLS waiver program. The request included funding for additional FPE to allow more clients to be served on the waiver programs in place of State Plan services, resulting in a negative fiscal impact.

Because the impact of this bill and the Department's FY 2014-15 R-8 Developmental Disabilities Full Program Equivalents request are difficult to disentangle from one another, the bottom-line impact for this bill and the FY 2014-15 R-8 have been combined. Please see the FY 2014-15 R-8 component of the HB 14-1336 long bill on page 88 for the dollar impact of these two changes.

HB 14-1357 – In-Home Support Services in Medicaid Program

HB 14-1357 makes several changes to in-home support services (IHSS) provided by the Department. This bill allows IHSS to be provided inside the home or within the community, adds spouses as an eligible family member to act as an attendant providing IHSS to an HCBS waiver client, allows eligible clients or their representative the ability to determine the amount of oversight needed, allows family members to be reimbursed for providing IHSS, expands IHSS to clients receiving services through the Spinal Cord Injury waiver, and adds IHSS to the list of services under the Elderly, Blind, and Disabled waiver program.

Implementation of these program changes is on track for FY 2014-15 and is expected to increase expenditure by $297,986.

SB 14-130 – Increase Personal Care Allowance Nursing Facility

SB 14-130 raises the personal need allowance (PNA) of Medicaid nursing facility residents from $50 to $75. The increase would actually decrease the patient payment made to nursing facilities, resulting in a loss of revenue. The Department is offsetting the loss in revenue

to nursing facilities due to the increase in PNA with General Fund. The PNA allows for the purchase of clothing and other goods and services that are not reimbursed by any state or federal program. This is expected to increase expenditure by $1,057,300 in FY 2014-15.

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

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

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

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

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

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

Implementation of this program is currently on hold due to systems issues.

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

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

management and immunizations -- performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

The Department estimates the difference in rates between July 1, 2009, and January 1, 2013, will generate an estimated $31,918,911 total funds impact in FY 2013-14 and a $609,631 total funds impact in FY 2014-15, and a negative $39,365,571 total funds impact in FY 2015-16, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July 1, 2009. This gap represents rate cuts that were taken since July 1, 2009, due to budget reduction measures. The Department estimates increasing rates to the July 1, 2009 level will increase expenditure by $3,512,863 in FY 2013-14, a negative $62,643 in FY 2014-15, and a negative $4,207,240 in FY 2015-16. These amounts will be matched by the federal government at the standard FMAP rates. The enhanced federal funding is not available in CY 2015. Consequently, the bottom line impact in Acute Care, Exhibit F for FY 2014-15 accounts for a half year impact after which expenditure returns to original levels.

ACC Savings

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefits package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients' care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The program began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently at an average monthly enrollment level of 704,702 for the first half of FY 2014-15. The central goals of the program are to improve health outcomes through a coordinated, client-centered system and to control costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

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

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

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

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

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

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

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. Due to attrition and replacement enrollments, it is no longer possible to isolate an original 60,000 member cohort or expansion cohort. Consequently, expenditure and savings adjustments are shown in aggregate for the program. Because children make up a large portion of caseload in Medicaid, the greatest opportunity for ACC expansion lies within this population. As children also have relatively lower per capita expenditure, the savings opportunity from enrollment in the ACC for this population is smaller than other populations. The Department has assumed a decreasing return to investment in each subsequent year on a per client basis. Further, RCCO rates have been adjusted to reflect the new case mix under an expanded program. In FY 2013-14 and subsequent years, the savings distribution has been adjusted to account for more actual savings in the disabled populations than children.

Two new policy changes began in fall of FY 2014-15; a $0.50 base reduction for PMPM for RCCOs began in September 2014, and a 35% reduction in PMPM for clients who are unattributed to a PCMP for six consecutive months began in October 2014. The reduction in funding would be paid out the following fiscal year as an incentive payment to PCMPs for the former and to the RCCOs for the latter.

The chart below shows program expenditure and estimated savings for FY 2014-15, FY 2015-16, and FY 2016-17. RCCO administrative payments include the reductions attributable to the policy changes mentioned above.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2011-12	FY 2012-13	FY 2013-14[2]	FY 2014-15	FY 2015-16	FY 2016-17
Program Administration (Exhibit I, PIHP)	**SDAC**	$2,700,000	$2,902,500	$2,950,000	$3,250,000	$3,250,000	$3,250,000
	RCCO	$12,303,473	$27,696,161	$52,945,462	$84,409,671	$110,587,955	$122,077,992
	PCMP	$2,904,360	$6,130,270	$12,674,868	$24,224,374	$32,343,011	$35,098,806
	Total Administration	**$17,907,833**	**$36,728,931**	**$68,570,330**	**$111,884,045**	**$146,180,966**	**$160,426,798**
Program Savings (Exhibit F, Acute)	**Total**	**($20,616,544)**	**($43,647,968)**	**($98,000,000)**	**($144,193,108)**	**($198,907,049)**	**($221,106,960)**
	Incremental[1]		**($23,031,424)**	**($50,147,776)**	**($46,193,108)**	**($54,713,941)**	**($22,199,911)**
Net ACC Program Fiscal Impact				**($29,429,670)**	**($32,309,063)**	**($52,726,083)**	**($60,680,162)**

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

(2) The total and incremental savings and net ACC program fiscal impact have been restated for FY 2013-14 to reflect updated savings estimation methodology that is in line with the November 1, 2014 Legislative Request for Information #4 regarding the Accountable Care Collaborative. This new methodology more accurately reflects savings rates by population.

Client Overutilization Program Expansion (BRI-1)

This BRI originally sought to increase enrollment to 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department is currently re-evaluating the COUP program as it was originally designed and as such savings have been removed from the budget until an implementation plan is in place and assumptions are re-evaluated. The Department intends to adjust savings estimates in future requests as the COUP program is re-evaluated.

Medicaid Budget Balancing Reductions (2011-12 BA-9)

In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions. Only one part of this initiative remains to be implemented, limiting the number of physical and occupational therapy units for adults.

- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until July 1, 2016 to make use of the new MMIS system. The Department adjusted its request accordingly.

Estimated Impact of Increasing PACE Enrollment

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

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

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

The estimated decrease in expenditures due to increased PACE enrollment is $4,443,598 in FY 2014-15 $2,441,737 in FY 2015-16, and $1,900,349 in FY 2016-17.

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

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, and annualizing to $3,699,827 in FY 2011-12, by requiring the Department to implement a number of initiatives. The Department has been able to partially implement the components of SB 10-167, though full implementation is ongoing. Consequently, a portion of the savings originally anticipated in FY 2012-13 has been shifted to FY 2013-14 and subsequent years. The initiatives are as follows:

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over 3 million in total) to achieve savings despite delays in implementation. NCCI was fully implemented in April 2013. The Department expects a partial year savings in FY 2013-14 of $629,100 and for savings to be incorporated into the base in subsequent years.

Health Insurance Buy-In Program Expansion

The Department anticipates purchasing private health insurance coverage through the Health Insurance Buy-In (HIBI) Program for an additional 1,500 eligible clients to create cost savings for the State by enrolling clients into individual insurance plans where enrollment is deemed cost-effective. This initiative was delayed to implement in FY 2013-14 to allow for contract execution. The Department has identified a vendor and has begun the enrollment process, but it has gone more slowly than anticipated. As of December 2014, there were 470 clients enrolled in HIBI. The vendor had previously anticipated approximately 70 clients would be enrolled per month until the maximum of 2,000 clients was reached; however, this did not occur, and so assumptions have been adjusted to account for approximately 2% enrollment growth per month through FY 2016-17.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes

this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2012-13 per capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2014-15through FY 2015-16.

FY 2014-15 and FY 2015-16 Total HIBI Impact from SB 10-167

Item	FY 2014-15	FY 2015-16	FY 2016-17
Provider Payment	$162,108	$191,401	$240,346
Premiums Payment	$1,353,077	$1,597,580	$2,006,114
Total Savings (Realized in Acute Care)	($2,512,856)	($2,966,934)	($3,725,640)
Incremental Savings for Bottom-Line Impact in Exhibit F	($248,641)	($454,078)	($758,706)
Total Impact	**($997,672)**	**($1,177,953)**	**($1,479,180)**

Colorado Choice Transitions (Money Follows the Person Grant)

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

The Department had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented March 1, 2013, with the first client transitioning in May 2013. The Department anticipates approximately 100 clients will transition per 365 day period beginning in May 2013. The Department estimates the total impact to Medical Services Premiums to be $155,748 total funds in FY 2013-14, $1,026,418 savings in FY 2014-15, and $4,133,659 savings in FY 2015-16. These figures do not include any expenditure from the rebalancing fund.

Medicaid Budget Reductions (2012-13 R-6)

This budget action encompassed 16 different policy initiatives targeted at addressing the statewide budget shortfall. The majority of the proposals are efficiency measures that align Medicaid practices with industry standards to maximize clinical efficacy while maintaining fiscal responsibility. Only some elements of this budget action have not been implemented.

- *Dental Efficiencies*: The Department will clarify rules regarding eligibility for orthodontics. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion. Until the Dental Benefits Collaborative process is complete in early 2015, full implementation of this reduction cannot be implemented. Full implementation is noted in FY 2015-16 with an additional reduction of $1,704,632.
- *Augmentative Communication Devices:* The Department's efforts to provide new, less expensive communication assistance technology for clients with disabilities impairing their ability to communicate have met with difficulty in two areas: The first is a systems issue that causes claims for these devices to be rejected and the second is a proprietary license issue that causes vendors to have difficulty in obtaining these devices to supply to clients. The Department is proactively looking for solutions in both areas and the problems are expected to be resolved before the end of FY 2014-15. The adjustment of negative $112,750 in FY 2014-15 accounts for the delayed implementation as the Department resolves these issues. Full implementation is expected in FY 2015-16 and the initiative is annualized for a reduction of $338,250 in that fiscal year as well.

53 Pay Periods in FY 2013-14

The Department must account for an additional pay period in FY 2013-14. The decrease estimated in the February request was $38,288,901 in FY 2013-14. The Department updated this estimate to a decrease of $49,726,790 in FY 2014-15.

FY 2013-14 R-7: Substance Abuse Disorder Benefit

The Department was approved funding to enhance the current substance use disorder benefit through the Behavioral Health Organizations (BHOs), expanding limitations on current services and adding appropriate services to create a more robust program due to a high number of individuals with mental health disorders having a co-occurring substance abuse disorder. Integrating substance use disorder services with the BHO benefit will provide clients with better care coordination and ensure that clients receive services necessary for recovery. Previously, substance use disorder services are provided in a fee-for-service setting and were unmanaged. This program has a negative $1,485,982 impact in FY 2014-15 as a result of properly managed mental health and/or substance use disorders.

FY 2013-14 R-9: Dental ASO for Children

The Department was approved funding to implement a dental administrative services organization (ASO) for the Medicaid children's benefit. The program will allow the Department to deliver and manage dental services for children and increase the available provider network while increasing savings through the reduction of preventable and costly restorative services. This program is anticipated to have a budget savings of $576,072 in FY 2014-15.

SB 13-200: Medicaid Expansion

This bill amends Medicaid eligibility criteria for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line. It also amends the Medicaid eligibility criteria for MAGI Adults to 133% of the federal poverty line and ages 19 through 64. This bill also expanded the funds to the SDAC by $250,000 per year.

SB 13-242: Adult Dental Benefit

This bill implements a limited dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit. Dental services were previously available to only children 21 years of age and under through the EPSDT program. For clients over 21, the Department previously only reimbursed for emergency dental services. This program is expected to increase State expenditures by $82,329,956 in FY 2014-15 as well as an increased service management cost of $567,726.

Fluoride Benefit Expansion

The 2013 Long Bill also added a requirement that the Department will allow primary care providers to receive reimbursement for providing oral health risk assessments and applying fluoride varnishes up to three times per year for children five years and older. The fiscal impact of this implementation is included as a bottom line adjustment in Exhibit F.

FY 2013-14 R-13: 2% Provider Rate Increase

The Department increased provider rates for services impacted by rate reductions in recent years. During the economic recession, the state imposed multiple provider rate reductions to create General Fund relief. This placed financial strain on providers and potentially put client's health care at risk. The annualization of these rate increases are expected to increase expenditures by $5,507,961 in FY 2014-15.

Non-Newly Eligible Resource Proxy

The Department anticipates that it would be able to receive 100% FMAP for 75% of the expenditures for this sub-group of the 100% federally funded Medicaid expansion group. The current request reflects this update as a decrease to Hospital Provider Fee Cash Funds and an increase to federal funds.