Department of Health Care Policy and Financing
Medical Services Premiums

FY 2016-17, FY 2017-18, and FY 2018-19 Budget Request

February 2017

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MEDICAL SERVICES PREMIUMS

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $151.1 million under the November request in total funds. The $151.1 million decrease consists of a $108.6 million decrease in federal funds and a decrease of $30.3 million General Fund compared to the November request. The decreases in federal funds are primarily driven by changes in caseload expectations for the MAGI Parents/Caretakers to 133% FPL (a decrease of 13,593, or 13.7%), and a reduction in the per capita trend for MAGI Adults (a decrease of 1.2%) compared to the November Request. The decrease in General Fund is primarily driven by changes in caseload expectations for MAGI Eligible Children (a decrease of 13,469, or 2.8%), MAGI Parents/Caretakers to 68% FPL (a decrease of 27,856, or 14.5%), and Disabled Individuals to 59 (AND/AB) (a decrease of 1,322, or 1.9%). Several small increases in per capita trends for General Fund populations were offset by caseload decreases.
- Community-Based Long-Term Care – The current request is approximately $28.1 million above the November request. The increase is primarily due to a large increase in PDN and LTHH monthly enrollment and per client utilization. This decrease was slightly dampened by a decrease in enrollment for the waivers.
- Class I Nursing Facilities - The current request is approximately $6.6 million above the November request. The increase is due to underestimating the aggregate nursing facility FY 2016-17 rate.
- Supplemental Medicare Insurance Benefit – The current request takes into account the actual 2017 Medicare Part B premium of $134.00. Similarly, to the November request, in CY 2018 and 2019, the Department is using the 2016 Medicare Trustees Report estimates of $124.40 and $131.60, respectively. The Department's November forecast estimated the premium to be $149.00 in CY 2017, which was based on the 2016 Medicare Trustees Report forecast as well and the forecast was updated to actuals where appropriate.

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 FY 2014-15, rates were increased 2% across the board. Some services received varying targeted rate increases in FY 2014-15 as well. Rates were also increased in FY 2015-16, at 0.50% across the board along with various targeted rate increases for some services.

3. The Department's request identifies, and in some cases amends, the fiscal impact of these changes 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 can 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's request incorporates estimates for revised eligibility requirements and new expansion populations, which gained 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.

5. 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% federal medical assistance percentage (FMAP) while Family Planning Services receive a 90% FMAP. Breast and Cervical Cancer Program (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 97.5% FMAP in FY 2016-17, a 94.5% FMAP in FY 2017-18, and a 93.5% FMAP in FY 2018-19 as the federal match for these populations falls from 100% to 95% in January 2017, 94% in January 2018, and 93% in January 2019. 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 approximately 65% with an additional 23 percentage point FMAP increase; the enhanced FMAP is expected to be 88.13% in FY 2016-17 and 88.00% in FY 2017-18 and FY 2018-19.

6. 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.

7. The State's FMAP for Medicaid services will decrease from 50.72% to 50.02% beginning October 1, 2016. With the new FMAP of 50.02% beginning October 2016, FMAP for FY 2016-17 will be 50.72% for the first quarter and 50.02% for the latter three quarters, resulting in an effective FMAP of 50.20% for the fiscal year. Data from the Colorado Population Forecast, the U.S. Census, and the Legislative Council is used to estimate the FMAP for FY 2017-18 and FY 2018-19, at 50.00%. These changes are outlined in Exhibit R. This FMAP change applies to Medicaid services only; Medicaid administrative costs would continue to receive a 50.00% FMAP. If the FMAP changes from Department estimates, the Department would submit a supplemental funding request to account for the change in federal funds. More information can be found about the FMAP estimates in Exhibit R.

8. Significant differences in the types and utilization of various home health services have caused the Department to evaluate the placement of these services. Previously, all home health services were placed under Acute Care. Effective in the November 2015 request, the Department has now separated home health services into two categories: Acute Home Health and Long-Term Home Health (LTHH). Acute Home Health is included in Acute Care and information about this change can be found in Exhibit F. LTHH is included in Community-Based Long-Term Care and information about this change can be found in Exhibit G.

9. The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until March of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously. It is possible that the FY 2015-16 actuals may change in the next request. The Department does not expect major changes to FY 2015-16 actuals. The FY 2015-16 actuals contained within this request reflect data for FY 2015-16 as of August 29, 2016.

10. The Department provided descriptions of any federal sanctions or potential sanctions for state activities of which the Department is already aware in its hearing responses on December 14, 2016. The following items are new or have updated information since that submission.

    - CHIPRA Audit: The Office of the Inspector General (OIG) began auditing the Department in 2014 as to whether bonus payments awarded to the State through the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) were consistent with CHIPRA statute. In August 2016, the OIG concluded the Department incorrectly included blind or disabled children in the State's reported caseload numbers, artificially inflating the bonus payments. OIG recommended to Centers for Medicare & Medicaid Services (CMS) that the State return $38.4 million of the $157.5 million in bonus payments the State received between 2010 and 2014. OIG made similar findings in audits of other states, including Washington, New Mexico, Alabama, Wisconsin, and North Carolina. The Department strongly disagreed with the audit findings. Colorado maintains that all bonus payments received were fully allowable and that CMS's methodology and rationale for excluding blind and disabled children from the bonus payment program was

contrary to the express language of the federal statute. In a letter dated September 28, 2016, CMS states it does not concur with the State's response and will provide further guidance to the State for returning the overpayments. The Department appealed the decision and CMS filed a response to the appeal stating that it has not yet issued a final agency decision and therefore the DAB does not have jurisdiction. The Department did not contest that decision.

- School Health Services Program Disallowance: The School Health Services Program allows participating school districts and Boards of Cooperative Education Services to receive federal Medicaid funds for health services provided to students who are enrolled in Medicaid and have an Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). On September 16, 2016, the Department received a disallowance of $594,318 in federal funds drawn through the School Health Services Program in FY 2008-09. This disallowance is the result of an audit conducted by the OIG and finalized in April 2012. The audit report recommended that the Department return $871,246 in federal funds. The Department agreed with several of the findings and promptly returned $276,328 of federal funds related to the issues not in dispute. The Department disagreed with findings related to $594,918 in federal funds, which have now been disallowed. The Department requested reconsideration of the disallowance with the Secretary of the U.S. Department of Health and Human Services and the request for reconsideration was denied. Because the Department retains a portion of the federal funds drawn under this program for administrative expenses and has sufficient reserves to repay the disallowed funds, no impact to participating school districts or the General Fund is expected.

- OIG performed an audit on the Department and issued a report entitled Colorado Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs. The Department disagreed to refund the federal government $5,229,604 for claims for single-source physician administered drugs that were eligible for reimbursement. The Department also disagreed to refund the federal government $1,296,954 in federal share for claims for top-20 multiple source physician-administered drugs that were ineligible for federal reimbursement. Instead the Department is working with Magellan Medicaid Administration (Magellan) to invoice all rebate-eligible units in order to bring the Department into compliance with the federal requirements for reimbursement for physician-administered drugs. In the event any rebate-eligible units cannot be invoiced, the Department will work with CMS to determine whether funds should be refunded based on the federal share of the claim reimbursement or the federal share of the uncollected rebate.

- The Department agreed to work with CMS to determine the unallowable portion of $1,293,696 in federal share for other claims for covered outpatient physician-administered drugs that were reimbursed without NDCs and that may have been ineligible for federal reimbursement and refund that amount; and to determine whether the remaining $317,343 in federal share of other physician-administered drug claims could have been invoiced to the manufacturers to receive rebates and, if so, upon receipt of the rebates, refund the federal share of the manufacturers' rebates for those claims. The Department is working with Magellan to determine if the appropriate NDC numbers can be identified and to review the claims. The

Department also agreed to work with CMS to determine and refund the unallowable portion of the federal reimbursement for physician administered drugs that were not invoiced for rebates after December 31, 2012. In the event any rebate-eligible units cannot be invoiced, the Department will work with CMS to determine whether funds should be refunded based on the federal share of the claim reimbursement or federal share of the uncollected rebate.

- As allowed under federal regulations, the Department reimburses hospital providers that help enroll eligible Coloradans into the Medicaid program, referred to as outstationed eligibility services or outstationing. Recently, the Centers for Medicare and Medicaid Services (CMS) raised questions about the Department's outstationing payments made to hospitals over the last 5 years. The Department has suspended current payments while it works to address CMS's questions. No deferral or disallowance of federal funds has been received to date.

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 person with disabilities each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums needed for current and request years. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

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

Rationale for Grouping Services for Projection Purposes

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

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: 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
- Colorado Choice Transitions - Services
- Private Duty Nursing
- Long-Term Home Health
- 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
- 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 Community Based Long-Term Care, 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 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 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 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 typically around 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 State's FMAP for Medicaid services decreased from 51.01% to 50.72% effective October 1, 2015, and decreased from 50.72% to 50.02% effective October 1, 2016. The Department has estimated the FMAP for Medicaid services going forward, based on data from the Bureau of Economic Analysis, the U.S. Census, the Department of Local Affairs' Population Forecasts, and the Colorado Legislative Council's U.S. and Colorado Personal Income forecasts, resulting in an estimated FMAP of 50.00% beginning October 1, 2017.

Certain populations and services receive different FMAPs than the new standard 50.02% that begins October 2016. This is summarized below. Clients transitioning from CHP+ to Medicaid receive the CHP+ FMAP, which is usually 65% but has been recalculated at 65.01% effective October 2016 and 65.00% effective October 2017 forward. 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 88.13% FMAP in FY 2016-17, and 88.00% FMAP in FY 2017-18 forward. Clients in the BCCP program also receive a 65% match, or 65.01% effective October 2016 and 65.00% effective October 2017 forward. Since the FMAP decrease to 50.02% occurs at the start of the second quarter of FY 2016-17, the FMAP would be 50.72% for quarter one and 50.02% for the remainder of the year, resulting in a final FMAP of 50.20% for FY 2016-17. This logic is applied to the populations receiving 65.50% for quarter one and 65.01% the remainder of the fiscal year, resulting in a final FMAP of 65.13% for FY 2016-17. 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 populations for FY 2016-17. The match for this population falls again to 94% beginning January 1, 2018, resulting in a final FMAP of 94.50% for these populations for FY 2017-18, and falls to 93% beginning January 1, 2019, resulting in a final FMAP of 93.50% for FY 2018-19. However, any Community-Based Long-Term Care waiver services for these individuals must be claimed at the standard match as they are not eligible to receive the enhanced FMAP. A sub-group of MAGI Adults, non-newly eligible individuals with disabilities, receive the ACA expansion FMAP for 75% of their expenditure and the standard FMAP for the remaining 25%, resulting in an effective FMAP of 85.68%, 83.38%, and 82.63% for FY 2016-17, FY 2017-18, and FY 2018-19 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 2016-17	88.13%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.13%	Clients in the BCCP program	Please see Exhibit F
	97.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	85.68%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.20%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.20%, Medicaid Buy-In Fund 0%
FY 2017-18	88.00%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	94.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	83.38%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2018-19	88.00%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	93.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	82.63%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	Hospital Provider Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2016-17	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.20%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2017-18	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2018-19	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51%	ACA Preventive Services	Please see Exhibit A
	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, 49.28% General Fund and 50.72% federal funds in October 2015, and 49.98% General Fund and 50.02% federal funds in October 2016. 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 and 65.13% effective October 2016. 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%. Please see Exhibit F for calculations.

- 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.

- Non-Emergency Medical Transportation (NEMT): These services receive the administrative federal financial participation (FFP) rate of 50% rather than the various service FMAP rates. This entry adjusts the fund splits between federal and State funding to properly account for this service receiving FFP.

- 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 and 65.01% effective October 2016. 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 2016-17, FY 2017-18, and FY 2018-19 is expected to be 88.13%, 88.00%, and 88.00% 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 increased to 65.71% effective October 2014 and then decreased to 65.50% effective October 2015 and 65.01% effective October 2016. Previously, the State had authority to claim the enhanced FMAP on this population through July 31, 2015; after which date, the FMAP would be reduced to the standard Medicaid match rate. However, the Department received permission from the Centers for Medicare and Medicaid Services (CMS) to continue receiving a higher match rate for this population, including Section 1205(b) of the Social Security Act, similar to the population under SB 11-008 "Aligning Medicaid Eligibility for Children". Therefore, FMAP for this population for FY 2016-17, FY 2017-18, and FY 2018-19 is expected to be 88.13%, 88.00%, and 88.00% respectively.

- 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 FMAP 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% and to 94% in CY 2018 and to 93% in CY 2019. This results in a 97.50% federal match rate for this population in FY 2016-17 and a 94.50% federal match rate in FY 2017-18 and 93.50% federal match rate in FY 2018-19. 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 is funded with a combination of federal funds and Hospital Provider Fee. 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, a 95% federal match rate in CY 2017, a 94% federal match rate in CY 2018, and a 93% federal match rate in CY 2019. This results in a 97.50% federal match rate for this population in FY 2016-17 and a 94.50% federal match rate in FY 2017-18 and 93.50% federal match rate in FY 2018-19. However, waiver services for this population receive the standard FMAP and not the enhanced FMAP per CMS. Calculations and information regarding this population can be found in Exhibit J.

- Continuous Eligibility for Children: HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, beginning March 2014, 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. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department has broken this population out in its respective service categories to better show the impact of continuous eligibility for children. 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 receives federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculations of fund splits can be found in Exhibit J.

- Non-Newly Eligibles: MAGI Parents/Caretakers 69% to 133% FPL and MAGI Adults are 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, though it ramps down over time beginning in CY 2017. A caveat of this enhanced federal match rate is that the expansion population cannot have been eligible for Medicaid services prior to 2009 (or else those individuals 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 the full enhanced expansion FMAP on their expenditure. These clients are now eligible for Medicaid under the expansion, and receive FMAP determined by a resource proxy with the State portion funded through the Hospital Provider Fee, as required by statute. The Department can claim 75% of the expenditures for Non-Newly Eligible clients at the enhanced expansion 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: Parents/Caretakers over 60% FPL are 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, with a ramp down beginning January 1, 2017. 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 required by statute. Please refer to Exhibit J for calculations and additional details.

- Adult Dental Benefit Financing: SB 13-242 created a limited dental benefit for adults in the Medicaid program, implemented 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. Please refer to Exhibit F for calculations and additional details.

- HB 16-1408 Primary Care Rate Increase Financing: This bill created a new cash fund, the Primary Care Provider Sustainability Fund, which received funding from the CHP+ Trust fund balance in order to continue the Physician Rate Increase to 100% Medicare (Section 1202 of the Health Care and Education Reconciliation Act) through June 2017. The bill continued the rate increase at a lower rate than the original increase and for select primary care procedures only. This accounts for the impact of the rate increases that are paid for with the Primary Care Provider Sustainability Fund, adjusting for claims runout. Please refer to Exhibit F for additional details.

- HB 16-1408 State Plan Autism Treatment: CMS denied the Department's request to expand the Children with Autism Waiver, which was authorized through HB 15-1186. CMS directed the Department to provide behavioral therapy services deemed medically necessary under EPSDT. HB 16-1408 increased the General Fund offset for these services, funded through the Colorado Autism Treatment Fund. Effective with the November 2016 request, the Department is accounting for the state plan costs under Acute Care rather than under Community Based Long-Term Care Services.

- Children with Autism Wavier Services: Home and Community Based Services for children with autism are paid through The Children with Autism Cash Fund, created by SB 04-177.

- 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 (FFP) and certain individuals with limited resources qualify as a "Qualified Individual", which receives 100% FFP. In aggregate, the Department estimates that approximately 13.0% of the total will receive receives no FFP, while 5.0% receives 100% FFP. These assumptions are held constant in FY 2016-17, 2017-18, and in FY 2018-19.

- Tobacco Quit Line: The Tobacco Quit Line is administered by the Department of Public Health and Environment (DPHE); the Department pays for the share of costs for the quit line related to serving Medicaid members. The costs are administrative and therefore receive FFP rather than the applicable FMAP by eligibility category.

- Memorial Hospital High Volume Payment: Colorado public hospitals that meet the definition of a high volume Medicaid and Colorado Indigent Care Program (CICP) Hospital qualify to receive an additional supplemental reimbursement for uncompensated inpatient hospital care for Medicaid clients. To meet the definition of a high volume Medicaid and CICP Hospital a hospital must be: licensed as a General Hospital by the Department, classified as a state-owned government or non-state owned government

hospital, a High Volume Medicaid and CICP hospital, defined as those hospitals which participate in CICP, whose Medicaid inpatient days per year total at least 35,000 and whose Medicaid and CICP days combined equal at least 30% of their total inpatient days, and maintain the hospital's percentage of Medicaid inpatient days compared total days at or above the prior State Fiscal Year's level. Historically, Memorial Health has been the only hospital to qualify for this payment. It has not met the requirements to receive this supplemental payment in the last few fiscal years, however it did qualify in FY 2016-17. The Department assumes Memorial Hospital will continue to meet the criteria to receive this supplemental payment in the current year, request year and out year.

- 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. These payments are to be made with General Fund rather than certified public expenditures going forward; however, the Department is currently pursuing approval of the new payment model from CMS and cannot change payment methods without that approval. The Department anticipates the State share of these payments to be exclusively certified public expenditures in FY 2016-17 and fully General Funded with federal financial participation in FY 2017-18 and FY 2018-19, dependent upon CMS approval. Recently, CMS raised questions about the Department's outstationing payments made to hospitals over the last five years. The Department has suspended current payments it works to address CMS's questions. No deferral or disallowance of federal funds has been received to date. The FY 2016-17 estimate is based on outstationing payments in the current fiscal year to date. The FY 2017-18, and FY 2018-19 estimates are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- 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.

- 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.

- Physician Supplemental Payments: Federal funds are drawn to reimburse Denver Health and the Memorial Health Systems in Colorado Springs for physician services provided in excess of the current reimbursement methodology. The Department retains 10% of the federally matched dollars as a General Fund offset. The FY 2016-17, FY 2017-18, and FY 2018-19 totals are based on the total amounts Denver Health and Memorial Health Systems were 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. The FY 2016-17, FY 2017-18, and FY 2018-19 estimates are based on the Legislative Council's Amendment 35 revenue forecasts. The adjustment for FY 2016-17 also includes $2,606,930 in unspent reserves from FY 2015-16.

- Intergovernmental Transfer for Difficult to Discharge Clients: Privately owned nursing facilities are eligible for receiving supplemental Medicaid reimbursements for costs incurred treating medically complex clients, such that the sum of all Medicaid reimbursement remains below the Upper Payment Limit for privately-owned nursing facilities. In order to be eligible for these payments, nursing facilities must be privately owned; enter into an agreement with the discharging hospital regarding timelines and initial plans of care for the affected medically complex patients; and provide long term care services and supports in the least restrictive manner for medically complex clients residing in an inpatient hospital setting for whom no other suitable discharge arrangements are available. The transfer is an annual payment of $1,000,000 total funds with the State share being transferred through Denver Health & Hospital Authority. The Department is waiting for the State Plan Amendment (SPA) associated with this program to be approved by CMS and anticipates payments to begin in FY 2017-18.

- Repayment of Federal Funds for Physical and Occupational Therapy Unit Limit Policy: The Department submitted a state plan amendment (SPA) to implement a limit on the number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization, which was approved on October 1, 2011. The Department was unable to implement the policy until July 1, 2016 due to system issues. Any claims paid for services delivered in the interim above the 48-unit limit are out of compliance with the State Plan and unallowable. The Department repaid those funds in FY 2016-17.

- Denver Health Ambulance Payments: Federal funds are drawn to reimburse Denver Health for ambulance services in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund; the Department retains

10% of the federally matched dollars as a General Fund offset. The FY 2016-17, FY 2017-18, and FY 2018-19 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Technical Adjustment of Systems Issue for Children: Adjusts for a data issue that took place July 2015 through December 2015 that incorrectly moved clients from Children's Health Plan (CHP) and Eligible Children into categories for individuals with disabilities, including Children with Disabilities – Buy In. Because of the issue, the Department incorrectly funded services for certain affected clients with Hospital Provider Fee instead of General Fund and will adjust the funding source in FY 2016-17. See the Medicaid caseload narrative for more information.

- Historic Adjustment for Non-Newly Eligible Definition: Starting in FY 2015-16 Q3, the Department updated the income criteria used to identify non-newly eligible population to be consistent with the SPA[1] submitted to CMS. The previously used income criteria did not account for the income limit of couples and consequently excluded members who should have received the blended FMAP for the non-newly eligible population, rather than the expansion FMAP. In FY 2016-17, the $3,386,387 in Hospital Provider Fee accounts for the amount the Department should have paid for non-newly eligible members; there is also a corresponding decrease of $3,386,387 federal funds.

- Cash and Reappropriated Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash and reappropriated fund transfers. Starting in FY 2016-17, the General Fund offset from the Old Age Pension Health and Medical Care Fund will come entirely from reappropriated funds based on JBC approval of JBC staff recommendations. This methodology ensures that the full $10 million authorized by Colorado's constitution can be allocated to people who qualify for services from the Old Age Pension Medical Program and that these funds are not tied up in another line. 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 2016-17, FY 2017-18, and FY 2018-19.

Cash and Reappropriated Funds	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Tobacco Tax Cash Fund (SB 11-210)	$2,162,950	$2,201,700	$2,201,700
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)	$9,102,709	$9,031,044	$8,951,417
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$27,166,119**	**$27,133,204**	**$27,053,577**

[1] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-14-035.pdf

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1997-98 through FY 2018-19. 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 FY 2015-16.

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

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

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

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 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 five years to qualify for Medicaid as pregnant adults, Medicaid children, or CHP+ clients, provided there is 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. Funding for Medicaid children was available July 2015.

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, I, and J and caseload information from Exhibit B.

Comparison of November 2016 Request to FY 2016-17 Appropriation and FY 2017-18 Base Spending Authority

This exhibit contains a detailed summary of the Department's Budget Request by service category. In addition, this exhibit directly compares the Department's November 2016 Budget Request to the Department's Long Bill plus Special Bills appropriation for FY 2016-17, the February 2017 Budget Request, and the Department's base spending authority for FY 2017-18. 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 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. 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 2016-17, FY 2017-18, and FY 2018-19. In some cases, though not all, the Department has held the trend constant among the three years. 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.

In aggregate, the Department has selected trends that are slightly lower than may be suggested by historical data. The Department believes that the long term effect of enrolling clients into the Accountable Care Collaborative program, which helps to manage the care of clients, will provide downward pressure on cost growth, which will ultimately be reflected in lower than expected per capita cost trends.

The selected trend factors for FY 2016-17, FY 2017-18, and FY 2018-19, with the rationale for selection, are as follows:

Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
Adults 65 and Older (OAP-A)	3.00%	2.30%	2.00%	The Department has selected a positive trend to account for large increases in co-insurance expenditure for this category.
Disabled Adults 60 to 64 (OAP-B)	-2.50%	0.80%	1.00%	The Department has selected a negative trend to account for lower than anticipated expenditure for the first half of the year as well as reduction in utilization for inpatient and outpatient hospital services.
Disabled Individuals to 59 (AND/AB)	1.78%	0.10%	0.30%	The Department has slightly increased the trend for this population to account for a higher per capita increase in FY 2015-16 and higher than anticipated first half actuals for FY 2016-17. The increase in trend is driven primarily by increases in prescription drugs and inpatient hospital costs.
Disabled Buy-in	4.00%	1.00%	1.00%	The Department has increased the trend for this population to account for higher than anticipated per capita for the first half of FY 2016-17. The increased trend is primarily driven by prescription drugs and inpatient hospital expenditure.

Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
MAGI Parents/ Caretakers to 68% FPL	-1.00%	-2.20%	-2.00%	The Department has selected a downward trend as per capita increases seen in FY 2015-16 were primarily driven by reductions in caseload. The Department anticipates caseload will return to normal levels and negative per capita trends for the major service categories will continue to drive a negative per capita trend for this eligibility group.
MAGI Parents/ Caretakers 69% to 133% FPL	0.00%	0.00%	0.00%	The Department has selected a flat trend as per capita growth is expected to level out. Additionally, per capita expenditure is showing very little growth halfway through FY 2016-17.
MAGI Adults	-1.50%	-0.50%	0.00%	The Department has lowered the trend for this population as anticipated double digit caseload growth outpaces increases in overall expenditure putting negative pressure on per capita trends.
Breast and Cervical Cancer Program	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)	3.61%	0.30%	0.50%	The Department has chosen to increase the per capita trend for this population. Lower caseload growth and higher than anticipated half year per capita for FY 2016-17 are the primary drivers behind the increase.

Aid Category	FY 2016-17 Trend Selection	FY 2017-18 Trend Selection	FY 2018-19 Trend Selection	Justification
SB 11-008 Eligible Children	1.70%	-0.20%	0.00%	The Department has chosen a positive trend for this population driven by positive per capita trends for the major service categories utilized by this population. Additionally, slowing caseload growth puts positive pressure on per capita.
Foster Care	1.06 %	0.62%	0.82%	The Department has maintained the per capita growth trend for this population as half year actuals are in line with the Department's projections. The positive trend is driven by prescription drugs and physician services.
MAGI Pregnant Adults	0.68%	1.00%	1.00%	The Department has slightly lowered per capita trend from FY 2015-16 due to lower than expected per capita expenditure. A small positive growth is anticipated for this population going forward.
SB 11-250 Eligible Pregnant Adults	0.68%	1.00%	1.00%	The trend for this category is tied to MAGI Pregnant Adults, as the Department assumes similar utilization within these populations.
Non-Citizens	0.00%	0.00%	0.00%	The Department has maintained the per capita trend for this population given almost zero growth in per capita for this population in FY 2015-16.
Partial Dual Eligibles	20.00%	1.83%	1.83%	The Department has maintained the per capita growth trend for this population despite the per capita trend remaining very high. This population is driven primarily by large expenditure in co-insurance.

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, Over the Counter (OTC) Medications allows for pharmacists to prescribe certain over-the-counter drugs to Medicaid Clients. The program reduces expenditure by reducing costlier visits to the emergency room or physicians for over-the-counter prescriptions.
- 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 service group 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 2016, there were 661 enrollees in the program. The Department expects to increase enrollment by approximately 2% per month through FY 2017-18.
- R-6 (FY 2012-13), Dental Efficiency, will reduce expenditure through refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated and revised.
- 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.
- 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 through June 30, 2016.
- BA-12 (FY 2014-15), State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees, accounts for anticipated reductions in expenditure related to enrolling clients dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they will receive care coordination.
- R-12 (FY 2015-16), Community Provider Rate Increases, accounts for added expenditure from a 0.50% across the board increase for eligible providers.
- R-12 (FY 2015-16), Targeted Community Provider Rate Increases, accounts for added expenditure from targeted rate increases for the purpose of addressing issues with clients' access to cost-effective services. The separate components of the rate increases are broken out in Exhibit F.

- HB 15-1309, Protective Restorations by Dental Hygienists, allows a dental hygienist to apply to the Colorado Dental Board for a permit to place interim therapeutic restorations, when they have met specific criteria determined by the Interim Therapeutic Restorations Advisory Committee, increasing expenditure for dental services in Acute Care.
- SB 11-177, Annualization of Sunset Teen Pregnancy and Dropout Program, removes the Teen Pregnancy and Dropout Program from Acute Care when the program sunsets September 1, 2016.
- SB 16-027, Medicaid Option for Prescribed Drugs by Mail, allows Medicaid clients to receive maintenance medications through the mail, regardless of physical hardship or third-party insurance status as previously required by SB 08-90. As many maintenance medication prescriptions delivered by mail come in ninety-day supplies, the Department anticipates a shift towards receiving medications in larger supplies. This shift would result in a decrease in prescription drug expenditures due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.
- HB 16-1408, Allocation of Cash Fund Revenues from Tobacco MSA, accounts for partially maintaining the rate increases authorized under Section 1202 of the Affordable Care Act for specific services through FY 2016-17.
- HB 16-1097, PUC Permit for Medicaid Transportation Providers, changes the requirements of Medicaid providers of Non-Emergent Medical Transportation (NEMT) to register with the Public Utilities Commission (PUC) as a limited liability carrier instead of as a common carrier. There are fewer restrictions to registering as a limited liability carrier which will have the effect of increasing the number of NEMT providers, which will increase access to transportation and produce savings through increased access to preventive services through NEMT.
- State Plan Autism Treatment, adds in the cost of providing autism services through EPSDT to Acute Care and removing the impact from Community Based Long Term Care (CBLTC).
- Copay 5% of Income, adjusts for the additional amount the Department will need to pay providers to comply with a federal rule stating that copays cannot exceed 5% of a Medicaid client's income. The new MMIS, which will be implemented March 1, 2017, must demonstrate compliance with this rule; the current MMIS is unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new system will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department will need to reimburse providers for the full cost of the service without subtracting copay for these clients.
- Kaiser-Access Health Maintenance Organization (HMO), moves expenditure related to clients enrolled in this new HMO from the regular ACC program. This has the effect of shifting expenditure from the ACC to Acute Care.
- Home Health Final Rule (Location Expansion), expands where home health services can be received. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional acute home health services in the community. The Department must demonstrate compliance with this rule by July 1, 2017.

- Hepatitis C Criteria Change, accounts for an increase in hepatitis C drug treatments. After reviewing hepatitis C criteria in place, the Department expanded treatment to members with a fibrosis score of F2 and other members who were previously restricted from treatment through the PAR process.

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 (CDPHE) 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 an enhanced federal match rate of approximately 65%. Please refer to Exhibit A and Exhibit R for more specific information on the federal match rate for this program.

Beginning January 2017, the age range for clients receiving cervical cancer screening and treatment will expand to include ages 21 through 39, based on CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion." This change has been accounted for in the request as a caseload adjustment.

Per Capita Cost

The Department assumes base per capita growth for this population will remain flat and that all increases or decreases to per capita are a result of bottom line adjustments.

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 Cash Fund-eligible 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, funded through the Unclaimed Property Tax Fund. The Adult Dental Cash Fund provides the funding for the State share of the Dental Benefit program, for expenditure that would otherwise be funded by General Fund for the State share. 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 Cash Fund-Eligible Dental Services Exhibit on pages EF-6 through EF-8 reports total Dental expenditure for populations that have the State share of expenditure funded with the Adult Dental Cash Fund and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate expenditure that requires financing from the Adult 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 moved antipsychotic drugs from the Department of Human Services' portion of the budget to the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group within the Prescription Drugs service category. Exhibit F, pages EF-11 through EF-12, 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. FY 2014-15 resumed growth due to increases in cost, utilization, and caseload, which continued in FY 2015-16.

Federal Funds Only Pharmacy Rebates

The Patient Protection and 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 2015-16. Quarter four of FY 2015-16 appears artificially low due to large historic adjustments. The trend for FY 2016-17 has been adjusted upward to account for the negative expenditure that appears in quarter 4 of FY 2015-16. 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 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-14 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 was 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 2016-17 estimate for total reported expenditure is the average of annual total reported expenditure increases since FY 2007-08, attributing 8.0% growth. 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 2017-18 and FY 2018-19 total expenditures are the result of the application of the average of annual growth rates for FY 2007-08 and FY 2015-16 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-14.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" was expected to contribute $29,000 in local funds for FY 2015-16. The Department had previously contracted with Montrose to provide the program, but because questions surrounding appropriate federal matching funds the contract was terminated. Therefore, local cash funds will no longer be included in the estimate. 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 FY 2014-15, the Department migrated from fee-for-service to encounter-based expenditure tracking per CMS. This allows the Department to allocate expenditure under Indian Health Service in a way that wasn't previously possible, especially for pharmacy expenditure. Because pharmacy related Indian Health

Service expenditure was not tracked prior to FY 2014-15, the Department applied the growth from FY 2014-15 to FY 2015-16 to FY 2015-16 expenditure to forecast FY 2016-17.

Expenditure by Half-Year

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 2015-16, the Department paid HCBS claims for an average of 26,481 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[2]
- Disabled Children's Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver

[2] Previously known as "Persons with Mental Illness"

- Children with Life Limiting Illness Waiver[3]
- Spinal Cord Injury Adult Waiver[4]

Calculation of Community-Based Long-Term Care Waiver 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. From FY 2012-13 to FY 2014-15, the Department used enrollment from a static caseload report which places clients into their waiver. During FY 2014-15, the Department noticed that the enrollment was not trending with utilization and that clients enrolled in some waivers were actually enrolled in other waivers based upon their claims utilization. Thus, in FY 2015-16, the Department decided to depict waiver enrollment as the average number of clients per month with an active prior authorization (PAR) for services on each waiver since services under waivers cannot be rendered without an active PAR. Recent concerns with the consistency of the PAR data, however, has prompted the Department to return to using the steadier number of clients with paid claims per month measure for waiver enrollment for this forecast. While the Department works to identify and correct for the retroactive adjustment of PARs, the Department believes number of paid claims is the most accurate depiction of waiver enrollment.

The selected enrollment and cost per enrollee trend factors for FY 2016-17, FY 2017-18, and FY 2018-19, with the rationale for selection, are below. In most cases, the Department kept the cost per enrollee 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.

[3] Previously known as "Pediatric Hospice Waiver"
[4] 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 2016-17 through FY 2018-19: 3.96%, 2.93%, 2.93% respectively.	FY 2016-17 through FY 2018-19: 4.49%, 4.15%, 4.15% respectively	Enrollment history is fairly steady, growing at an average of just over 6% each year. After low growth in FY 2014-15, enrollment growth was 4% in FY 2015-16. To account for this recent behavior, the trend selected in FY 2016-17 is the average growth over the last 36 months. Per enrollee cost history has grown on average since FY 2008-09 at approximately 4.50%. Recent growth has been in line with the historical average so the selected trend is the average yearly growth of 4.49%. This trend is slightly dampened in future years.
Community Mental Health Supports Waiver (CMHS)	FY 2016-17 through FY 2018-19: 8.01%, 6.60%, 4.44% respectively.	FY 2016-17 through FY 2018-19: 2.22%, 3.35%, 3.35% respectively.	Enrollment growth is on a steady incline, growing at almost 7% per year, however growth in recent years has been lower than average which indicates the trend might be slowing. In order to account for recent changes, the selected trend is the average monthly growth from the previous 12 months. Per enrollee cost has grown minimally over the years for the CMHS waiver. There is a slight positive trend applied to the final six months of FY 2016-17 and then the projected yearly increase returns to the 4-year average growth rate.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2016-17 through FY 2018-19: 16.43%, 13.39%, 9.17% respectively.	FY 2016-17 through FY 2018-19: 8.45%, 3.10%, 3.10% respectively.	Historically, enrollment growth has been negative; however, the Department has made significant efforts to better manage the waitlist, and enrollment has increased steadily since FY 2011-12. Recent enrollment has been higher than expected and has only slowed slightly. The chosen growth trend applies the average monthly growth of the last 36 months for FY 2016-17 and half that trend for the years beyond. 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 historical growth in per-utilizer costs were driven by IHSS - Health Maintenance Activities client utilization. Given current average per enrollee costs, the Department applied average second half growth to the final six months of FY 2016-17 and lowered the positive trend in future years due to the further slowing of the per enrollee cost.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Consumer Directed Attendant Support-State Plan	FY 2016-17 through FY 2018-19: 0.00%	FY 2016-17 through FY 2018-19: 0.00%	Additional enrollment in this program is currently prohibited. When CDASS becomes available on other 1915(c) waivers, members will leave this program. The adjustment for this decrease in enrollment is shown as a bottom line impact and is not captured in the selected growth trend. With the majority of clients leaving for CDASS expansion under the Supported Living Services waiver, enrollment is expected to only be one client after FY 2018-19. 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 has decreased every year after, suggesting that client allocations have reached stability. FY 2015-16 average cost per enrollee were lower than previous estimates. The Department keeps per enrollee costs at its current level for all years in the forecast.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Brain Injury Waiver	FY 2016-17 through FY 2018-19: 3.45%, 3.23%, 3.23% respectively.	FY 2016-17 through FY 2018-19: 3.70%, 1.72%, 1.72% respectively.	Historically there has been slow and steady growth in BI enrollment. The Department saw this growth increase rapidly in FY 2012-13 and has continued through the current year. Driven by an increase in beds state wide available for the supported living program (SLP), a waiver service for nursing facility level of care waiver enrollees, the Department expects waiver enrollment to grow through the out-year using a yearly linear regression. Historic cost per enrollee growth has been just over 2% annually. Current per enrollee cost is higher than anticipated so the Department corrected for this in FY 2016-17 by applying a positive growth trend to the second half of the current fiscal year. The Department expects cost per enrollee growth to continue into the out year at the average 3-year annual growth rate.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Autism Waiver	FY 2016-17 through FY 2018-19: 7.41%, 6.90%, 6.45% respectively.	FY 2016-17 through FY 2018-19: 6.67%, 0.00%, 0.00% respectively.	CMS has denied the Department's request to expand the CWA Waiver which was authorized through House Bill 15-1186. CMS has directed the Department to provide services authorized that are deemed medically necessary under EPSDT. The waiver is set to expire December 31, 2018. The Department is currently working on a transition plan and until finalized, the Department has projected enrollment to continue through FY 2018-19. This is not a policy stance but rather a temporary assumption that may be adjusted once the transition plan is finalized. The Department expects the enrollment trends to stay relatively flat, with two new clients joining each year through FY 2018-19. Average cost per enrollee has been on a downward trend since FY 2009-10. However, current per enrollee cost is higher than expectation and on trend to surpass the FY 2015-16 average. For these reasons, the Department has selected a positive trend in the current year, given recent growth, but has zeroed out the trend in future years as service utilization is expected to level off.

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 2016-17 through FY 2018-19: 26.17%, 7.09%, 8.61% respectively.	FY 2016-17 through FY 2018-19: 4.84%, 2.42%, 2.42% respectively.	Waiver programmatic changes have improved the program resulting in large positive growth. After a slight downturn, enrollment growth has returned to a high level and was over 32% in FY 2015-16. Enrollment is expected to increase as more providers become available as they become aware of recent rate increases and programmatic changes that were fully implemented in FY 2015-16. Because this initial increase in enrollment resulting from these programmatic changes is unlikely to extend into future years, the growth trend is dampened in FY 2017-18 and beyond. Cost per enrollee growth has been sporadic but positive for most of the time the waiver has been in operation. Programmatic changes have been fully implemented and the Department has selected a modest positive growth trend for future years.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Spinal Cord Injury Adult Waiver	FY 2016-17 through FY 2018-19: 42.86%, 0.00%, 0.00% respectively	FY 2016-17 through FY 2018-19: 3.68%, 1.84%, 1.84% respectively.	Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" reauthorizes the waiver for five years, allowing for increased enrollment beyond the previous cap of 67 and replaced administrative funding from gifts, grants, and donations with General Fund. The bill allows growth in enrollment beyond 100 at any point-in-time. For FY 2017-18 and FY 2018-19, the Department adjusts enrollment through the bottom line impact of Senate Bill 15-011 instead of through the enrollment growth trend. The positive growth trend in per enrollee costs reflects the anticipated increases in both service utilization and number of service providers due to changes in minimum qualifications for Complementary and Integrative Health Service (CIHS) providers. This rule change modifies minimum qualifications in order to allow more providers to enroll to better serve the SCI waiver population.

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:

<u>Expenditure</u>

- 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. Program implementation occurred in March 2016.

- 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. The program has seen enrollment expectations decrease due to issues with payment methodology and low rates; however, with recent access changes, enrollment is expected to increase in each year of this request. To address this, the Department increased rates to transition coordination agencies to deal with the emergency access issue. Low enrollment caused long-term home health utilization and CCT service utilization to decrease below original expectations, which decreased the amount of cumulative nursing facility cost avoidance. The Department has decreased enrollment expectations which also decreased the cumulative nursing facility cost avoidance from the November request.
- Consumer Transition Services (CTS) Rate Increase – Implemented on January 1, 2016, this policy increased rates for two services included in the Colorado Choice Transitions (CCT) program for HCBS clients. The rate increases address Transition Coordination Agency (TCA) capacity issues and will encourage more transitions per year from institutionalized care to HCBS or DIDD waivers.
- FY 2014-15 JBC Action "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. Due to delays in approval from CMS, the Department expected implementation by December 1, 2015 but did not receive approval to implement until late January 2016, and the increased lifetime cap on home modifications was implemented March 1, 2016.
- Annualization of 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.
- Annualization of 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.
- 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. The implementation of this has been delayed due to provider recruitment, training and systems issues. The Departments expects utilization to keep increasing and the FY 2016-17 impact has not changed since the previous request.

- FY 2015-16 R#12: "Community Provider Rate Increase" 0.5% Across the Board – The Joint Budget Committee approved a 0.5% across-the-board rate increase, effective July 1, 2015, which affects services provided by HCBS waivers. Due to delays in approval from CMS, implementation occurred March 1, 2016.
- FY 2015-16 R#12: "Community Provider Rate Increase" Targeted – Homemaker and Personal Care to $17 per hour, In-Home Respite to $4.87 - The Joint Budget Committee approved these targeted rate increases, effective July 1, 2014, which affects the Elderly, Blind, and Disabled, Brain Injury, Community Mental Health Supports, and Spinal Cord Injury waivers. Implementation of the new rates occurred March 1, 2016.
- FY 2015-16 JBC Action "Raising the Cap on Home Modifications" – A Joint Budget Committee action raised the cap on home modifications in FY 2015-16, resulting in an impact to waivers that include home modifications. The new lifetime cap of approximately $14,000 was implemented on March 1, 2016.
- HB 15-1186: "Children with Autism Waiver Expansion" – HB 15-1186 increases the age limit from six to eight, allows for 3 years stay on the waiver (regardless of entry age), eliminated with waitlist and allows for natural growth in enrollment and expenditure cap increases at the Joint Budget Committees purview. The legislation also allows for General Fund to be used for payment once the Autism Treatment Fund is exhausted. The expansion was expected to be implemented on July 1, 2015, but was denied by CMS on September 14, 2015. CMS requested that the state provide behavioral therapy to children with autism through the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program. The Department expects increased utilization in FY 2016-17 as the EPSDT benefit is further established. As such, Department has left the impact of the waiver expansion in FY 2016-17 to ensure proper funding in case a substantial amount of behavioral therapy is deemed medically necessary for current Medicaid eligible clients. This impact, however, has been moved from a CBLTC impact to an increase acute care costs.
- SB 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" – SB 15-011 reauthorized the Spinal Cord Injury Waiver for another five years, starting in FY 2015-16. The bill also eliminates the enrollment cap, allowing for natural growth in enrollment and changes administrative funding from gifts, grants, and donations to General Fund. The reauthorization and expansion was implemented on March 1, 2016.
- Independent Living Skills Training (ILST) Provider Rule Change – the Department was not able to recruit providers under current rules in rural areas resulting in gaps in coverage. Provider rule changes implemented on January 1, 2016 will allow for ILST to be provided in rural areas, filling the gap in coverage.
- SB 16-192: "Single Assessment Tool" – SB 16-192 requires the state to select a needs assessment tool for persons receiving Long Term Services and Supports, including persons with intellectual and developmental disabilities. FY 2019-20 costs to CLTBC result

from reassessing a sample of Long Term Services and Supports members in the pilot program. The Department assumes pilot program implementation will begin January 1, 2019 with full program implementation estimated on August 1, 2019. Costs in the years after FY 2018-19 include reassessing every Long Term Services and Supports members with the selected needs assessment tool.

- HB 16-1321: "Medicaid Buy-In Certain Medicaid Waivers" – HB 16-1321 authorizes the Department to seek federal approval to implement a buy-in program for people eligible to receive services through the Home and Community Based Services - Supported Livings Services (HCBS-SLS) waiver, the Home and Community Based Services - Brain Injury Waiver (HCBS-BI), and the Home and Community Based Services – Spinal Cost Injury Waiver (HCBS-SCI) and that it shall be implemented no later than three months after receiving federal approval. The Department initially assumed it would be able to begin enrolling HCBS-SLS, HCBS-BI, and HCBS-SCI clients into the Buy-In program on July 1, 2017. However, this implementation date has been moved up to March 1, 2017. Because the policy will only be in effect for four months, the enrollment adjustment is made in the next year, FY 2017-18. In FY 2017-18 and beyond, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers.

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 estimated costs avoided anticipated from transitioning clients from nursing facilities. 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 anticipated that approximately 100 clients would transition per 365 days beginning in May 2013. Due to rate and rate methodology issues for Transition Coordination Agencies, enrollment has been less than anticipated. The Department anticipates that enrollment will be below 100 in FY 2016-17, FY 2017-18, and FY 2018-19 and less than November expectations, despite that the Transition

Coordination Agencies rates were adjusted to ensure clients receive the services they need. The Department estimates the total impact to Medical Services Premiums to be a reduction of $4,177,950 total funds in FY 2016-17 and a reduction of $5,912,689 in FY 2017-18. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2015-16 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2016-17, FY 2017-18, and FY 2018-19 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 70% of total hospice expenditure in FY 2015-16. 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.

Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted room-and-board per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year. 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. The Department used an autoregressive model with monthly control variables to estimate FY 2016-17 patient days; this added 5,028 patient days to the fiscal year relative to the November 2016 forecast. The assumed growth rate for patient days in FY 2017-18 and FY 2018-19 is 0.96%. This trend estimate was made with the assumption that patient days would level off. 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 roughly the same 3% per-year rate[5]. The Department assumed a slightly

[5] Because the distribution of patient days across facilities is likely different between class I nursing facility and hospice services, the aggregate rate for hospice might not grow at exactly 3% as outlined in statute.

higher growth rate at 4.5% for FY 2016-17 based on half year actual rates. 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.

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 2015-16, Hospice Routine Home Care expenditure was approximately $11.5 million and thus represented 82% of Hospice Services expenditure and 22% of total hospice expenditure. Hospice Routine Home Care expenditure is computed as a product of patient days and the daily rate. The Department arrived at estimates for days by trending forward total patient days in FY 2015-16 by 2.0% for FY 2016-17 estimates, 1.0% for FY 2017-18 estimates, and 1.0% for FY 2017-18 estimates; the trends were selected with the assumption that patient days would level off over time. The Hospice Routine Home Care per diem is forecasted by applying approximately a 2%trend to observed daily rates in the first six months of FY 2016-17. This 2% trend was selected based on previous CMS hospice rate increases. Starting on January 1, 2016, the Department was instructed by CMS to implement a tiered rate system for Routine Home Care Services.[6] Patient days incurred in the first sixty days of service would be billed a higher rate than days incurred beyond the sixty-day threshold.

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 2015-16, the Department paid approximately $2.4 million for Hospice General Inpatient Care. The Department estimated FY 2016-17, FY 2017-18, and FY 2018-19 service costs by forecasting its rates and patient days. Patient days were presumed to stay relatively flat in growth based on actual patient days in the first half of FY 2016-17 and rates were estimated by applying a 3.81% trend (growth in rates between FY 2015-16 and the first half of FY 2016-17) to FY 2015-16 observed rates.

The remaining components of hospice services expenditures in total represent approximately $54,000 of expenditure based on FY 2015-16 actual expenditure. There is significant variation in these remaining services by fiscal year. For example, FY 2016-17 half year

[6] For more information, refer to: https://www.colorado.gov/pacific/sites/default/files/2016%20Hospice%20Rates%20and%20Rules.pdf

expenditures for this category is $122,870; the Department estimates full year expenditures would be approximately $222,870. This estimate is held constant for FY 2017-18 and FY 2018-19.

Hospice is not normally affected by bottom line impacts, except through items that also affect Class I Nursing Facilities, such as the HB 13-1152 1.5% permanent rate reduction on Nursing Facility core per-diem. However, the current request includes the estimated impacts of a rate increase that affect Hospice services other than Nursing Facility Room and Board: the annualization of the FY 2015-16 R-12 Community Provider Rate Increase, which increases the Hospice rate by 0.50%. This increase does not apply to Nursing Facility Room and Board.

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 similar rates. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. However, during the FY 2015-16 Legislative Session, PDN RN received a targeted rate increase to bring the rate up 10.95% to $45, while the remaining four services received the 0.5% across the board rate increases. The rate increases were implemented on August 1, 2015.

As PDN expenditure is the product of the units utilized per client and the number of utilizers, and the Department expects rates to remain constant, expenditure forecasts for FY 2016-17, FY 2017-18, and FY 2018-19 are primarily based on units per utilizers and utilizers forecasts for those fiscal years. The units per utilizer and utilizers forecast are separated into three pieces: RN; LPN; and grouped RN Group, LPN Group, and Blended Group.

Final expenditure estimates for FY 2016-17, FY 2017-18, and FY 2018-19 are produced by multiplying average monthly utilizers by the average units per utilizer by the projected rate for RN, LPN, the grouped services and then summing these figures. The Department is forecasting growth in FY 2016-17 at 23.79%, which is due to much higher than expected growth in average monthly enrollment and average units per utilizer. The trend is decreased in the request and out-years to 16.05% and 15.31% respectively, which is consistent with historical growth patterns.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN)	FY 2016-17 through FY 2018-19: 18.75%, 14.57%, and 14.66% respectively.	FY 2016-17 through FY 2018-19: 5.69%, 1.52%, 1.53%, respectively.	RN is expected to drive about 71.43% of total expenditure in FY 2016-17, when the Department expects to pay claims for 850 utilizers on average per month for PDN services; 494 of those utilizers are expected to bill for RN services. RN average utilizers per month had grown in the double digits from FY 2008-09 to FY 2014-15. This growth slowed in FY 2015-16, when the annual average utilizers per month growth dropped to 4.52%, but increased again in the first half of FY 2016-17 with expected growth for the year of 18.75%. Average monthly growth has grown steadily recently and the Department chose to apply this monthly growth trend to historical claims data to produce estimates for this request. RN units per client have decreased on average, almost every year since FY 2011-12, with average yearly growth of -3.88%; however, in FY 2015-16 there was growth of 7.44% and based on half year actuals 2016-17 is expected to end at 5.69% growth. The Department expects growth in units per client to remain positive. This differs from the November forecast that predicted the units per client to grow much slower in FY 2016-17.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Licensed Practical Nursing (LPN)	FY 2016-17 through FY 2018-19: 13.75%, 12.45%, and 11.07%, respectively.	FY 2016-17 through FY 2018-19: 4.40%, 1.00%, and 0.94%, respectively.	LPN is expected to drive about 17.75% of total expenditure in FY 2016-17. Similar to RN, LPN average utilizers per month have grown mostly in the double digits over time, with an average of 16.65% per year, and reaching maximum growth in FY 2013-14 of 43.65%. In FY 2016-17, average utilizers per month yearly growth dropped to grew to 10.00%. Average monthly growth has been growing steadily over time and the Department chose to apply a modified linear time trend to historical claims data over this time frame to produce estimates for FY 2017-18 and FY 2018-19. Average Utilizers per month grew faster than the Department's November expectations. Again, much like RN units per client, LPN units per client have been decreasing on average, every year since FY 2011-12, with average yearly growth of -8.34%, however in FY 2016-17 growth was positive again at 4.40%. Growth in units per clients in the FY 2016-17 half year outpaced the November requests expectations slightly. As this increase was only slightly higher than the November predictions, the Department has slightly raised the expectations for the years being forecasted and has held growth in the request and out year almost constant at 1.00%, and 0.94% respectively.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN	FY 2016-17 through FY 2018-19: 11.76%, 14.47%, and 12.64%, respectively.	FY 2016-17 through FY 2018-19: 1.41%, 0.87%, and 0.38%, respectively.	LPN-group, RN-group, and Blended RN/LPN are expected to drive about 10.82% of total expenditure in FY 2016-17 and represent the smallest number of average utilizers per month as well. Due to recent large growth years and slow growth in FY 2015-16, the Department has chosen to forecast FY 2016-17, FY 2017-18, and FY 2018-19 linearly at 11.76%, 14.47%, and 12.64% This represents an increase over expectations in the November request. For the grouped and blended PDN services, units per client growth has been very positive over the last few years, but trended upward for blended and downward for RN and LPN Groups in FY 2016-17. For this reason, the Department used weighted average yearly growth to forecast FY 2016-17, FY 2017-18, and FY 2018-19 which resulted in growth rates of 1.41%, 0.87% and 0.38% respectively.

Long-Term Home Health

The Long-Term Home Health (LTHH) exhibit was new starting in FY 2015-16. LTHH services are considered Long-Term Services and Supports (LTSS) but have been previously forecasted in the acute care forecast. Since these services are not acute, they were carved out of the acute care forecast, with only acute home health remaining in acute. LTHH services are deemed necessary by a medical need and are skilled nursing and therapy services that are generally provided in a client's home. LTHH services are either billed hourly or on a visit basis with a maximum number of hours. There are nine services under LTHH that are for both children under 21 and adults: clients under 21 that have a medical need can access Physical, Occupational, Speech and Language Therapies (PT, OT, and S/LT respectively), all clients have access to Registered Nursing/Licensed Practical Nursing (RN/LPN), Home Health Aid Basic and Extended (HHA), Registered Nursing – Brief first visit of day and Brief Second or More Visit of Day, and telehealth. The therapy and RN/LPN services are associated with the highest rates and HHA services with the lowest nursing rates since they are provided by a Certified Nursing Aid (CNA). The remaining RN visits services charge less than therapies and RN/LPN but more than HHA, with telehealth having the lowest rate. LTHH rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. Although during the FY 2015-16 Legislative Session, LTHH services received the 0.5% across the board rate increases. The rate increases were implemented on October 1, 2015.

All but one of the services in LTHH are forecasted individually using the average monthly service utilizers, the average units per utilizer and the rate. The rate is assumed to be constant beyond the current year legislative rate increases. Due to the low utilization, telehealth is forecasted by total expenditure.

Final expenditure estimates for FY 2016-17, FY 2017-18, and FY 2018-19 are produced by multiplying average monthly utilizers by the average units per utilizer by the projected rate for all LTHH services and then summing these figures. The Department is forecasting growth in FY 2016-17 as 16.74%, which is a notable increase from November's expected growth of 6.79%. This increase can largely be attributed to two factors, namely an unexpected increase in both monthly utilizers and utilization per utilizer and the increase being far outside what was predicted in the November request. The trend is decreased in the request year to 8.86%, which has increased from the November expected growth of 5.94%, and decreased to 7.95% in the out year, which is an increase from the November projections of 5.19%. Total expenditure growth for FY 2016-17 is much higher than historic average yearly growth, due to the spike in average utilizers per month and average utilization per utilizer in the first six months of FY 2016-17. The trends were brought up as a result, which brought them more in line with historical average yearly growth.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Home Health Aid Basic and Home Health Aid Extended	Home Health Aid Basic: FY 2016-17 through FY 2018-19: 11.29%, 6.91%, and 6.91% respectively. Home Health Aid Extended: FY 2016-17 through FY 2018-19: 13.79%, 8.65%, and 8.67% respectively.	Home Health Aid Basic: FY 2016-17 through FY 2018-19: 5.54%, 1.28%, and 1.15% respectively. Home Health Aid Extended: FY 2016-17 through FY 2018-19: 2.92%, 0.98%, and 0.97% respectively.	HHA Basic and HHA Extended account for the bulk of the total expected FY 2016-17 expenditure coming in at 70.06% of the total. Average utilizers per month for HHA Basic and Extended have steadily increased along a linear path since FY 2008-09. In FY 2016-17 both services continued to increased, at an abnormally higher rate than usual. The Department brought up both forecasts from the November levels to compensate for the decrease in growth. HHA Basic units per utilizer growth has been historically positive at 2.03% with more rapid growth recently. In the first six months of FY 2016-17, units per client increased over the November expectations, so the forecast was brought up and resides around 1.2% in the request and out year. HHA Extended has seen units per utilizers increase in the recent half year of FY 2016-17, and came in higher than expected as average yearly growth since FY 2008-09 has been -1.11%. Given that HHA Extended had higher growth in FY 2016-17, it made sense to bring the trend up to 0.98% and leave it there. Like HHA Basic, the Department is using the average yearly historical growth to forecast HHA Extended for FY 2016-17, FY 2017-18, and FY 2018-19.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Registered Nursing/Licensed Practical Nurse	FY 2016-17 through FY 2018-19: 4.82%, 2.30%, and 2.25%, respectively.	FY 2016-17 through FY 2018-19: 0.96%, 0.95%, and 0.94%, respectively.	RN/LPN account for about 13.55% of the expected FY 2016-17 LTHH total expenditure and has seen both average monthly utilizers and units per utilizer increase, on average, since FY 2008-09. Average monthly utilizers have been growing linearly since FY 2012-13, with some slowing in the most recent half year. Given the linear growth and recent slowing, the Department chose to use a reduced yearly linear regression to forecast average monthly utilizers for FY 2016-17, FY 2017-18, and FY 2018-19, which equates to an average of 2.30% growth per year. Growth in the first half of FY 2016-17 was lower than expected in November. Units per utilizer have also grown over time, but have growth at about 0.95% per year on average, which is what the Department is using to forecast units per utilizer for FY 2015-16, FY 2016-17, and FY 2017-18. Growth in FY 2016-17 was exactly in line with the November forecasts predictions.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
RN Brief First of Day and RN Brief Second or more	RN Brief First of Day: FY 2016-17 through FY 2018-19: 6.04%, 4.10%, and 3.72%, respectively. RN Brief Second or more: FY 2016-17 through FY 2018-19: 12.90%, 8.00%, and 8.99%, respectively.	RN Brief First of Day: FY 2016-17 through FY 2018-19: 0%. RN Brief Second or more: FY 2016-17 through FY 2017-18: -3.60%, 1.07%, and 1.32%, respectively	RN Brief First of Day and RN Brief Second or more account for 4.26% of the expected FY 2016-17 total expenditure and have averaged positive historical growth for both metrics in this table. For RN Brief First of Day, the Department chose a reduced linear regression to model growth, due to the slowing in the recent half year. For the Second or more visit of the day, the Department expects average monthly client growth to stabilize at historic growth and used average yearly growth to forecast this service. In the FY 2016-17 half year, Brief First of Day utilization was lower than expected in November, and Brief Second or More aligned with November predictions, only slightly over utilized. Units per client growth for RN Brief First of Day is relatively flat over time, so the Department maintained 0% for all years in the forecast. The Second or More Visit of the day units per utilizer dipped in the FY 2016-17 half year but otherwise grew steadily since FY 2008-09, except FY 2013-14. The Department expects negative growth in FY 2016-17, with steady growth in FY 2017-18 and FY 2018-19. In the FY 2016-17 half year, RN Brief Second or More services were under-utilized compared to what was expected in November, however RN First Visit of the day came in at exactly what was predicted in November.

Long-Term Home Health Utilization Trends and Justification			
Service	**Average Monthly Utilizer Trend Selection**	**Average Units Per Client Trend Selection**	**Justification**
Physical (PT), Occupational (OT), and Speech/Language Therapy (S/LT)	Physical Therapy: FY 2016-17 through FY 2018-19: 16.50%, 8.98%, and 8.91%, respectively. Occupational Therapy: FY 2016-17 through FY 2018-19: 25.29%, 15.02%, and 15.02%, respectively. Speech/Language Therapy: FY 2016-17 through FY 2018-19: 35.89%, 22.04%, and 10.97%, respectively.	Physical Therapy: FY 2016-17 through FY 2018-19: 3.70%, 0.00%, and 0.00% respectively. Occupational Therapy: FY 2016-17 through FY 2018-19: 0.00% Speech/Language Therapy: FY 2016-17 through FY 2018-19: -1.85%, 0.00%, and 0.00% respectively.	PT, OT, and S/LT account for 11.86% of the expected expenditure in FY 2016-17, but with large utilizer growth over the last few years, that share is expected to continue to increase. In the FY 2016-17 half year all three services came in much higher than expected. Due to this increase in growth the Department selected Yearly average growth trends for all three, each was just brought down slightly to help make them reasonable, as they were far too high to be reasonable without adjustment. All of the services are expected to continue their rapid growth, at around levels the Department has seen in the past. In the FY 2016-17 half year, units per client utilization followed expectations, with only slight negative variations so all three services have a flat 0% trend in the request and out years, with the slight negatives adjusting units to where they are expected to land at the end of FY 2016-17.

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 Long Term Home Health:

Expenditure

- Annualization of 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 LTHH is due to the increased caseload and per capita costs for the DIDD Medicaid waivers attributable to those formerly on LTHH. This shows as savings to LTHH.
- Annualization of FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" – This impact shows as savings to Long Term Home Health due to the waitlist reduction of the DIDD Adult Supported Living Services waiver for the clients formerly on LTHH services who transitioned over.
- In the fall of 2015 the Department implemented personal care within the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. It is a CMS requirement that clients under the age of 20, and have the medical need, have access to personal care. The Department expects most utilizers of personal care on waivers to move utilization from waiver personal care to EPSDT personal care. The Department is also expecting clients to substitute out of costlier HHA Basic and Extended and into EPSDT personal care. There is a bottom line adjustment listed under HHA basic for the net impact of implementing EPSDT personal care of $1,110,298. The net increase is due to clients having access to personal care, who have a need for it but not a high enough need for HHA, and have never had access before. Once implemented and clients have access, EPSDT personal care will have its own forecast similar to the other services under LTHH, but until then, the net impact is listed under HHA Basic. Clients have been slow to utilize the EPSDT Personal Care Benefit and the impact has been shifted fully into FY 2016-17. After this year, the impact will have become fully incorporated into the budget and will no longer be seen in the bottom line impacts.
- HB 16-1321: "Medicaid Buy-In Certain Medicaid Waivers" – HB 16-1321 authorizes the Department to seek federal approval to implement a buy-in program for people eligible to receive services through the Home and Community Based Services - Supported Livings Services (HCBS-SLS) waiver, the Home and Community Based Services - Brain Injury Waiver (HCBS-BI), and the Home and Community Based Services – Spinal Cost Injury Waiver (HCBS-SCI) and that it shall be implemented no later than three months after receiving federal approval. The Department initially assumed it would be able to begin enrolling HCBS-SLS, HCBS-BI, and HCBS-SCI clients into the Buy-In program on July 1, 2017. However, this implementation date has been moved up to March 1, 2017. In FY 2017-18 and beyond, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers. These clients are expected to have a minimal impact for the LTHH services they are expected to utilize, which can be seen starting in FY 2016-17.
- 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. The program has seen enrollment expectations decrease due to issues with payment methodology and low

rates; however, with recent access changes, enrollment is expected to increase in each year of this request. To address this, the Department increased rates to transition coordination agencies to deal with the emergency access issue. Low enrollment caused long-term home health utilization and CCT service utilization to decrease below original expectations, which decreased the amount of cumulative nursing facility cost avoidance. The Department has decreased enrollment expectations which also decreased the cumulative nursing facility cost avoidance from the November request. This adjustment to LTHH captures the additional cost of LTHH services these CCT clients are expected to use.

- Telehealth Expenditure Adjustment: Due to small cell sizes that prevent the Telehealth forecast from using the same methodology as the other LTHH services, expenditure for Telehealth is adjusted via bottom line impact.
- FY 2015-16 R#7 "Participant Directed Programs Expansion": The Departments FY 2015-16 R#7 request expands access to Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services (SLS) Home and Community Based Services (HCBS) waiver. The savings to LTHH are expected from the clients who currently utilize LTHH services in the SLS waiver who would then shift into using CDASS services instead. Due to several implementation delays this will not take effect until FY 2017-18.
- Like Acute Care in Exhibit F, the LTHH exhibit includes a bottom line adjustment to account for the implementation of new federal rules related to home health. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional long term home health services in the community.

<u>Enrollment</u>

- N/A

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 changed to a slight negative trend in FY 2011-12 through FY 2013-14. Most recently, patient days increased in FY 2014-15, and continued to increase in FY 2015-16; the Department is closely monitoring this growth.

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-5 through EH-8 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[7]:

[7] For clarity, FY 2016-17 is used as an example. The estimates for FY 2017-18 and FY 2018-19 are based on the estimate for FY 2016-17, and follow the same methodology.

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2016-17.
- 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 2016-17. 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 2016-17 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2016-17.
- 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 2016-17.
- Of the estimated total reimbursement for claims incurred in FY 2016-17, only a portion of those claims will be paid in FY 2016-17. The remainder is assumed to be paid in FY 2017-18. The Department estimates that 92.88% of claims incurred in FY 2016-17 will also be paid during FY 2016-17. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2016-17
- During FY 2016-17, the Department will also pay for some claims incurred during FY 2015-16 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2015-16 to calculate an estimate of outstanding claims to be paid in FY 2016-17.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2016-17 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2016-17, this includes HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2016-17 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 2016-17, FY 2017-18, and FY 2018-19 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2016-17 through FY 2018-19. Please refer to Footnote 6 on page EH-7 for more detail. The estimate for FY 2016-17, FY 2017-18, and FY 2018-19 is calculated by multiplying the average per diem in the first half of FY 2016-17 by the anticipated number of client days in FY 2016-17.
- 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 of 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 2016-17, FY 2017-18, and FY 2018-19. 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-7 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 extended into FY 2013-14. Footnote 8 on page EH-8 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 is able to fully fund quality/performance incentives and acuity based adjustments but is unable to fully fund growth beyond the General Fund cap. Starting in FY 2015-16, the supplemental payments formerly made as part of the growth beyond the General Fund cap will instead be made as part of the prior year rate reconciliation; the payments in this latter category still represent the components of the per diem rate greater than the 3% growth cap. Historically, the Department would set a nursing facility's interim rate at the lesser of the facility's unaudited "as-filed" rate as determined by the MED-13 cost report and the individual-facility growth limit rate that targets the aggregate 3% growth. It was these interim rates, some of them based on the "as-filed" rate from the MED-13, that were used to calculate the supplemental payments that were part of the growth beyond the General Fund cap. The issue with this approach was that once the rate based on the MED-13 cost sheet was audited and finalized, it would need to be reconciled with the chosen interim rate. To simplify this process, the Department chose to instead use the maximum allowable growth rate of the facility as the facility's interim rate and then reconcile this allowable growth rate with the final audited rate. Due to this change in methodology, the supplemental payment previously attributed to growth beyond the General Fund cap is instead considered a rate true-up payment to the final audited rate.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.
- Previous to the current request, the Colorado Choice Transitions adjustment accounted 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. This

adjustment was taken out as it was assumed that these transitions are already incorporated into the base trends. Additional detail can be found in Exhibit G. Estimates of Class I Nursing Facility costs avoided are for informational purposes only.

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 five 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, even 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-6. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2015-16 that will be paid in FY 2016-17 and the percentage of claims incurred in FY 2016-17 that will be paid in FY 2017-18 and subsequent years. The Department applies the same factor to the FY 2017-18 and FY 2018-19 estimates.

The Department uses the IBNR adjustment calculation for the February 2017 Request using paid claims data through December 2016. 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%
November 2015	92.48%
February 2016	92.61%
November 2016	92.88%
February 2017	93.17%

Patient Days Forecast[8]

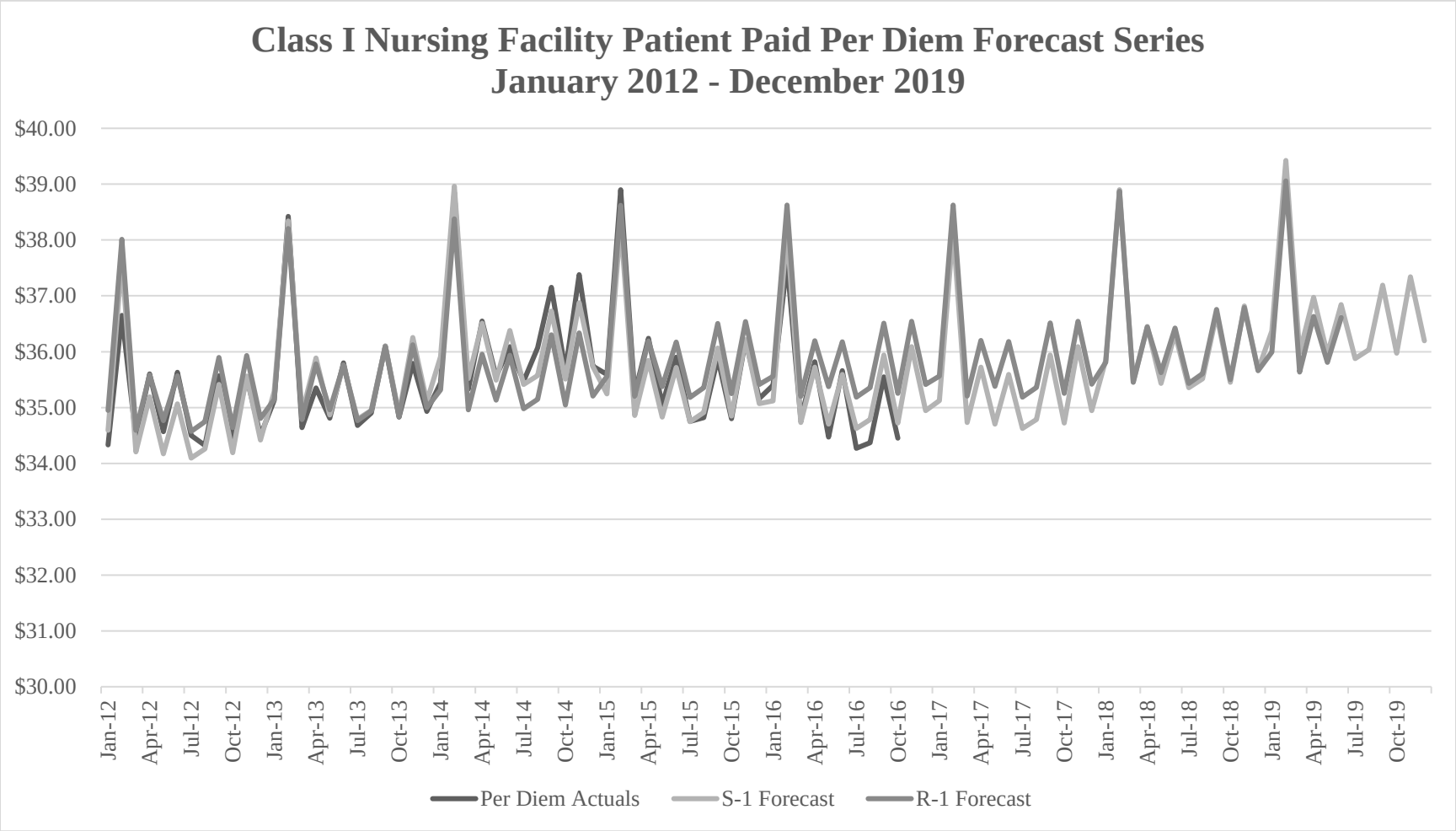
The Department observed a 2.11% increase in patient days as a result of new clients using the service in FY 2015-16. As such, the Department forecasted patient days by trending forward FY 2015-16 patient days by lowered trends; these trends were 1.11% for FY 2016-17, 0.55% in FY 2017-18, and 0.28% in FY 2018-19, with the assumption that patient days would keep growing, but level out in

[8] In previous requests, the Department forecasted patient days by using an auto-regressive model using IBNR-adjusted days. This methodology introduced a large negative trend that seemed unlikely given the growth in patient days in FY 2015-16.

later fiscal years. The Department will continue to monitor this growth in patient days to determine whether it represents a change in the underlying trend and update the February 2017 Request accordingly.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model that accounts for cost of living adjustment (COLA) increases and SB 14-130 "Increase to Personal Care Allowance" 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 0.00000 and is statistically significant at the 99% confidence level. The Adjusted R-squared for the model is 0.9736, suggesting 97.36% of the variation in this series can be explained by the monthly seasonality, COLA increases, and SB 14-130 "Increase to Personal Care Allowance."

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; this increase was effective as of July 1, 2014. This amount increases by 3.0% annually on January 1st of each year.

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-1. 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. There is currently one Class II Nursing Facility provider in Colorado: Bethesda Lutheran Communities (Bethesda). As of January 1, 2017 Bethesda operates 5 facilities with a total of 27 beds. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. Class II nursing facilities are authorized to receive an annual cost-based rate adjustment, similar to Class I Nursing Facilities. Enrollment has remained steady over FY 2015-16. Due to the opening of a new facility in July, 2016, there has been a slight increase in caseload over the first six months of FY 2016-17. The Department anticipates a slight increase in enrollment in FY 2016-17 and FY 2017-18 as new beds are filled,

leveling off in FY 2018-19 as facility capacity is reached. Should additional facilities open the Department will revise the caseload forecast accordingly. Cost per-capita decreased over FY 2015-16 and the first six months of FY 2016-17. The Department assumes that cost per-capita will maintain a similar level of expenditure seen over this period in future 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. 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 opened in northern Colorado in November 2015. Most recently, TRU Community Care opened in February 2017 and serves Boulder and Weld counties. Two new facilities, St. James and HopeWest, are expected to open in spring of 2018.

Expenditure estimates for PACE for FY 2016-17, FY 2017-18, and FY 2018-19 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 since CY 2013 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. The Department added a bottom line impact to FY 2016-17 in the February 2017 Request for retroactive payments made for services received in FY 2015-16. The Department is closely monitoring these systems issues going forward. To account for fluctuation due to the historic systems issues, the Department incorporated enrollment on a date of service basis to inform estimates. Based on date of service measures, enrollment in PACE programs has been steadily increasing, and as a result, the enrollment forecast in the February 2017 request has slightly increased from the November 2016 request.

Per-enrollee costs for FY 2016-17 are determined by cross-walking the actual FY 2016-17 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2016-17 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2016-17 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast. 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. Rates continued to increase in aggregate in FY 2014-15 and FY 2015-16. For FY 2016-17, rates were set at a slightly lower level than in the previous fiscal year.

SB 16-199 requires the Department to develop a new actuarially sound Upper Payment Limit (UPL) methodology that uses "grade of membership methods to characterize the health deficit structure of long-term services and supports populations," provided that sufficient gifts, grants, and donations are received to fund the work done by the actuarial firm contracted to assist with developing this methodology. Until the new methodology is developed, the Department is required to keep rates at or above the percentage of the upper payment limit used to calculate capitations for FY 2016-17. As the upper payment limit is based on nursing facility rates and home and community-based waivers rates, the Department assumed for FY 2017-18 and FY 2018-19 that PACE rates would grow by an average of 1.5% or half of the statutory allowed maximum growth in nursing facilities rates per HB 08-1114, as approximately 50% to 55% of clients in the PACE program are assumed to be high-cost institutional-level clients. The Department anticipates developing the new UPL methodology within the next fiscal year.

The Department notes that the table showing the average cost per enrollee on page EH-15 represents the total net amount spent in a fiscal year on PACE programs divided by the average number of monthly capitations paid in that specific year. These figures include retroactive capitations and recoupments and do not completely reflect the cost of services received in that fiscal year. For example, the

average cost per enrollee in FY 2014-15 factors in approximately $12.9 million in retroactive payments, while the average cost per enrollee in FY 2015-16 encompasses approximately $5.4 million in recoupments.

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.[9] 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:[10]

[9] 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.

[10] 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%
2016	$411.00	0.98%	$123.70	17.92%
2017	$413.00	0.49%	$134.00	8.33%

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 2016-17, the Department inflates the actual expenditure in the first half of FY 2016-17 by half the estimated increase in caseload along with the anticipated growth in Medicare Part B Premiums. The total estimated expenditure for FY 2016-17 is the sum of the first half actual expenditure and the second half estimated expenditure.

To forecast FY 2017-18, the Department first inflates the estimated expenditure from the second half of FY 2016-17 by half the estimated caseload trend for FY 2017-18 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2017-18. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2017-18 and the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2017-

18 is the sum of the first half and second half estimates. The forecast of FY 2018-19 expenditure utilizes the same methodology as the forecast of FY 2017-18. In this request, the Department assumes that the Medicare Part B premium will be $124.40 in CY 2018 and $131.60 in CY 2019.

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 the past, 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 2016-17 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 2016-17. 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 adjusted for 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 2016-17, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2016-17 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For the request and out-year, the Department uses HCBS waiver enrollment growth to project SEP expenditure growth.

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 2016-17 through FY 2018-19.

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.

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.

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.

The only remaining expenditure in the Disease Management program is for the tobacco quit line, administered by the Department of Public Health and Environment (DPHE). The Department pays for the share of costs for the quit line related to serving Medicaid members. The February 2017 request aligns the Department's projected expenditure with the reappropriated funds in DPHE's budget that are funded by Medicaid.

Accountable Care Collaborative

In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Collaborative Care 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.

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 966,000 by June 2016. 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 Accountable Care Collaborative exhibit. The fees in FY 2015-16 include payments for 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 but is no longer included in AwDC PMPMs.

Based on program operation experience, the Department assumes that approximately 22% 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. 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. A portion of these funds would be spent in the following fiscal year as incentive payments to PCMPs with the rest paid as incentive payments to RCCOs or to State Innovation Model (SIM) practices. 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 current fiscal year or the following fiscal year as incentive payments to RCCOs that meet predetermined benchmarks as well as to support SIM practices. For this reason, administrative payments for the ACC were lower in FY 2014-15 and FY 2015-16 than previously anticipated, as some portion of these payments were 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 2014-15, due to Medicaid expansion and the enrollment of clients who were eligible for Medicaid prior to expansion, but not enrolled previously. Enrollment for adults, children, and pregnant women was lower in the first half of FY 2016-17 than anticipated in the previous request. The Department therefore revised its estimates of the savings from the ACC to Acute Care in Exhibit F, to a lower level than was previously assumed.

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 $20.00 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 ACC exhibit.

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 a bottom-line impact for the implementation of the ACC:MMP, as detailed above.

The Department also added a one-time bottom-line impact to account for the recoupment of an overpayment of incentive payments in the first quarter of FY 2015-16.

The November 2016 request included a bottom-line impact to account for movement of clients from the PMPM-based ACC to the new Kaiser-Access health maintenance organization, a pilot payment reform initiative under HB 12-1281. This bottom-line impact was removed in the February 2017 forecast with the assumption that the shift of clients to Kaiser-Access was already accounted for in the base FY 2016-17 ACC enrollment trends.

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 and Health Independence (CAHI).

Currently, there are no prepaid inpatient health plans, as Rocky Mountain Health Plans ended in November of 2014. The exhibit contains historical information only.

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. Beginning January 1, 2017, the enhanced federal match falls to 95%, and on January 1, 2018, it falls to 94%.

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. Beginning January 1, 2017, the enhanced federal match falls to 95%, and on January 1, 2018, it falls to 94%. Clients in this category are not eligible to receive HCBS Waiver services; in cases where it appears that these clients have received waiver

services, those expenditures receive the standard match rate and not the expansion match rate. This incidence can occur for numerous reasons, including clients awaiting disability redeterminations that have caused them to be temporarily moved from their usual eligibility category to this one.

Currently, the Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

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, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditures receive expansion FMAP while the remaining 25% 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.

Continuous Eligibility for Children

HB 09-1293, the Colorado Health Care Affordability Act of 2009, established continuous eligibility for twelve months for children on Medicaid, even if the family experiences an income change during any given year, contingent on available funding. The Department implemented continuous eligibility for children in March 2014 and 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. Previously, the Department showed this adjustment in funding as a General Fund offset under Cash Funds Financing. Effective with the November 2016 request, the Department has broken this population out in its respective service categories in Exhibit J to better show the impact of continuous eligibility for children.

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.

The Department uses historical actuals as a basis for projecting both caseload and per capita costs for this population.

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.

Cash Fund Financing

An offset of $15,700,000 is made from the Hospital Provider Fee to offset the loss of federal matching funds due to the decrease in certification of public expenditure for outpatient hospital services resulting from the authorization of the Hospital Provider Fee in HB 09-1293.

Other Adjustments

- Technical Adjustments of Systems Issue for Children: Adjusts for a data issue that took place July 2015 through December 2015 that incorrectly moved clients from Children's Health Plan (CHP) and Eligible Children into categories for individuals with disabilities, including Children with Disabilities – Buy In. Because of the issue, the Department incorrectly funded services for certain affected clients with Hospital Provider Fee instead of General Fund and will adjust the funding source in FY 2016-17. See the Medicaid caseload narrative for more information.

- Historic Adjustment for Non-Newly Eligible Definition: Starting in FY 2015-16 Q3, the Department updated the income criteria used to identify non-newly eligible population to be consistent with the SPA[11] submitted to CMS. The previously used income criteria did not account for the income limit of couples and consequently excluded members who should have received the blended FMAP for the non-newly eligible population, rather than the expansion FMAP. In FY 2016-17, the $3,386,387 in Hospital Provider Fee accounts for the amount the Department should have paid for non-newly eligible members; there is also a corresponding decrease of $3,386,387 federal funds.

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 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.

[11] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-14-035.pdf

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.

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 2016 Budget Request, the Department has included a breakout for Community Choice Transitions (CCT) – Services under the Community-Based Long-Term Care Services section of these exhibits. This category represents services that individuals consume on waivers while they are transitioning through the CCT program. Prior to this breakout, these services appeared under the HCBS Elderly, Blind, and Disabled waiver.

The Colorado Operations Resource Engine (CORE) was implemented as a replacement for the Colorado Financial Reporting System (COFRS) in July 2014. Under COFRS, the previous fiscal year closed and the data became final at the beginning of the current fiscal year. Under CORE, the previous fiscal year may not close until March of the current fiscal year. This introduces a small degree of uncertainty regarding FY 2015-16 actuals that was not present previously. It is possible that the FY 2015-16 actuals may change in the next request. The Department does not expect major changes to FY 2015-16 actuals. The FY 2015-16 actuals contained within this request reflect data for FY 2015-16 as of January 9th, 2017.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2006-07 through FY 2015-16 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 2015-16 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2015-16 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 2015-16, FY 2016-17 and FY 2017-18 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 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 Department of Human Services (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. Effective with the November 2016 Budget Request, the Department added the request amounts for the current, request, and out years to this exhibit.

EXHIBIT R – FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

Effective with the November 2015 Budget Request, the Department included a new exhibit calculating expected FMAP for the current year, the request year, and the out year. CMS calculates FMAP using Bureau of Economic Analysis (BEA) personal income data and population data for the United States and each state. FMAP is calculated using the following formula:

$$FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2/(\text{Per capita income}_{U.S.})^2 * 0.45)$$

where per capita incomes are based on a rolling three-year average and the FMAP for a given year is taken from the calculation from two years prior.

Due to the nature of this calculation, federal fiscal year FMAP for 2015-16 is calculated using data for calendar year 2013 at the latest. Therefore, FY 2017-18 and FY 2018-19 FMAP estimates are both calculated using historical data from the BEA. These FMAP calculations would only change if the BEA restates its historical data, which can sometimes occur. However, CMS has informed the Department of the FMAP the Department is eligible for beginning both October 1, 2015 and October 1, 2016. Therefore, FMAP for FY 2015-16 and FY 2016-17 is not subject to change, as CMS does not restate announced FMAP even in cases where the BEA's updated

data results in different calculations. The FY 2017-18 and FY 2018-19 FMAP estimates are based on data after calendar year 2015, which the BEA does not estimate. The estimates for personal income come from the legislative council's most recent estimates for the U.S. and Colorado, and the population estimates come from the U.S. census for U.S. data and the Department of Local Affair's most recent estimates for Colorado.

Forecasts throughout this request use these FMAP estimates rather than holding FMAP constant in the request and out years, as was previously done. In cases where a restatement of the BEA's data would result in a different FMAP than was previously anticipated, the Department would submit a supplemental funding request to account for the change in federal funds.

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 2016-17 Budget Cycle Requests

This section describes the impact from legislation passed during the 2016 Legislative Session, including impacts from the Department's FY 2016-17 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

HB 16-1405 – FY 2016-17 Long Bill - Non-Prioritized Cervical Cancer Eligibility Expansion

CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion" extended cervical cancer screenings and treatment to women ages 21 to 39, which will increase enrollment in the Breast and Cervical Cancer Program. Previously, this service was limited to women between the ages of 40 and 64. The cash fund source of this program is the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 16-027 "Medicaid Option for Prescribed Drugs by Mail"

SB 16-027, Medicaid Option for Prescribed Drugs by Mail, allows Medicaid clients to receive maintenance medications through the mail, regardless of physical hardship or third-party insurance status as previously required by SB 08-90. As many maintenance medication prescriptions delivered by mail come in ninety-day supplies, the Department anticipates a shift in receiving medications in larger supplies. This shift would result in a decrease in prescription drug expenditures due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.

HB 16-1408 "Allocation of Cash Fund Revenues from Tobacco MSA"

HB 16-1408, Allocation of Cash Fund Revenues from Tobacco MSA, establishes a new formula for the allocation of the annual payment received by the state as part of the Tobacco Master Settlement Agreement (Tobacco MSA), impacting the Department's allocations for the Children's Basic Health Plan Trust and the Autism Treatment Fund. In addition, the bill increased the General Fund offset for early and periodic screening diagnosis and treatment services provided to eligible children from the Autism Treatment Fund in FY 2016-17 and accounts for partially maintaining the rate increases authorized under Section 1202 of the Affordable Care Act for specific services through FY 2016-17.

The Department requested to continue the rate increases implemented under HB 16-1408 in FY 2017-18 and as part of ongoing payment reform efforts in FY 2018-19 and ongoing in FY 2017-18 R-6 "Delivery System and Payment Reform". In that request, the Department adjusted the estimated impact from the rate increases based on FY 2015-16 actual utilization, resulting in a lower total amount. The Department has not adjusted the impact of the rate increases in this request for FY 2016-17, as the costs accrued in that year are paid from a specific cash fund source that may not be able to support an overexpenditure if the Department's estimates are below actual costs.

HB 16-1097 "PUC Permit for Medicaid Transportation Providers"

HB 16-1097, PUC Permit for Medicaid Transportation Providers, changes the requirements of Medicaid providers of Non-Emergent Medical Transportation (NEMT) to register with the Public Utilities Commission (PUC) as a limited liability carrier instead of as a common carrier. There are fewer restrictions to registering as a limited liability carrier which will have the effect of increasing the number of NEMT providers, which will increase access to transportation and produce savings through increased access to preventive services through NEMT.

HB 16-1321 "Medicaid Buy-In Certain Medicaid Waivers"

HB 16-1321 allows the Department to seek federal approval to implement a buy-in program for people eligible to receive services through the Supported Livings Services waiver, the Persons with Brian Injury Waiver, and the Spinal Cord Injury Waiver Pilot Program and that it shall be implemented no later than three months after federal approval. The Department assumes enrollment into the Buy-In programs will begin July 1, 2017. Starting in FY 2017-18, there will be a mix of existing HCBS-BI and HCBS-SCI clients transitioning into the Buy-In program for the respective waivers and new clients entering the HCBS waiver program through the Buy-In program. The Department included a corresponding increase to the Supported Living Services waiver in FY 2017-18 R-5, Office of Community Living Cost and Caseload Adjustments.

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 until January FY 2017-18 when the new Pharmacy Benefit Management System is implemented and other necessary system edits are completed.

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 1,005,632 in FY 2016-17 as of December 2016. 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 Collaborative Care Organizations (RCCOs), the Primary Care Medical Providers (PCMPs), and the Statewide Data and Analytics Contractor (SDAC), which are outlined below.

The 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.

The 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 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. 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 populations of individuals with disabilities than children. Six-month actual data for FY 2016-17shows that enrollment into the ACC was slower than anticipated in the November 2016 request. While the Department estimates savings for the ACC, these estimates have been reduced from the previous request.

Two new policy changes began in the 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 2016-17, FY 2017-18, and FY 2018-19. RCCO administrative payments include the reductions attributable to the policy changes mentioned above.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Program Administration (Exhibit I, PIHP)	**SDAC**	$2,950,000	$3,059,475	$2,975,000	$2,250,000	$0	$0
	RCCO	$52,945,462	$79,471,841	$102,794,192	$104,315,184	$121,410,054	$127,513,058
	PCMP	$12,674,868	$21,419,450	$30,705,518	$36,689,333	$35,293,824	$37,108,989
	Total Administration	**$68,570,330**	**$103,950,766**	**$136,474,710**	**$143,254,517**	**$156,703,878**	**$164,622,047**
Program Savings (Exhibit F, Acute)	**Incremental**	**($50,147,776)**	**($43,062,535)**	**($28,277,387)**	**($7,652,146)**	**($17,180,454)**	**($16,372,021)**

(1) Total savings is calculated using estimated savings per member from the 2016 Legislative Request for Information (LRFI) on the implementation of the ACC.

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

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. The Department previously implemented all but one of the policy initiatives from this request; the remaining one was implemented July 1, 2016.

- 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.

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. The Department adjusts its request for new clients enrolled in PACE and assumes each additional client will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to Acute Care 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 is calculated as the percentage of the PACE cost per enrollee attributable to Acute Care 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.

The estimated decrease in expenditures due to increased PACE enrollment to Acute Care is $2,766,057 in FY 2016-17, $2,656,345 in FY 2017-18, and $3,345,197 in FY 2018-19.

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 that impact the current budget are as follows:

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 1,300 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 begun the enrollment process, but it has gone more slowly than anticipated. As of December 2016, there were 661 clients enrolled in HIBI. The Department assumes approximately 2% enrollment growth per month through FY 2018-19.

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 2015-16 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 2016-17 through FY 2018-19.

FY 2016-17 through FY 2018-19 Total HIBI Impact from SB 10-167

Item	FY 2016-17	FY 2017-18	FY 218-19
Provider Payment	$231,843	$288,894	$365,824
Premiums Payment	$1,681,335	$2,095,069	$2,652,970
Total Savings (Realized in Acute Care)	($4,116,373)	($5,129,307)	($6,495,204)
Incremental Savings for Bottom-Line Impact in Exhibit F	($531,403)	($1,012,935)	($1,365,896)
Total Impact	**($2,734,598)**	**($3,758,279)**	**($5,207,765)**

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 estimates the total impact to Medical Services Premiums to be $4,177,950 total funds costs avoided in FY 2016-17, $5,912,689 costs avoided in FY 2017-18, and $7,812,004 costs avoided in FY 2018-19. These figures do not include any expenditure from the rebalancing fund. Please see the narrative on CCT in Exhibit G for more detail.

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 one element of this budget action has not been implemented.

- *Dental Efficiencies*: The Department will clarify rules regarding eligibility for orthodontics and evaluate payment structure and methods. These clarifications will stop up-front payments for orthodontia as well as reduce inappropriate reimbursement for imaging and evaluation treatments. Full implementation is noted in FY 2017-18 due to delays in the stakeholder and rulemaking processes, with an additional reduction of $1,704,632.

FY 2014-15 R-7: Adult Supported Living Service Waiting List Reduction

The Department was approved funding to decrease the waitlist for the Supported Living Services waiver. Savings to Community-Based Long-Term Care result from clients utilizing waiver services in place of State Plan services. The annualization of this policy is expected to decrease expenditure by $185,234 in FY 2016-17

FY 2014-15 R-8: Developmental 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 disentangle the two policies 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 HBCS-CES waiver programs that was used to rebalance over-expenditure in the HBCS-SLS waiver program. The request included 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. The annualization of these policies is expected to decrease expenditure by $281,540 in FY 2016-17.

FY 2014-15 R-10: 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, resulting in savings through better management of medical conditions and proper use of specialty care. The software necessary for the implementation of this policy was delayed and this program implemented in January 2017 for interested providers. This is expected to decrease expenditures by $136,221 in FY 2016-17.

FY 2014-15 BA-10: Continuation of the "1202 Provider Rate Increase"

The Department continued the 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, through June 30, 2016. The annualization of this policy is expected to be a decrease of $118,943,931 in FY 2016-17, to remove the impact of the higher rates accounting for runout.

FY 2014-15 BA-12: State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees

The Department enrolled clients dually eligible for Medicaid and Medicare in the Accountable Care Collaborative (ACC) so that they can receive care coordination, reducing duplicative use of services. The annualization of this program is expected to decrease expenditure by $12,210,629 in FY 2016-17.

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.

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

HB 14-1357 made several changes to in-home support services (IHSS) provided by the Department. This bill allowed IHSS to be provided inside the home or within the community, added spouses as an eligible family member to act as an attendant providing IHSS to an HCBS waiver client, allowed eligible clients or their representative the ability to determine the amount of oversight needed, allowed family members to be reimbursed for providing IHSS, expanded IHSS to clients receiving services through the Spinal Cord Injury waiver, and added IHSS to the list of services under the Elderly, Blind, and Disabled waiver program. These program changes were implemented after several delays in March 2016 and are expected to increase expenditure by $1,117,446 in FY 2016-17.

FY 2015-16 R-7 Participant Directed Programs Expansion

The Department was approved funding to expand Consumer Directed Support Services (CDASS) to the Supported Living Services waiver. Savings to Community-Based Long-Term Care (CBLTC) result from clients substituting long-term home health for the health maintenance component of CDASS on the waiver. The Department is still awaiting CMS approval and anticipated implementation will begin on July 1, 2017.

FY 2015-16 R-12 Community Provider Rate Increases

The Department was approved funding to increase eligible provider rates 0.50% across the board. The FY 2016-17 annualization amount for this policy is estimated at $3,400,588. For some services, the expected increase in expenditure is different from appropriation due to the need for a State Plan Amendment and approval from CMS resulting in delays in the start date of the increase.

FY 2015-16 R-12 Targeted Community Provider Rate Increase

The Department was approved funding for the purpose of addressing issues with client access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F and Exhibit G. The annualization amount of the targeted rate increases is an estimated $12,871,891 in FY 2016-17. For some services, the expected increase in expenditure is different from appropriation due to the need for a waiver or State Plan Amendment and approval from CMS resulting in delays in the start date of the increase.

FY 2015-16 JBC Action, Raising the Cap on Home Modifications

The JBC increased the cap on home modifications during the 2015 Legislative Session. The Department received approval in late January and was implemented March 1, 2016. The annualization of this policy is expected to increase expenditure by $564,288 in FY 2016-17.

HB 15-1186 Children with Autism Waiver

HB 15-1186 reduces the wait list for the Children with Autism waiver, and also extends the maximum age from six years old to eight years old and guarantees three years of service once a child is on the waiver. This would help ensure that clients do not age out of the waiver before they are on the waiver. The bill would also allow for the use of General Fund to cover CWA services after the Autism Treatment Fund is exhausted. To comply with this bill, the Department requires a Waiver Amendment, which must be approved by CMS. On September 14, 2015, the expansion of the waiver was denied by CMS. CMS directed the Department to provide medically necessary behavioral therapies for children with autism provided through the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program instead. The Department is waiting for CMS guidance on what to do with the current waiver and will properly adjust

accordingly as information is obtained. Currently, the Department is removing the impact of the expansion from FY 2016-17, but keeping a portion of the impact in FY 2016-17 to account for utilization of EPSDT services that are medically necessary.

Other Adjustments to the February 2017 Budget Request

- Copay 5% of Income, adjusts for the additional amount the Department will need to pay providers to comply with a federal rule stating that copays cannot exceed 5% of a Medicaid client's income. The new MMIS, which will be implemented March 1, 2017, must demonstrate compliance with this rule; the current MMIS is unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new system will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department will need to reimburse providers for the full cost of the service without subtracting copay for these clients.
- Home Health Final Rule (Location Expansion), expands where home health services can be received. As part of 42 CFR 440 "Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health," CMS specified that states may not restrict beneficiaries from receiving home health services in any setting in which normal life activities take place. The adjustment accounts for an increase in utilization due to clients desiring to receive additional home health services in the community. The Department must demonstrate compliance with this rule by July 1, 2017.
- Hepatitis C Criteria Change, accounts for an increase in hepatitis C drug treatments. After reviewing hepatitis C criteria in place, the Department expanded treatment to members with a fibrosis score of F2 and other members who were previously restricted from treatment through the PAR process.

Policy Changes with an Indeterminate Fiscal Impact

- Transgender Policy Change – A recently issued Department of Health and Human Services rule, titled Nondiscrimination in Health Programs and Activities, takes effect this year. This final rule implements Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The rule mandates that Medicaid agencies cover gender transition-related services if those services are currently covered for other medically necessary reasons. The Department is not creating a new benefit in response to this rule, but codifying an existing benefit to ensure that transgender individuals can access existing services, such as mastectomy or hysterectomy, when medically necessary for the purpose of gender transition.
- Face-to-Face Federal Requirements for Home Health – 42 CFR 440 "Face-to-Face Requirements for Home Health Services: Policy Changes and Clarifications Related to Home Health" requires physicians to document a face-to-face encounter that is related to the primary reason the member requires home health services no more than 90 days before or 30 days after the start of services. For the initial ordering of medical supplies, equipment, or appliances, an authorized medical care giver must document a face-to-face encounter occurred no more than six months prior to the member receiving those medical supplies. The Department estimates an

indeterminate fiscal impact in physician's visits as a result of these sections of the Face-to-Face rules as it is unable to determine currently to what extent members are receiving home health and DME services without an initial encounter with a physician.